| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>31826<br><br>Based on resident interview, record review and staff interview the facility failed to ensure residents were treated with respect and dignity. Resident #24 was provided care by a male Nurse Aide when it was known she preferred a female Nurse Aide to provide her care. In addition a Nurse Aide took photographs of Resident #63, #65, #24, #36, and #28 to prove they were in need of incontinence care before providing the needed care. This failed practice was true for five (5) of five (5) residents reviewed for the care area of dignity during the long term care survey process. Resident Identifiers: #63, #65, #24, #36 and #28. Facility Census: 63.<br><br>Findings Include:<br><br>a) Resident #24<br><br>During an interview on 07/22/24 at 1:29 PM Resident #24 stated, I don't think they can read to good here. When she was asked to elaborate the resident stated, They know I only want a female nurse aide. It is written down somewhere, but a few days not too long ago I had a male nurse side. He is a good aide and he took good care of me, but I did not like it because he was a man.<br><br>A review of the residents care plan found Resident #24 has a care plan related to Activities of Daily Living (ADL) self care performance. One of the interventions related to this care plan indicated the resident prefers only female staff members for incontinence care.<br><br>A review of the ADL flow sheet found a male provided Incontinence care to Resident #24 on 07/12/24 and 07/17/24 Nurse Aide #15 (a male Nurse Aide) provided Resident #24 care in the ADL area of toilet use.<br><br>A review of the daily nurse aide assignment sheets for the dates of 07/12/24 found Nurse Aide #15 was the assigned caregiver for Resident #24. Also written on the sheet was Resident #24's room number and indicated she preferred a female nurse aide. On 07/17/24 Nurse Aide #15 was not assigned to Resident #24. However, he did document he completed care for Resident #24.<br><br>During and interview with Social Worker # 75 on 07/25/24 at 10:42 AM it was confirmed Resident #24 did receive care from a male nurse aide on 07/12/24 and 07/17/24.<br><br>b) Nurse Aide #160 .<br><br>(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: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the reportable incidents on 07/22/24 there were five (5) reportables noted all related to the same issue dated 05/13/24 for an incident which took place on 05/11/24. Nurse Aide #160 had admitted to taking photographs of Resident #63, #65, #24, #36 and #28. The photographs were taken on the nurse aides personal cell phone. During the course of the investigation Nurse Aide #160 admitted to taking the photos and stated she did so to prove the residents were in need of incontinence care. The residents were not her assigned residents and she wanted to prove with photos the assigned aide was not giving them care. The photos did not contain the residents faces but the residents briefs and buttocks were exposed.<br><br>Of all five (5) residents, Resident #24 was the only one who was cognitively intact and could be interviewed. An interview with Resident #24 on 07/25/24 at approximately 9:00 am, confirmed she remembered the nurse aide taking the photos. She stated, I didn't object or tell her to stop. I just assume you all (referring to staff of the facility) know what you are doing and it is necessary. I did tell her not to put may face in it. She stated I remember, I was wearing and white shirt and my brief was wet and I needed changed.<br><br>During an Interview with Social Worker #75 at 10:13 am on 07/25/24, she confirmed Nurse Aide #160 did take photographs of all five (5) residents. She stated, Nurse Aide #160 showed them to the Assistant director of nursing the following morning and that is how we became aware of it. Social Worker #75 agreed, Nurse Aide #160 should not have taken the photos. She stated, she should not even have her phone on the floor while providing care. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>50552<br><br>Based on record review and staff interview, the facility failed to ensure the resident and or representative was informed in advance by the physician, other practitioner or health professional of the risks and benefits of proposed care, of treatment alternatives or treatment options and to choose the alternative option preferred prior to the administration of an psychotropic medication. This was true for 1 (one) of 5 (five) residents reviewed for unnecessary medications in the Long Term Care Survey Process. Resident identifier: #5. Facility census: 63.<br><br>Findings include:<br><br>a) Resident #5<br><br>On 07/24/24 at approximately 2:24 PM, a review of Resident #5's medical record was performed which revealed Resident #5 was receiving 2 (two) antipsychotic's and 1 (one) antidepressant. The physicians orders were as follows:<br><br>* Quetiapine Fumarate (Seroquel) 25 mg 1 (one) tablet by mouth at bedtime for dementia with behavioral disturbance.<br><br>* Nuplazid 34 mg 1 (one) capsule by mouth one time a day for Parkinson's with psychosis as evidenced by delusions/hallucination.<br><br>* Fluoxetine (Prozac) 20 mg 1 (one) capsule by mouth one time a day for depression.<br><br>At this time, a review of Resident #5's diagnosis list and Psychotherapeutic Medication Informed Consents was conducted. Resident #5 was noted to have the following diagnoses:<br><br>* Alzheimer's Disease, Unspecified Date 03/22/19.<br><br>* Dementia in other Diseases Classified Elsewhere, Unspecified Severity, with Other Behavioral Disturbance Date 02/02/22.<br><br>* Hallucinations, Unspecified Date 09/2/21.<br><br>* Other Hallucinations Date 12/07/22.<br><br>* Major Depressive Disorder, Single Episode, unspecified Date 03/22/19.<br><br>During the review of Resident #5's Psychotherapeutic Medication Informed Consents it was revealed Resident #5 had signed consents for the following medications: Seroquel, Prozac and Xanax.<br><br>On 07/24/24 at approximately 3:40 PM, a review of the policy and procedure titled, Use of Psychotropic Medication was conducted which revealed that resident's and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive, Charleston, WV 25311 | |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/24/24 at 3:45 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON acknowledged there is no documentation that Resident #5 and/or her Representative received education on the risks and benefits, as well as alternative treatments/non-pharmacological interventions, of the administration and use of Nuplazid. In addition, the DON acknowledged there was no form titled, Psychotherapeutic Medication Informed Consent, present for the use of Nuplazid for Resident #5.<br><br>. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>50552<br><br>Based on record review and staff interview the facility failed to notify the physician of a significant weight loss for Resident #14. This was true for 1 (one) of 2 (two) residents reviewed for the care area of nutrition during the Long Term Care Survey Process.Resident identifier: Resident #14.n Facility census: 63.<br><br>Findings include:<br><br>a) Resident #14<br><br>On 07/24/24 at 10:09 AM, a review of Resident #14's medical record was conducted which revealed on 02/02/24, Resident #14 weighed 203.2 lbs. On 07/09/24, Resident #14 weighed 178.2 pounds which is a -12. 30 % loss. Further review of Resident #14's medical record revealed no evidence te residents attending physcian had been notified of the residents weight loss.<br><br>On 7/24/24 at approximately 2:30 PM, a review of Policy and Procedure titled, Weight Monitoring revealed that the physician should be informed of a significant change in weight.<br><br>On 07/24/24 at 3:38 PM, during an interview with the Director of Nursing (DON), the DON acknowledged that per facility policy and procedure Resident #14's physician should have been notified of the weight loss and was not. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826<br><br>Based on resident interview, staff interview, and record review the facility to ensure residents were free from mental abuse and additionally failed to identify what happened to the residents as Mental Abuse when the investigation was complete. Nurse Aide #160 took photos of Resident #63, #65, #24, #36, and #28 which to a reasonable person would cause the resident to suffer humiliation, shame and/or degradation. This was true for Five (5) of eight (8) residents reviewed for the care area of Abuse during the long term care survey process. Resident Identifiers: #63, #65, #24, #36 and #28. Facility Census: 63.<br><br>Findings include:<br><br>a) Nurse Aide (NA) #160<br><br>A review of the facility's reportable incidents found on 05/13/24 the facility reported five (5) separate reportable incidents related to the same nurse aide.<br><br>A review of each reportable found they all contained the following allegation, Nurse aide took photos of resident to prove incontinence care was needed. Photos of resident's did not include their face; however briefs with incontinence and buttocks were showing in photos. This was the allegation listed on each reportable for Resident #63, #65, #24, #36, and #28.<br><br>A review of the investigation revealed the following statements were obtained for each of the five (5) investigations (typed as written):<br><br>-- Statement from Licensed Practical Nurse (LPN) #161 (a former facility employee). The statement is dated 05/14/24. I heard (First name and Last Initial of NA #160) say something about taking pictures of the residents. (First name of LPN #17) and I turned around and told her not to take pictures because it was a HIPPAA violation. (First Name of Registered Nurse (RN) #44) addressed this with (first name of NA #160) in the charting room. I did not hear anymore about it.'