

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Bluestone Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Bland Street Bluefield, WV 24701	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, resident interview, and staff interview the facility failed to ensure a safe, clean, comfortable, homelike environment by not maintaining appropriate temperatures in the residents shower room. This failed practice was a random opportunity for discovery and had the potential to effect more than a limited number of residents during the complaint survey. Facility Census 59. Findings Include:a) Short hall shower roomA tour of the short hall shower room on 12/15/25 at 11:45 AM, found that when you walk in the door of the shower room, it felt to be a good temperature. In the shower stall where the residents sit under the water felt to be cool. The Director of Maintenance (DOM), took the temperature of the room and confirmed that where the residents shower, was currently at 61 degrees Fahrenheit. The , Director of Maintenance (DOM) stated, That is absolutely to cold to take a shower in. I don't know what else to do. We put in this (2) two water proof heaters. The other shower room is warmer, but this one is bigger and everyone likes to use it. Maybe I can get up in the attic and see if something is wrong. Further interview with the DOM stated, I found the problem, there was a vent open and it was pulling in cold air. I fixed it. The DOM could not confirm how long the vent had been opened.During an interview on 12/15/25 at 2:00 PM, Resident #19 stated, The shower room is cold all the time. Most of the time I just have them wash my hair, because its to damn cold to wash anything else.During an interview on 12/15/25 at 2:00 PM, Resident #49 stated, I have only been here for (3) three weeks and have taken (3) three showers and every time the shower room has been cold.b) PolicyA review on 12/16/25 at 3:15 PM, of the policy titled {Loss of Heating or Cooling}, under Policy reads as follows: It is the policy of this facility to take immediate actions when the facility's heating or cooling systems are inoperable in order to maintain temperatures within the facility at 71-81 degrees Farenheit.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and staff interview, the facility failed to implement the care plan for Resident # 2 regarding taking blood pressures in a restricted arm due to a mastectomy. This is true for one (1) of 11 residents reviewed during the survey process. Resident Identifier: #2. Facility Census: 59. Findings included: a) Resident #2 On 12/16/25 at 1:00 PM, a record review was completed for Resident #2. The review found on the care plan under special instructions No B/P (blood pressure) or lab sticks in the left arm. The resident's left arm was restricted due to a mastectomy. The following dates the blood pressures were taken in the restricted arm: --09/14/25 at 2:59 PM--09/14/24 at 11:14 PM--09/15/25 at 9:06 AM--09/17/25 at 3:03 PM--10/21/25 at 6:14 PM--11/12/25 at 1:37 PM--11/13/25 at 2:42 PM--11/16/25 at 3:04 PM--11/18/25 at 2:05 PM On 12/16/25 at 2:05 PM, the Director of Nursing (DON) was notified and confirmed the blood pressures should not have been obtained from the restricted arm.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and record review the facility failed to provide Activities of Daily Living (ADL) care to dependent resident in a timely manner. This failed practice was found true for (5) five of (5) five residents reviewed for ADL care during the complaint survey. Resident identifiers #19, #17, #49, #2, #10, #37. Facility census 59. Findings Include: Findings Include:a) Resident #19On 12/11/25 Program Manager II was on the phone with Resident #19 for 52 minutes. The call started at 8:32 AM. Resident #19 said she currently had a Urinary Tract Infection (UTI) and was soiled. She said they (nurse aides) had taken people out to smoke, and no one was answering her call light. Resident #19 confirmed that her call light was on. During the 52-minute phone call the only staff member who came in was from dietary and they were asking about her preferences for the lunch and dinner meal. After approximately 45 minutes Program Manager II had Health and Human Resource Associate (HHRA) call the facility to try and get help for this resident. During the first call the receptionist transferred the HHRA to the nursing station and there was no answer. During a second call the HHRA was sent to the administrator with no success. During a third call HHRA announced to receptionist that he was from OHFLAC and that (Resident #19 name) had called and that she