<br><br>-- Statement from LPN #59. Dated 05/14/24. (First Name of LPN #161) and (First Name of LPN #17) told me that (First name and last initial of NA #160) took pictures of the residents that needed changed. I told (First name of RN #44) about this concern. (First name of RN #44) addressed (First Name of NA #160). She called her into the charting room. I was not present for this conversation. I did not see the pictures.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -- Statement from RN #44. This statement did not contain a date. (First name and Last initial of NA #160) told me she took photos of (first name of Resident #36). The other nurses told me it was a HIPPAA violation to take resident's photos. I took (First name and last initial of NA #160) in the charting room and [NAME] her I wasn't certain, but she could possibly get in trouble for taking pictures. I did not instruct her to delete them because I wasn't sure, because I was only going off what other nurses told me. Toward the end of my shift, (First name and last initial of NA #160) came to me and said she knew it was not a HIPPAA violation because she'd been a nurse aide a few years now. I told he I didn't know and was just going by what the other nurses told me and I didn't want her to get in trouble.<br><br>-- Statement from LPN #17 dated 05/13/24. During dinner either (First Name of NA #19) or (First Name of NA #160) came to the nurse's station, stating that several residents needed care on the 300 hall. The nurses went to the hall to check the residents needing care. Later I overheard (First name of RN #44) say she though (First name of NA #160) was taking pictures of residents. (First name of LPN #59), LPN and I told (First Name of RN #44) that it wasn't appropriate, and she could get in trouble for that. (First name of RN #44) pulled her aside and spoke to her about the inappropriateness of photographing residents.<br><br>-- Statement from NA #160 dated 05/15/24. 'I did take pictures of (First and Last Name of Resident #24), (First and Last Name of Resident #65), (First and Last Name of Resident #36), (First and Last name of Resident #25), and (First and Last Name of Resident #63) Saturday evening. I did not include their faces or any identifying information. I did not show anyone else the photos, until I showed (First and Last name of the Assistant Director of Nursing (ADON)) on Monday. Besides their roommate, (First Name of NA #19) CNA was the only person present. I was not directed to take these photos; I took them on my own. (First name of RN #44) did pull me aside and state she was unsure, but the other nurses were saying this could breach HIPPAA. She sated the other nurses were saying I might get in trouble for taking the photos. I did not delete the photos at that time. I deleted the photos immediately when (First and Last Name of the Nursing Home Administrator (NHA)), NHA directed me to do so.<br><br>Included in the investigations for Resident #36, #63, #25 and #65 was the following Narrative investigation report (typed as written):<br><br>The social worker observed the resident for psychosocial or emotional distress, and the resident remains at baseline. The CNA, (First and Last Name of NA #160) was interviewed She admitted to taking the photos, but did not include the resident's face or any other identifying information. She also did not share the photos with anyone until Monday when she self reported to the Assistant Director of Nursing. (First and Last Name of NA #160), CNA was disciplined according to the company handbook for violating work rules. She was required to complete re-education on resident rights, HIPPAA and abuse prior to returning to work.<br><br>Please note Resident #36, #63, #25, and #65 are severely cognitively impaired and could not be interviewed about the situation or verbalize how this made them feel.<br><br>Resident #24 was the only resident who was cognitively intact and was able to be interviewed, therefore her Narrative investigation report was different than the other four (4) residents. It read as follows:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive Charleston, WV 25311 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The social worker interviewed and observed the resident for psychosocial or emotional distress, and the resident remains at baseline. (First Name of Resident #24) was also interviewed and stated she was aware the photo was taken and wasn't opposed to it. The CNA, (First and Last Name of NA #160) was interviewed She admitted to taking the photos, but did not include the resident's face or any other identifying information. She also did not share the photos with anyone until Monday when she self reported to the Assistant Director of Nursing. (First and Last Name of NA #160), CNA was disciplined according to the company handbook for violating work rules. She was required to complete re-education on resident rights, HIPAA and abuse prior to returning to work.<br><br>This surveyor also interviewed Resident #24 on 07/25/24 at approximately 9:00 am. She indicated she remembered the nurse aide taking the photos. She stated, I didn't object or tell her to stop. I just assume you all (referring to staff of the facility) know what you are doing and it is necessary. I did tell her not to put may face in it. She stated I remember, I was wearing and white shirt and my brief was wet and I needed changed. She then asked this surveyor if I knew why the nurse aide had taken the pictures because no one ever told her why she had taken the pictures. Resident #24 was asked if anyone from the facility had ever asked her about the pictures. Resident #24 stated, You are the first person to talk to me about them since she took them.<br><br>An interview with Social Worker #75 was completed on 07/25/24 at 10:06 AM. She stated, they did not substantiate this as abuse because the photos did not include the residents faces and she deleted them when instructed too. Social Worker #75 stated We know what she did was wrong and inappropriate but we did not feel it was abuse.<br><br>Social Worker #75 was asked if NA #160 was terminated as a result of the investigation she stated, no she was not terminated she quit after completing her required training.<br><br>A review of the State Operations Manual (SOM) on page 75 in the interpretive guidelines for F600 the following is written pertaining to mental abuse:<br><br>Mental abuse includes abuse that is facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident(s), regardless of whether the resident provided consent and regardless of the resident ' s cognitive status, the surveyor must consider non-compliance related to abuse at this tag. This would include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident ' s face, labeling resident ' s pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position. Depending on what was photographed or recorded, physical and/or sexual abuse may also be identified.<br><br>No further information was provided prior to the conclusion of the survey. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive Charleston, WV 25311 |

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 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826

Based on record review and staff interview the facility failed to implement their policy titled: Compliance with Reporting Allegations of Abuse/Neglect/Exploitation. The faicliity failed to report all allegations of abuse related to Resident #12. Also for Resident #63, #65, #24, #36 and #28 the facility failed to identify the actions of Nurse Aide #160 as mental abuse when she took pictures of the residents in their briefs. This failed practice was true for six (6) of eight (8) residents reviewed for the care area of abuse during the long term care survey process. Resident Identifiers: #12. #63, #65, #24, #36, and #28. Facility Census: 63.

a) Resident #12

On 07/24/24 at 1:28 PM the Director of Rehab (DOR) was interviewed in regards to a complaint investigation in which it was alleged Physical Therapist (PT) #102 was documenting and billing for therapy services which the residents never received. When asked if anyone had ever brought to her attention that PT #102 may be billing and documenting therapy services which the residents never received she stated, Yes Physical Therapist Assistant (PTA) #98 had reported this to her. She stated, she called her corporate office and they advised her to take the social worker and go talk to all the residents currently receiving therapy.

During an interview with Social Worker #75 on 07/24/24 at 2:18 PM, Social Worker #75 stated, PTA #98 came into her office and reported Resident #12 stated she did not receive her therapy yesterday. (She could not recall the date of this interaction.) The social worker stated she went over to therapy immediately and asked Resident #12 about this. She indicated the resident stated she did not receive therapy yesterday. The social worker then asked the DOR for a print out of any therapy notes for the previous day and was given a note written by PT #102 indicating the resident was given therapy.

The social worker was then asked if Resident #12 was cognitively intact and she stated, She is she would remember if she got therapy the day before or not.

When asked if this allegation was reported she stated, No I took it to the Administrator who reported to the compliance officer at the therapy departments corporate office.