had been requesting incontinence care assistance for over 45 minutes. During that call an employee came to Resident 19's room and offered to change her. That employee was identified as Registered Nurse Supervisor (RNS) #59. Resident #19 later confirmed this employee was an RN who never answers call lights. Resident #19 said that RNS #59 told her they only had two nurse aides on shift. Resident #19 was very upset about this and how this was going to impact her care for the day and night. During an interview on 12/15/2025 at 2:00 PM, Resident #19 stated , They only have (2) two Nursing Assistants (NA's) for the entire building today. They had night shift stay over till 10:00 this morning and after that they only had (1) one. They have three (3) now because they got a restorative aide to come help and the one aide called her mom on her day off and had her come in and help. They will say the nurses help, but they don't. They just set behind that desk. On Saturday there was a new girl who worked by herself after 12:30. That was only because the night shift girl stayed which put her working 18 and 1/2 hours. There are times that I have dirtied myself and have to wait an hour or more to get changed. This is getting old. Its been happening for a while, I now have a Urinary Tract Infection (UTI) because of this.A record review on 12/16/25 at 1:30 PM, of Resident #19's care plan, revealed a care plan that reads as follows: Focus: The resident is frequently incontinent of bladder and bowels and is not a candidate for a toileting program due to weakness, impaired mobility, diagnosis of overactive bladder.Intervention: Dependent for toiletingb) Resident #17During an interview on 12/15/25 at 1:45 PM, Resident #17 stated, About 2 weeks ago, I needed to go to the bathroom. The aide told me I would have to hold it and take my smoke break. She said you will have to wait. I called my daughter; she called here and I was immediately helped to the bathroom. On 12/02/25, I reported waiting over 2 hours to be changed. They are always short-staffed; it's every shift but worse on nights. I have not heard anything back about what I reported. Resident was tearful and visibly upset regarding the situation. Resident #17 further stated, I'm upset over all of it.A record review on 12/16/25 at 1:40 PM, revealed a care plan for Resident # 17 that reads as follows:Focus: The resident is a long term care or respite resident and requires assistance with their ADL's related to recent hospitalization for UTI and encephalopathy. Has chronic health conditions, chronic obstructive pulmonary disease (COPD), Cirrhosis , left above knee amputation, schizoaffective disorder resulting in cognitive impairment, inability to perform ADL's independently, muscle weakness. Intervention: Dependent for bed mobility, Dependent with dressing, Dependent for bathing, Substantial or Maximal assistance with dressing.c) Resident #49During an interview on 12/15/25 at 2:00 PM, Resident #49 stated, I have only been here for three (3) weeks, and already I have had to wait for (3) three hours to be changed. I waited that long with poo on me. My NA was told (4) four times. She would come in and turn the light off and then leave.A record review on 12/16/25 at 1:55 PM, revealed a care plan for Resident #49 that reads as follows:Focus: The resident has been admitted to rehabilitation with potential for long term care or respite services and requires assistance with their ADL's related to chronic health conditions: Hypertensive heart and CKD with heart failure and ESRD, COPD, Chronic hypoxic Respiratory Failure, Anemia in CKD, Seizures recent hospitalization for pneumonia resulting in weakness, impaired mobility, decreased activity tolerance. Resident also has severe visual impairment.Intervention: Substantial assist for toileting hygiene, Substantial/maximal assistance with transfers. Substantial/maximal assistance with bed mobility</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review, and staff interview the facility failed to ensure it had a complete and accurate medical record. This failed practice was found true for (2) two of 11 residents reviewed for medical record accuracy during the Complaint Survey process. Resident identifiers #49, #2. Facility Census 59. b) Resident #2</p> <p>On 12/16/25 at 1:00 PM, a record review was completed for Resident #2. The review found a physician's order dated 08/28/25 stating, No B/P (blood pressure) or venipuncture to left arm related to malignant neoplasm of unspecified site of left female breast. The resident's left arm is restricted due to a mastectomy. The following dates the blood pressures were taken in the restricted arm:</p> <p>--09/14/25 at 2:59 PM</p> <p>--09/14/24 at 11:14 PM</p> <p>--09/15/25 at 9:06 AM</p> <p>--09/17/25 at 3:03 PM</p> <p>--10/21/25 at 6:14 PM</p> <p>--11/12/25 at 1:37 PM</p> <p>--11/13/25 at 2:42 PM</p> <p>--11/16/25 at 3:04 PM</p> <p>--11/18/25 at 2:05 PM</p> <p>On 12/16/25 at 2:05 PM, the Director of Nursing (DON) was notified and confirmed the blood pressures should not have been obtained from the restricted arm.