During an interview with the Nursing Home Administrator on 07/24/24 at 2:23 PM he confirmed he did not report this allegation. He stated, we didn't know if it was a documentation issue or if the PT did not perform the services he claimed he did. He stated I referred it to their corporate compliance and left it at that. The NHA was asked to provide the results of the therapy departments compliance investigation. He provided the following summary of the investigation on 07/25/24. This is typed as written:

Interviews of patients did not substantiate allegations. DOR instructed to remove billing 6/10 for (First and Last name of Resident #12) as questionable, but not substantiated as not provided. It also came to the DOR's attention that (First and Last Name of PTA #98) may have came in during the weekend to meet with those patients to interview them potentially skewing the investigation process. In addition, (First Name of PTA #98) refused to meet with the compliance office and cooperate with the investigation.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy titled, Compliance with reporting Allegations of Abuse/neglect/exploitation found the following:<br><br>. Reporting/Response: The facility will report all alleged violation and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation .<br><br>b) Nurse Aide (NA) #160<br><br>A review of the facility's reportable incidents found on 05/13/24 the facility reported five (5) separate reportable incidents related to the same nurse aide.<br><br>A review of each reportable found they all contained the following allegation, Nurse aide took photos of resident to prove incontinence care was needed. Photos of resident's did not include their face; however briefs with incontinence and buttocks were showing in photos. This was the allegation listed on each reportable for Resident #63, #65, #24, #36, and #28.<br><br>A review of the investigation revealed the following statements were obtained for each of the five (5) investigations (typed as written):<br><br>-- Statement from Licensed Practical Nurse (LPN) #161 (a former facility employee). The statement is dated 05/14/24. I heard (First name and Last Initial of NA #160) say something about taking pictures of the residents. (First name of LPN #17) and I turned around and told her not to take pictures because it was a HIPPAA violation. (First Name of Registered Nurse (RN) #44) addressed this with (first name of NA #160) in the charting room. I did not hear anymore about it.'<br><br>-- Statement from LPN #59. Dated 05/14/24. (First Name of LPN #161) and (First Name of LPN #17) told me that (First name and last initial of NA #160) took pictures of the residents that needed changed. I told (First name of RN #44) about this concern. (First name of RN #44) addressed (First Name of NA #160). She called her into the charting room. I was not present for this conversation. I did not see the pictures.<br><br>-- Statement from RN #44. This statement did not contain a date. (First name and Last initial of NA #160) told me she took photos of (first name of Resident #36). The other nurses told me it was a HIPPAA violation to take resident's photos. I took (First name and last initial of NA #160) in the charting room and [NAME] her I wasn't certain, but she could possibly get in trouble for taking pictures. I did not instruct her to delete them because I wasn't sure, because I was only going off what other nurses told me. Toward the end of my shift, (First name and last initial of NA #160) came to me and said she knew it was not a HIPPAA violation because she'd been a nurse aide a few years now. I told he I didn't know and was just going by what the other nurses told me and I didn't want her to get in trouble.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -- Statement from LPN #17 dated 05/13/24. During dinner either (First Name of NA #19) or (First Name of NA #160) came to the nurse's station, stating that several residents needed care on the 300 hall. The nurses went to the hall to check the residents needing care. Later I overheard (First name of RN #44) say she though (First name of NA #160) was taking pictures of residents. (First name of LPN #59), LPN and I told (First Name of RN #44) that it wasn't appropriate, and she could get in trouble for that. (First name of RN #44) pulled her aside and spoke to her about the inappropriateness of photographing residents.<br><br>-- Statement from NA #160 dated 05/15/24. 'I did take pictures of (First and Last Name of Resident #24), (First and Last Name of Resident #65), (First and Last Name of Resident #36), (First and Last name of Resident #25), and (First and Last Name of Resident #63) Saturday evening. I did not include their faces or any identifying information. I did not show anyone else the photos, until I showed (First and Last name of the Assistant Director of Nursing (ADON)) on Monday. Besides their roommate, (First Name of NA #19) CNA was the only person present. I was not directed to take these photos; I took them on my own. (First name of RN #44) did pull me aside and state she was unsure, but the other nurses were saying this could breach HIPPAA. She sated the other nurses were saying I might get in trouble for taking the photos. I did not delete the photos at that time. I deleted the photos immediately when (First and Last Name of the Nursing Home Administrator (NHA)), NHA directed me to do so.<br><br>Included in the investigations for Resident #36, #63, #25 and #65 was the following Narrative investigation report (typed as written):<br><br>The social worker observed the resident for psychosocial or emotional distress, and the resident remains at baseline. The CNA, (First and Last Name of NA #160) was interviewed She admitted to taking the photos, but did not include the resident's face or any other identifying information. She also did not share the photos with anyone until Monday when she self reported to the Assistant Director of Nursing. (First and Last Name of NA #160), CNA was disciplined according to the company handbook for violating work rules. She was required to complete re-education on resident rights, HIPPAA and abuse prior to returning to work.<br><br>Please note Resident #36, #63, #25, and #65 are severely cognitively impaired and could not be interviewed about the situation or verbalize how this made them feel.<br><br>Resident #24 was the only resident who was cognitively intact and was able to be interviewed, therefore her Narrative investigation report was different than the other four (4) residents. It read as follows:<br><br>The social worker interviewed and observed the resident for psychosocial or emotional distress, and the resident remains at baseline. (First Name of Resident #24) was also interviewed and stated she was aware the photo was taken and wasn't opposed to it. The CNA, (First and Last Name of NA #160) was interviewed She admitted to taking the photos, but did not include the resident's face or any other identifying information. She also did not share the photos with anyone until Monday when she self reported to the Assistant Director of Nursing. (First and Last Name of NA #160), CNA was disciplined according to the company handbook for violating work rules. She was required to complete re-education on resident rights, HIPAA and abuse prior to returning to work.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This surveyor also interviewed Resident #24 on 07/25/24 at approximately 9:00 am. She indicated she remembered the nurse aide taking the photos. She stated, I didn't object or tell her to stop. I just assume you all (referring to staff of the facility) know what you are doing and it is necessary. I did tell her not to put may face in it. She stated I remember, I was wearing and white shirt and my brief was wet and I needed changed. She then asked this surveyor if I knew why the nurse aide had taken the pictures because no one ever told her why she had taken the pictures. Resident #24 was asked if anyone from the facility had ever asked her about the pictures. Resident #24 stated, You are the first person to talk to me about them since she took them.<br><br>An interview with Social Worker #75 was completed on 07/25/24 at 10:06 AM. She stated they did not substantiate this as abuse because the photos did not include the residents faces and she deleted them when instructed too. Social Worker #75 stated We know what she did was wrong and inappropriate but we did not feel it was abuse.<br><br>Social Worker #75 was asked if NA #160 was terminated as a result of the investigation she stated, no she was not terminated she quit after completing her required training.<br><br>A review of the State Operations Manual (SOM) on page 75 in the interpretive guidelines for F600 the following is written pertaining to mental abuse:<br><br>Mental abuse includes abuse that is facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident(s), regardless of whether the resident provided consent and regardless of the resident ' s cognitive status, the surveyor must consider non-compliance related to abuse at this tag. This would include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident ' s face, labeling resident ' s pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position. Depending on what was photographed or recorded, physical and/or sexual abuse may also be identified.<br><br>A review of the faiclity's policy titled, Compliance with reporting Allegations of Abuse/neglect/exploitation found the following:<br><br>.4. Identification: The facility will identify events, occurrences, patterns, and trends that may constitute: .b. Abuse . iv. Mental abuse include, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident .<br><br>No further information was provided prior to the conclusion of the survey. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>31826<br><br>45171<br><br>Based on record review and staff interview the facility failed to report all allegations of abuse and/or neglect to the appropriate agencies as required by regulation. Resident Identifiers: #12 and #5. Facility Census: 63<br><br>Findings included:<br><br>a) Resident #12<br><br>On 07/24/24 at 1:28 PM the Director of Rehab (DOR) was interviewed in regards to a complaint investigation in which it was alleged Physical Therapist (PT) #102 was documenting and billing for therapy services which the residents never received. When asked if anyone had ever brought to her attention that PT #102 may be billing and documenting therapy services which the residents never received she stated, Yes Physical Therapist Assistant (PTA) #98 had reported this to her. She stated, she called her corporate office and they advised her to take the social worker and go talk to all the residents currently receiving therapy.<br><br>During an interview with Social Worker #75 on 07/24/24 at 2:18 PM, Social Worker #75 stated, PTA #98 came into her office and reported that Resident #12 stated she did not receive her therapy yesterday. (She could not recall the date of this interaction.) The social worker stated she went over to therapy immediately and asked Resident #12 about this. She indicated the resident stated she did not receive therapy yesterday. The social worker then asked the DOR for a print out of any therapy notes for the previous day and was given a note written by PT #102 indicating the resident was given therapy.<br><br>The social worker was then asked if Resident #12 was cognitively intact and she stated, She is she would remember if she got therapy the day before or not.<br><br>When asked if this allegation was reported she stated, No I took it to the Administrator who reported to the compliance officer at the therapy departments corporate office.<br><br>During an interview with the Nursing Home Administrator on 07/24/24 at 2:23 PM he confirmed he did not report this allegation. He stated, we didn't know if it was a documentation issue or if the PT did not perform the services he claimed he did. He stated I referred it to their corporate compliance and left it at that. The NHA was asked to provide the results of the therapy departments compliance investigation. He provided the following summary of the investigation on 07/25/24. This is typed as written:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
| --- | --- | --- | --- |
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interviews of patients did not substantiate allegations. DOR instructed to remove billing 6/10 for (First and Last name of Resident #12) as questionable, but not substantiated as not provided. It also came to the DOR's attention that (First and Last Name of PTA #98) may have came in during the weekend to meet with those patients to interview them potentially skewing the investigation process. In addition, (First Name of PTA #98) refused to meet with the compliance office and cooperate with the investigation.<br><br>c). Resident #5<br><br>On 07/22/24 at approximately 1:29 PM, during a review of the facility records it was identified on 06/16/24 Resident #5 was reported to have been laying on the floor and yelling for help. It is further identified the Nursing Assistant (NA) #140 had written a statement in regards to the incident and NA #140 admitted to putting Resident back in her bed without allowing the Licensed Practical Nurse #68 to assess the resident for injuries. The NA further stated in her statement she herself assessed the resident to make sure she didn't have any marks, bruises or skin tears. With further review it is identified the facility failed to report the incident in which the resident was not provided the services which was necessary to avoid any potential harm.<br><br>On 07/24/24 at approximately 1:17 PM, during an interview with the Administrator, he stated he did not feel this was a reportable at the time of the incident. He said he felt it was a breech of their policy and procedure for falls. He further stated he was looking at it as a work rule violation. The Administrator stated that NA #140 had became angry during the meeting when discussing the incident on 06/29/24 and that NA #140 tossed her badge down and left. During this interview the potential of harm the NA's actions created by not providing the service of a nurse assessing Resident #5 for injury and NA #140 purposely lifting the resident up and putting the resident back to bed without the assessment was reviewed. The Administrator agreed and stated he had an obligation to reporting this incident and was going to do so. He further stated NA #140's statement would substantiate the allegation as she admitted to doing it.<br><br>49650 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515174 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>31826<br><br>Based on record review and staff interview the facility failed to notify the ombudsman when Resident #23 was transferred to the hospital. This was true for one (1) of four (4) residents reviewed for the care area of hospitalization during the Long term care survey process. Resident Identifier: #23. Facility Census: 63.<br><br>a) Resident #23<br><br>A review of Resident #23's medical record on 07/23/24 found the residents was transferred to the hospital on 03/25/24.<br><br>An interview with Social Worker #75 on 07/25/24 at 9:45 AM found the resident did not print on the discharge list because he was on behold during this hospital stay. She confirmed the ombudsman was not notified of this transfer because he did not print on the discharge list for March 2024 and that is the list she faxes to the ombudsman monthly. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave.<br><br>31826<br><br>Based on record review and staff interview the facility failed to notify the resident and/or the resident representative of the bedhold policy when Resident #23 was transferred from the facility on three (3) occasions. This was true for one (1) of four (4) residents reviewed for the care area of hospitalization s during the long term care survey process. Resident Identifier: #23. Facility census: 63.<br><br>Findings Include:<br><br>a) Resident #23<br><br>A review of Resident #23's medical record on 07/23/24 found the resident was transferred to the hospital on 03/25/24, 05/31/24, and 07/12/24. The facility was asked to provide the bedhold policy notification for the three (3) discharges. They provided a bed hold policy for Resident #23 for each of the dates listed, however the bed hold policies were not signed by the resident and/or their representative. There was also no notes indicating the facility had verbally spoke with the resident and/or representative about the bed hold policy to see if they wanted to pay the bed hold fee.<br><br>An interview with the Admissions Director on 07/25/24 at 11:36 am confirmed she does not call or mail the bed hold notices. She stated we are usually no at bedhold and getting them readmitted is usually not a problem so I didn't think I needed to call them or mail the notice. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>49650<br><br>Based on medical record review and staff interview, the facility failed to complete an accurate [NAME] Virginia Pre-admission Screening (PASR) to include all diagnosis with a new condition. This was true for two (2) of two (2) residents whose PASR's were reviewed during the long term care survey process. Resident identifier #1 and #20. Facility Census: 63<br><br>Findings included:<br><br>a) Resident #1<br><br>During a medical record review of Resident #1 on 07/22/24 at 3:09 PM it was identified the most recent PASR was completed on 08/02/21 and this PASR did include a level II completion. A further review of this PASR found the PASR did not identify Resident #1's diagnosis of major depression disorder dated 07/01/21 and Resident #1 diagnosis of psychotic disorder with delusions dated 10/20/21 as Resident #1's current conditions at the time the PASR was completed.<br><br>During an interview on 07/23/24 at approximately 9:15 AM with Registered Nurse Clinical Reimbursement Coordinator (RN CRC) #16, she stated, the diagnosis should have been added to the PASR and it would be resubmitted now.<br><br>b) Resident #20<br><br>On 07/22/24 at 12:28 PM during a medical record review of Resident #20's medical record it was discovered the resident has a diagnosis of bipolar disorder dated 01/07/20 and a diagnosis of major depressive disorder dated 01/07/20. A further review of Resident #20's most current PASR dated 03/10/20 does not identify the bipolar disorder dated 01/07/20 and a diagnosis of major depressive disorder dated 01/07/20 as active diagnosis for Resident #20.<br><br>During an interview on 07/23/24 at approximately 09:15 AM with Registered Nurse Clinical Reimbursement Coordinator (RN CRC) #16, she stated that the diagnosis should have been added to the PASR and it would be resubmitted now. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>31826<br><br>Based on record review, observation, and staff interview the facility failed to ensure an accurate comprehensive care plan was developed for Resident #37 in the area of dental and for Resident #64 in the area of pressure ulcers. This was true for two (2) of 25 sampled residents reviewed during the long term care survey process. Resident Identifiers: #37 and #64. Facility Census: 63.<br><br>Findings Include:<br><br>a) Resident #37<br><br>An observation of Resident #37 on 07/22/24 at 1:28 PM found the resident had metal pieces visible in lower gum line.<br><br>On 07/24/24 at 2:45 PM the Director of Nursing was asked to look into the residents mouth to determine what the metal which was visible was. Upon the completion of the observation it was discovered the resident had a partial plate on the bottom and the metal was visible because she had no natural teeth left to hook it to. The Director of nursing was asked if she had any natural teeth in her mouth and she stated there was not any.<br><br>A review of Resident #37's medical record found a care plan related to her dental status which read:<br><br>Resident is at risk for oral health or dental care problems as evidenced by wears upper full and lower partial dentures. broken or loosely fitting partial dentures. obvious or likely cavity or broken natural teeth denies any concerns eating per interview.<br><br>Immediately following the dental observation with the Director of Nursing she was asked to review the care plan and confirmed it did not accurately reflect the residents dental status because she has no natural teeth left.<br><br>b) Resident #64<br><br>On 07/23/24 at 12:30 PM a review of document titled Wound Assessment for 06/28/24 reveals the following pressure ulcer for resident #64 wound measurements were reported as follows:<br><br>4.00 cm<br><br>Width: 5.00 cm<br><br>L x W: 20.00 cm2<br><br>Depth: 0.00 cm<br><br>Observations<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Location: left heel<br><br>Etiology: Pressure<br><br>Stage/Severity: DTI<br><br>Acquired in House: Yes<br><br>Date Wound Acquired: 06/28/2024<br><br>Wound Status: New<br><br>On 07/23/24 at 12:45 PM review of physician orders for resident included the following:<br><br>--Encourage/assist resident to float heels at all times while in bed as tolerated.<br><br>every day and night shift this order was dated 06/06/24,<br><br>-- Cleanse Right Heel with Wound Care Cleanser, Pat dry With Gauze, Apply Sure Prep every day shift for Preventive Measures this order was dated 06/11/24.<br><br>-- Remove Heel Protector Boot to Left Heel for Skin Inspection every shift for DTI to Left Heel. This order was dated 06/28/24.<br><br>-- Heel Protector Boot to Left Heel at all times, when in bed, Nurse to monitor placement.<br><br>every shift for DTI to Left Heel. This order was dated 06/28/24.<br><br>A review of Resident #67's care plan found no mention of te reisidents pressure ulcer to her heel.<br><br>On 07/24/24 at 9:45 am, an interview with Director of Nursing (DON) confirmed the pressure ulcer for resident's heel is not addressed in the care plan but it should have been.<br><br>50551 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive Charleston, WV 25311 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>49650<br><br>Based on medical record review and staff interview, the facility failed to update a care plan in regards to a diagnosis of psychosis r/t (related to) dementia. This was true for one (1) of five (5) residents reviewed for unnecessary medications, psychotropic medications, and medication regimen review during the long term care survey process. Resident Identifier: #1. Facility Census: 63.<br><br>Findings include:<br><br>a) Resident #1<br><br>During a medical record review on 07/23/24 at 11:35 AM, Resident #1 was identified to have a physician diagnosis of Parkinson's disease without dyskinesia, without mention of fluctuations, dementia in other diseases classified elsewhere moderate with agitation and a diagnosis of psychotic disorder with delusions due to known physiological condition. It is further identified the resident receives seroquel which is ordered for Resident #1's psychosis r/t (related to) dementia with the pharmacy reference to the diagnosis of the dementia in other diseases classified elsewhere, moderate with agitation and psychotic disorder with delusions due to know physiological condition.<br><br>During a review of the care plan on 07/23/24 at approximately 11:45 AM Resident #1 wass identified to be care planned with a focus for the use of seroquel (psychotropic medication) for the residents Parkinson's psychosis that is manifested by the residents verbal and physical outburst.<br><br>On 07/23/24 at 3:30 PM, during an interview with the Director of Nursing (DON) she confirmed the diagnosis for the order is dementia in other diseases classified elsewhere, moderate with agitation and psychotic disorder with delusions due to know physiological condition. She further stated, the care plan had not been updated as needed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>45171<br><br>Based on record review and staff interview the facility failed to implement physicians orders, failed to follow their weight policy for reweighs and failed to identify a significant weight gain. This was true for one (1) of two (2) residents reviewed for the care area of nutrition during the long term care survey process. Resident Identifier: #40 Facility Census: 63<br><br>Findings Include:<br><br>a) Physician orders<br><br>On 07/23/24 at 1:02 PM a review of Resident #40's medical record found a 17.6 pound weight gain from 07/09/24 until 07/16/24. According to the diagnosis sheet for this resident which was provided by the facility, Resident #40 had an active diagnosis of Congestive Heart Failure (CHF).<br><br>According to further record review of the last six (6) months, the following weeks had no weight documented for this resident. 01/23/24, 04/16/24, 04/30/24 and 06/25/24. The facility failed to follow the active physicians order for: Weekly weights every Tuesday every day shift for Congestive Heart Failure.<br><br>This was confirmed with the Director of Nursing on 07/23/24 at 1:30 PM who agreed with the missed weights on the above mentioned dates.<br><br>b) Change in Condition<br><br>On 07/23/24 at 1:02 PM a review of Resident #40's medical record found Resident #40 had a 17.6 pound weight gain from 07/09/24 until 07/16/24. According to the diagnosis sheet for this resident, which was provided by the facility, Resident #40 had an active diagnosis of Congestive Heart Failure (CHF).<br><br>According to the facility policy for Acute Condition Changes - Clinical Protocol . will help to identify individuals with a significant risk for having acute changes of condition during their stay .<br><br>On 07/25/24 at 10:30 AM during an interview with three (3) nursing staff members, Registered Nurse #44, Licensed Practical Nurse #17 and #38 all agreed there should have been a change in condition document completed with a 17.6 pound weight gain in 7 days on a resident ha who has a diagnosis of CHF.<br><br>The above findings were confirmed with the Director of Nursing on 07/23/24 at 1:30 PM who agreed a 17.6 pound weight gain in 7 days for a resident with CHF is considered a significant weight gain and should have been identified with a Change in Condition form completed.<br><br>c) Policy for weights<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/23/24 at 1:02 PM, a review of Resident #40's medical record found Resident #40 had a 17.6 pound weight gain from 07/09/24 until 07/16/24. According to the diagnosis sheet for this resident which was provided by the facility, Resident #40 has an active diagnosis of Congestive Heart Failure (CHF).<br><br>According to the Facility Clinical Operations Policy for Weighing the Resident last revised on 03/2023 which states PROTOCOL: . (4). Reweight of resident/patient is required with fluctuation of 5 lbs. from previous weight, with Licensed Nurse observation/validation.<br><br>Review of the documented weights since 01/02/24 found nine (9) instances of a five (5) pound weight fluctuation where a reweigh was not performed.<br><br>01/02/24 weight 251.2 pounds<br><br>01/09/24 weight 240.2 pounds for an 11 pound weight loss<br><br>01/09/24 weight 240.2 pounds<br><br>01/16/24 weight 249.4 pounds for a 9.2 pound weight gain<br><br>01/16/24 weight 249.4 pounds<br><br>01/30/24 weight 258.8 pounds for a 9.4 pound weight gain<br><br>02/13/24 weight 252.4 pounds<br><br>02/20/24 weight 258.9 pounds for a 6.5 pound weight gain<br><br>04/05/24 weight 256.2 pounds<br><br>04/11/24 weight 243 pounds for a 12.2 weight loss<br><br>04/11/24 weight 243 pounds<br><br>04/25/24 weight 256.2 pounds for a 13.2 pound weight gain<br><br>06/04/24 weight 257.3 pounds<br><br>06/11/24 weight 264.8 pounds for a 7.5 pound weight gain<br><br>06/11/24 weight 264.8 pounds<br><br>06/18/24 weight 255.4 pounds for a 9.4 pound weight loss<br><br>07/09/24 weight 261.8 pounds<br><br>07/16/24 weight 279.4 pounds for a 17.6 pound weight gain.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The above information was confirmed with the Director of Nursing on 07/23/24 at 1:20 PM at which time she agreed the above instances should have had reweighs performed and documented. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>50552<br><br>Based on record review and staff interview the facility failed ensure each resident maintains acceptable perimeters of nutrition. They specifically failed to timely assess and/or address a significant weight loss and the resident continued to lose weight. This failure resulted in actual harm for Resident #14. This was true for 1 (one) of 2 (two) residents reviewed for the care area of nutrition during the the Long Term Care Survey Process. Resident identifier: Resident #14. Facility census: 63.<br><br>Findings include:<br><br>a) Resident #14<br><br>On 07/24/24 at 10:09 AM, a review of Resident #14's medical record was conducted which revealed the following periods of time when the resident suffered a severe weight loss:<br><br>-- On 03/05/24 Resident #14 weighed 201.2 pounds and one (1) month later the resident weighed 187.2 on 04/03/24. This is a loss of 6.95 percent, which is considered a severe weight loss in one (1) month.<br><br>-- On 01/06/24 Resident #14 weighed 205.6 pounds and six (6) months later on 07/03/24 the resident weighed 182.6 pound which was a 12.95 percent, which is considered a severe weight loss in a six month period.<br><br>-- On 07/09/24 the resident weighed 178.2 pounds.<br><br>-- On 07/16/24 the resident weighed 177.8 pounds.<br><br>A further review of the record found the following pertinent information:<br><br>* Care Plan Note documented on 07/12/24 at 11:30 AM which stated, Nursing will refer resident to Speech Therapy (ST) for poor appetite and weight loss. (This was noted three (3) months after the first severe weight loss in a month.) Further review of the record found this referral was never completed.<br><br>* Diet order noted for Regular/Liberalized diet Dysphagia Advanced texture, thin consistency, may crush crushable medications/double portions for Gluten Free. noted to be initiated 03/18/24. (This diet was ordered prior to the first severe weight loss occurred.)<br><br>* Certified Nurse Aide (CNA) documentation of meal intakes which revealed 7 (seven) occurrences of Resident #14 consuming 0-25% of meals (since 06/25/24) . In addition, CNA documentation revealed for the last 30 days (since 06/25/24) Resident #14 had received assistance documented as:<br><br>Supervision- Oversight, encouragement or cueing for 15 of 90 meals provided, the other 75 meals were documented as Independent-No help or staff oversight at any time. Furthermore, no documentation was noted related to Resident #14 receiving or consuming an evening snack.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | * Activities of Daily Living care plan revealed Resident #14 requires extensive assistance and cueing for eating, which had an initiated date of 11/04/22 and a revision date of 11/17/22. (This intervention was not consistently carried out by nursing staff.)<br><br>* The medical record was void of any documentation to indicate a dietary supplement was ordered for Resident #14 to prevent future weight loss.<br><br>* The medical record was void of any documentation saying the physician had been notified of the residents severe weight loss.<br><br>On 07/24/24 at 11:45 AM, an interview conducted with the Director of Nursing (DON), Minimum data set coordinator (MDS-C) and Registered Nurse (RN) consultant. During this interview the DON acknowledged the following:<br><br>1. The speech therapy referral was not made as documented.<br><br>2. Resident #14's physician and/or Nurse Practitioner (NP) was not notified of Resident #14's 6.95 percent weight loss in one (1) month and was not notified of the 12.95 percent of weight loss in six (6) months.<br><br>3. No supplements were ordered or provided, the DON does not know why.<br><br>4. After reviewing the Certified Nurse Aide (CNA) documentation of meal intakes, there were 7 (seven) occurrences of Resident #14 consuming 0-25% of meals (since 06/25/24) .<br><br>5. Resident #14's care plan states resident requires extensive assist with cueing and eating, after reviewing the CNA documentation last 30 days (since 06/25/24) that Resident #14 had received assistance documented as Supervision- Oversight, encouragement or cueing for 15 of 90 meals provided, the other 75 meals were documented as Independent-No help or staff oversight at any time. The DON acknowledged Resident #14 did not receive the assistance required for eating.<br><br>6. No labs had been obtained to potentially assess Resident #14's nutritional health.<br><br>7. That Resident #14 had no documentation a evening snack provided or consumed.<br><br>On 7/24/24 at approximately 2:30 PM, a review of Policy and Procedure titled, Weight Monitoring revealed that the physician should be informed of a significant change in weight.<br><br>On 07/24/24 at approximately 3:00 PM, a review of Policy and Procedure titled, Nutritional Management revealed that care and services shall be provided to ensure that each resident maintains acceptable parameters of nutritional status which includes that resident's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values. In addition, this policy and procedure states that a systemic approach is used to optimize each resident's nutritional status:<br><br>1. Identifying and assessing each resident's nutritional status and risk factors.<br><br>2. Evaluating/analyzing the assessment information.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 3. Developing and consistently implementing pertinent approaches.<br><br>4. Monitoring the effectiveness of interventions and revising them as necessary.<br><br>Furthermore, the policy and procedure titled, Nutritional Management states the physician will be notified of significant changes in weight, intake, or nutritional status and lack of improvement towards goals.<br><br>On 07/24/24 at 3:38 PM, during an additional interview with the Director of Nursing, the DON acknowledged that per facility policy and procedure Resident #14's physician should have been notified of the weight loss and was not.<br><br>On 07/24/24 at approximately 4:00 PM, an interview was conducted with the facility Registered Dietician (RD), during this interview, the RD stated, she had identified Resident #14's weight loss in April of 2024. The RD stated she hadn't intervened until June 2024 by adding double portions to Resident #14's diet order because Resident #14's Body Mass Index (BMI) indicated Resident #14 was overweight. However, the RD acknowledged Resident #14 had the 12.95% weight loss over the last 6 (six) months. This Surveyor then asked the RD if she communicated with the physician and/or NP, with the RD responding that she was able to communicate with the physician and/or NP however that she did not, stating that the nursing department usually handled communicating with the physician and/or NP. This Surveyor then asked the RD, without the physician and/or NP being notified of Resident #14's significant weight loss and assessing Resident #14, how did the RD know that an underlying condition was not the cause of Resident #14's significant weight loss. The RD did not respond to this question, however, the RD stated that due to the most recently obtained weight for Resident #14, she would be initiating a supplement for Resident #14. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive Charleston, WV 25311 |

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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>49650<br><br>Based on record review and staff interview the facility failed to ensure Nurse Aides (NA's) completed all required competencies. This was true for five (5) of five (5) NA competencies reviewed during the long term care survey process. Identifier: NA #9, NA #20, NA #28, NA #40 and NA #53 Census: 63.<br><br>Findings included:<br><br>On 07/23/24 at approximately 7:30 PM during a review of the completed competencies provided for NA #09, NA #20, NA #28, NA #40 and NA #53 the following competencies was identified.<br><br>a) NA #09 - Date of Hire - 04/18/24<br><br>* NA safe O2 (oxygen) handling competency<br><br>* Competency Validation Total Lift<br><br>* Competency Validation Invacare Sit to Stand Lift<br><br>b) NA #20 - Date of Hire - 12/16/21<br><br>* NA safe O2 (oxygen) handling competency<br><br>c) NA #28 - Date of Hire - 09/22/09<br><br>* NA safe O2 (oxygen) handling competency<br><br>* Competency Validation Total Lift<br><br>* Competency Validation Invacare Sit to Stand Lift<br><br>d) NA #40 - Date of Hire - 04/18/24<br><br>* NA safe O2 (oxygen) handling competency<br><br>* Competency Validation Total Lift<br><br>* Competency Validation Invacare Sit to Stand Lift<br><br>e) NA #53 - Date of Hire - 04/18/24<br><br>* NA safe O2 (oxygen) handling competency<br><br>* Competency Validation Total Lift<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive Charleston, WV 25311 |

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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | * Competency Validation Invacare Sit to Stand Lift<br><br>* Competency Validation Eating Assistance<br><br>* Competency Validation Handle Dirty Laundry<br><br>During a review of the Facility Assessment Tool template on page 10 and 11 for the Staff training/educations and competencies had not been modified to be facility centered for the resident population and the resident needs to be met.<br><br>In reviewing the staff competencies with the Administrator on 07/24/25 at 11:30 AM the Facility Assessment Tool was reviewed and the Administrator acknowledged the staff training/educations and competencies section had not been revised to be center specific for this facility. He further stated his understanding the staff did not have all of the appropriate completed competencies to reflect the staffs knowledge, skills and abilities to perform the work roles needed for the resident population and the care areas resident needs have to be met. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>49650<br><br>Based on facility record review and staff interview, the facility failed to ensure nurse staff posting was accurate in the area of the number of staff with two (2) of eight (8) nursing staff postings reviewed and there were no total hours worked for the staff on eight (8) of eight (8) nurse staff postings reviewed. Census: 63<br><br>Findings include:<br><br>a) Accurate data- Number of staff<br><br>On 07/24/24 at 10:00 AM, during a review of the facilities Daily Staffing Posting forms, 07/06/23 and 04/21/24 forms it is identified the Registered Nurses (RN) listed is a total for three (3) for each day for the day shift RN staff.<br><br>On 07/24/24 at approximately 10:12 AM during an interview with the Schedule Manager (SM) #80 she stated the Nurse Practice Educator/Infection Preventions (NPE/IP) hours was included in the RN's listed for both days (07/06/23 and 04/1/24). In reviewing the determination of direct care classifications for the staffing posting forms for the RN hours to be listed, a review was completed of the The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6. This section defines the Labor Classification/Job Title Reporting shall be based on the employee's primary role and their official categorical title. It is understood most roles have a variety of non-primary duties are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of employee based on their primary role. CMS recognizes staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The SM #80 stated she was not aware of this information and based on the job description being administrative the NPE/IP RN should not have been included with the total of RN's for the referenced days.<br><br>b) Accurate data- Total hours<br><br>On 07/24/24 at 10:00 AM, during a review of the facilities Daily Staffing Posting forms for the days of 07/06/23, 11/23/23, 11/24/23, 01/01/24, 01/02/24, 04/21/24, 07/20/24 and 07/21/24 it was identified the actual total hours worked is not identified on the form as it only outlines the shift is scheduled.<br><br>On 07/24/24 at 10:30 AM, during an interview with the SM #80, of the facilities Daily Staffing Posting forms for 07/06/23, 11/23/23, 11/24/23, 01/01/24, 01/02/24, 04/21/24, 07/20/24 and 07/21/24 it was identified the actual total hours worked is not identified on the form. SM #80 agreed the total direct care hours worked is not indicated on the and stated she would change the format of the form to reflect the actual total hours worked as required. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>50551<br><br>Based on record review and staff interview the facility failed to take appropriate measures when they had knowledge a resident's court appointed guardian was no longer able to serve as the guardian because they had lost decision making capacity for themselves while a resident at the same facility as Resident #68. Resident Identifiers: #68 and #372. Facility Census: 63.<br><br>Findings include:<br><br>A review of records on 07/23/24 at 10:24 AM of care plan note dated for 5/23/2024 at 4:18 PM revealed the following:<br><br>Resident's niece requested to meet to discuss palliative care and hospice options. Nursing discussed resident has been declining and is not eating, drinking, etc. Her niece indicated she is agreeable to making resident palliative care and asked for a referral to hospice. She stated her biggest concern is resident be kept comfortable and pain managed. She noted she currently appears comfortable and does not appear to be in pain. No concerns or complaints voiced.<br><br>Interview with Social Worker #77 on 7/23/24 at 3:10 PM in regards to why resident's niece was in attendance to meeting and resident's legal guardian was not. Social Worker stated they had suspected the resident's legal guardian had been unable to make decisions for a while when they called her on the phone and the family would speak for her. He reported when the guardian, Resident #372, became a resident at this facility and lost capacity to make her own decisions. They began talking to the sister and the niece of the resident who both believed themselves to be able to make decisions for the resident and he encouraged them to petition the court. SW also reported he did not notify the court or Adult Protective Services resident's court appointed guardian no longer had capacity to make her own decisions.<br><br>Interview with Director of Nursing (DON) on 7/23/24 at approximately 3:30 PM who reported a referral was made to hospice but resident was not picked up due to the resident's court appointed guardian no longer had the capacity to make her own medical decisions. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>49650<br><br>Based on medical record review and staff interview, the facility failed to ensure resident had monthly drug regimen reviews. This was true for one (1) of five (5) residents reviewed for unnecessary medications, psychotropic medications, and Medication Regimen Review (MRR) during the long term care survey process. Resident Identifier: #1. Facility Census: 63.<br><br>Findings include:<br><br>a) Resident #1<br><br>During a medical record review on 07/23/24 at 11:35 AM a review of the past 12 months of MRR's identified the month of 10/01/23 did not have an MRR on file for Resident #1.<br><br>During an interview with the Director of Nursing (DON) on 07/23/24 3:30 PM the DON stated the MRR for October had not addressed by the physician during the month of October so the pharmacy had made recommendation again 11/29/23. She further stated this November MRR order was not entered until 12/04/23. The DON stated she did not know what had happened to the MRR for October. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50552<br><br>Based on observation and staff interview the failed to ensure appropriate environmental controls for safe medication storage by not obtaining the temperature in the Medication Refrigerator and maintaining these temperatures on the temperature log on a daily basis. This discovery was made during the Long Term Care Survey Process. Facility census: 63.<br><br>Findings include:<br><br>a) Facility<br><br>On 07/23/24 at approximately 2:30 PM, a observation was made of the facility medication storage room. At this time a log was noted for the medication refrigerator titled, Temperature Log for Refrigerator and Freezer which was dated July 2024. Upon reviewing this log, it revealed several areas without the required information documented. These areas were as follows:<br><br>Staff Initials for dates 07/04/24 dayshift, 07/05/24 dayshift and 07/19/24 dayshift.<br><br>Room temperature for dates 07/04/24 dayshift, 07/05/24 dayshift and 07/19/24 dayshift.<br><br>Exact time for dates 07/04/24 dayshift, 07/05/24 dayshift and 07/19/24 dayshift.<br><br>Furthermore, the instructions on this log states temperatures are to be checked in the refrigerator compartments at least twice each working day, staff are to place an X in the box corresponds with the temperature and record the ambient (room) temperature, the time of the temperature readings and staff initials.<br><br>On 07/24/24 at 12:27 PM, an interview was conducted with the Director of Nursing (DON). At this time the DON acknowledged the missing required documentation and stated the temperatures, along with other required missing documentation, should have been obtained and documented on this log.<br><br>On 07/25/24 at approximately 2:30 PM, a review of the policy and procedure titled, Medication Storage was conducted with revealed all medications requiring refrigeration are to be stored in refrigerators located in each medication room. In addition, it states temperatures are maintained within 36-46 egress Fahrenheit and temperature levels are to be recorded twice daily by the charge nurse or other designee.<br><br>Medication Storage<br><br>medications stored in secured locations accessible only to staff<br><br>clean and sanitary conditions maintained<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | schedule II-V controlled medications were maintained in a separately locked permanently affixed compartment/container<br><br>medication records are maintained<br><br>insulin pens labeled with resident name<br><br>Missing documentation on med fridge temperature log |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650<br><br>Based on observation, staff interview and the facility policy for Safe Handling for Foods from Visitors, the facility failed to ensure the freezers in the resident rooms was being monitored for temperatures daily. This was true for three (3) of three (3) refrigerators/freezers observed during the long term care survey process. Identifiers: Resident room [ROOM NUMBER]B, Resident room [ROOM NUMBER]B and Resident room [ROOM NUMBER]B. Census: 63.<br><br>Findings included:<br><br>a) Resident room [ROOM NUMBER]B, Resident room [ROOM NUMBER]B and Resident room [ROOM NUMBER]B<br><br>During a tour of the facility, Resident room [ROOM NUMBER]B, Resident room [ROOM NUMBER]B and Resident room [ROOM NUMBER]B all were observed and had refrigerators with freezers. Temperatures were noted to only be documented for the refrigerator and not for the freezer.<br><br>During a review of the facility policy for Safe Handling for Foods from Visitors it is identiifed on page one (1) under number five (5) stated the refrigerators/freezers will be properly maintained. It further states the refrigerators/freezers are to be equipped with thermometers and have temperature monitored daily for the refrigerator and freeze. the refrigerator temperature are to be equal to or less than 42 degrees farheinheit. The freezers are to be equal to or less than 0 degrees farheinheit.<br><br>During an interview with the Social Worker (SW) #75 on 07/24/24 at approximately 09:45 AM the SW #75 viewed each refrigerator/freezer Resident room [ROOM NUMBER]B, Resident room [ROOM NUMBER]B and Resident room [ROOM NUMBER]B. The SW #75 and agreed Resident room [ROOM NUMBER]B, Resident room [ROOM NUMBER]B and Resident room [ROOM NUMBER]B did not have freezer temperatures taken and documented as they should have been. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>49650<br><br>Based on facility record review and staff interview, the facility failed to ensure the facility assessment was modified to make it facility centered to identify the staff competencies required to provide the level and types of care needed for the resident population. This was a random opportunity for discovery during the long term care survey process and had the ability to affect more than a limited number of residents. Identifier: Facility Assessment Tool. Census: 63.<br><br>Findings included:<br><br>a) Facility Assessment Tool<br><br>On 07/24/24 at 10:55 AM during a review of the nursing competency requirements in the facility assessment it is identified that the facility assessment document provided is titled a Facility Assessment Tool. This document update was dated 12/28/23. The Requirement noted for this tool is (typed as written) Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. It further stated that the requirement for the facility assessment may be found in Attachment 1 and denotes the following (typed as written);<br><br>Attachment 1<br><br>*Medicare and Medicaid programs; reform of requirements for long term care facilities.<br><br>(ii) the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;<br><br>(iii) the staff competencies that are necessary to provide the level and types of care needed for the resident population.<br><br>In review of the Overview of the Assessment Tool on page 1 it identifies that this as an outlined tool that serves as an optional template provided for nursing facilities and it further states if used, it may be modified. It is further identified that the template has been modified or updated in areas such as the Example 3: Assistance with Activities of Daily Living on Page 6, Example 1. Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each residents needs on page 9, Example 2. Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs on page 9 and 10.<br><br>Other areas of the assessment not identified to be updated was page 10 and 11 of the Facility Assessment tool for the Staff training/educations and competencies states.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with the Administrator on 07/24/25 at 11:30 AM the Facility Assessment Tool was reviewed and the Administrator acknowledged that the staff training/educations and competencies section had not been revised to be center specific for this facility. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Association Drive Charleston, WV 25311 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>31826<br><br>Based on record Review and staff interview the facility failed to ensure the residents medical record was complete and accurate. This was true for one (1) of 25 residents reviewed during the long term care survey process. Resident Identifier: #10. Facility Census: 63.<br><br>Findings Include:<br><br>a) Resident #10<br><br>A review of Resident #10's medical record on 07/23/24, found an order for Hydrocodone five (5) milligram - 325 milligrams as needed every 24 hours. A review of the controlled substance log and medication administration record (MAR) since April 2024 through current found on through current found on the following days the Hydrocodone was signed out on the Controlled Substance log but was not documented as administered on the MAR:<br><br>04/24/24<br><br>04/30/24<br><br>05/09/24<br><br>05/13/24 and<br><br>05/21/24.<br><br>An interview with the Director of Nursing on 07/23/24 at 11:55 AM confirmed the above findings.<br><br>50552 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Complete Care at Oak Ridge LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Association Drive Charleston, WV 25311 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>50552<br><br>Based on observation and staff interview the facility failed to develop and implements an ongoing infection prevention and control program (PCP) to prevent, recognize, and control the onset and spread of infection. This was a random opportunity for discovery. Resident identifiers: Resident #270 and #5. Facility census: 63.<br><br>Findings include:<br><br>a) Facility<br><br>On 07/23/24 at 07:55 AM, a medication administration observation was made with RN #41. At this time, RN #41 entered Resident #270's room to administer medication and obtain a blood glucose reading using the glucometer from the medication administration cart. Upon entering Resident #270's room, RN #41 was observed to lay the glucometer on Resident #270's bed with no barrier. RN #41 then performed the blood glucose test on Resident #270. RN #41 then carried the glucometer out into the hallway and was observed to wipe the glucometer off with an alcohol prep pad and lay the glucometer on the medication cart, RN #41 was then was observed to place the glucometer into the top drawer of the medication cart. This Surveyor then asked RN #41, what she used to clean the glucometer with. RN #41 responded, An alcohol pad. This Surveyor then asked RN #41 what the dwell time would be for the alcohol to disinfect the glucometer. RN #41 then responded, I don't know. I usually just let it dry between patients. This Surveyor then asked RN #41, was the use of an alcohol pad sufficient to clean the glucometer. RN #41 responded, This is how I was taught. At this time RN #41 then acknowledged she laid the glucometer on Resident #270's bed without using a barrier when a barrier should have been used.<br><br>On 07/23/24 at 8:30 AM, a review of the Policy and Procedure titled, Glucometer Disinfection was conducted which revealed an EPA registered disinfectant is effective against HIV, Hepatitis C and Hepatitis B virus is to be used to disinfect the glucometer.<br><br>On 07/23/24 at approximately 9:00 AM, an interview was conducted with the Director of Nursing (DON). At time, the DON acknowledged the policy and procedure calls for the use of an EPA registered disinfectant and an alcohol pad is not an EPA registered product. The DON further acknowledged an alcohol pad is not an effective cleaner to prevent the transmission of blood borne pathogens and the Policy and Procedure titled, Glucometer Disinfection had not been followed by RN #41.<br><br>b) Resident #5<br><br>On 07/24/24 at approximately 1:30 PM, a review of Resident #5's physicians orders was conducted which revealed the following orders:<br><br>1. Enteral Feed every 6 hours flush enteral tube with 150cc water q 6 hours<br><br>2. Resident requires enhanced barrier precautions r/t hx of MDRO (ESBL) and surgical opening.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/24/24 at 1:42 PM, an observation was made of LPN #39 administering Resident #5's Percutaneous Endoscopic Gastrostomy (PEG) tube flush administration. Prior to entering Resident #5's room, a sign was noted to be placed on her door stated the following:<br><br>Enhanced Barrier Precautions Everyone Must:<br><br>Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting, Device care or use of central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing.<br><br>Prior to completing the flush, Resident #5 was transferred from the Geri-chair to the bed via mechanical lift by LPN #39 and LPN #17. The transfer was completed without the use of a gown. Upon completion of the transfer, this Surveyor asked LPN #39 why Resident #5 was on Enhanced Barrier Precautions. LPN #39 responded, Because of her tube. This Surveyor then asked LPN #39 if she should have wore a gown to transferr Resident #5, to which LPN #39 responded, I'll have to ask. This Surveyor then pointed out the EBP sign on Resident #5's door. LPN #39 then stated, I see now, yes we should have wore a gown.<br><br>On 07/24/24 at approximately 02:00 PM, a review of the Policy and Procedure titled, Enhanced Barrier Precautions was conducted which stated EBP refer to the use of a gown and gloves for high-contact resident care activities for residents known to be colonized or infected with a Multi-drug Resistant Organism (MDRO) as well as those at increased risk for MDRO acquisision (e.g. residents with wounds or indwelling medical devices). Furthermore the Policy and Procedure Enhanced Barrier Precautions' define indwelling medical devices as (e.g. feeding tubes). In addition, high contact resident care activities including transferring. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515174 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Oak Ridge LLC | 1000 Association Drive<br>Charleston, WV 25311 |

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 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>49650<br><br>Based on facility record review and staff interview, the facility failed to ensure all Nursing Assistants (NA's)received the required minimum of 12 hours of nurse aide training per year. This was true for one (1) of five (5) NA's reviewed during the long term care survey process. Identifier: NA #28. Census: 63.<br><br>Findings include:<br><br>a) NA #28 - Hire date - 09/22/09<br><br>On 07/23/24 at approximately 7:15 PM during a review of the 12 hours of nurse aid training, the NA training reviewed from 05/01/23 to current identified the following nurse aide training hours completed:<br><br>*11/22/23 - Abuse Neglect and Exploitation - .75 hours<br><br>* 07/07/24 - Catheter and Perineal Care - .25 hours<br><br>In reviewing the required minimum of 12 hours of nurse aid training per year, and NA #28's one (1) hour of completed training with the Administrator on 07/24/25 at approximately 11:45 AM. The Administrator agreed NA #28 had not completed the required minimum of 12 hours of nurse aid training per year. |