</p> <p>Findings Include:</p> <p>a) Resident #49</p> <p>During an interview on 12/15/25 at 2:00 PM, Resident #49 stated, There is this one nurse who never checks my blood sugar and does not give me insulin.</p> <p>A record review on 12/16/25 at 11:17 AM, of Resident #49's orders, revealed an order dated 12/04/25 that reads as follows: Insulin Lispro Injection Solution. Inject 4 units subcutaneously before meals for DM2 related to Type 2 Diabetes Mellitus with Hyperglycemia. Give only if BS is less than 140.</p> <p>A review of Resident #49's Medication Administration Record (MAR) for 12/2025 shows that blood sugar was to be checked before each meal and then to be indicated if insulin was given. From 12/04/25 to 12/13/25 no Blood sugars were recorded on the MAR.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further record review of Resident #49's vitals shows that No Blood sugar was recorded from 12/04/25 to 12/13/25.</p> <p>During an interview on 12/16/25 at 2:20 PM, The Director of Nursing (DON) stated, The order was put in poorly. I have now fixed it. She was given the insulin how it was ordered they just was not documenting the blood sugar.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, family interview, and staff interview the facility failed to assure that there is sufficient nursing staff available at all times to provide nursing and related services to meet the needs of the residents. This failed practice was a random opportunity for discovery and had the potential to effect all residents currently living in the facility during the complaint survey process. Resident identifiers #60, #37, #19, #10, #19, #49, #2. Facility Census 59. Findings Include:a) Resident #60During an interview on 12/15/25 at 1:08 PM, Resident #60's Medical Power of Attorney (MPOA) stated, It was a constant battle .there were always issues especially on night shift with getting him changed. He would watch the clock, and it has been from 2 hours to 11 hours waiting to be changed. They always seemed short-staffed and constantly new staff. Dad felt they had not been trained. I am very upset because there were always issues. He will not be going back there.During an interview on 12/15/25 at 1:33 PM, Resident #9 stated, They are slow when calling for help. They are short staffed. Especially evenings.During an interview on 12/15/25 at 1:45 PM, Resident #17 stated, About 2 weeks ago, I needed to go to the bathroom. The aide told me I would have to hold it and take my smoke break. She said you will have to wait. I called my daughter; she called here and I was immediately helped to the bathroom. On 12/02/25, I reported waiting over 2 hours to be changed. They are always short-staffed; it's every shift but worse on nights. I have not heard anything back about what I reported. Resident was tearful and visibly upset regarding the situation. Resident further stated, I'm upset over all of it. b) Resident #10During an interview on 12/15/25 at 1:55 PM, Resident #10 stated, They are always short-staffed. All shifts .evenings and nights can be bad. This is the way it always is. Sometimes they don't answer the call lights for quite awhile.c) Resident #19During an interview on 12/15/2025 at 2:00 PM, Resident #19 stated , They only have (2) two Nursing Assistants (NA's) for the entire building today. They had night shift stay over till 10:00 this morning and after that they only had (1) one. They have three (3) now because they got a restorative aide to come help and the one aide called her mom on her day off and had her come in and help. They will say the nurses help, but they don't. They just set behind that desk. On Saturday there was a new girl who worked by herself after 12:30 AM. That was only because the night shift girl stayed which put her working 18 and 1/2 hours. There are times that I have dirtied myself and have to wait an hour or more to get changed. This is getting old. It's been happening for a while, I now have a Urinary Tract Infection (UTI) because of this.On 12/11/25 Program Manager II was on the phone with Resident #19 for 52 minutes. The call started at 8:32 AM. Resident #19 said she currently had a Urinary Tract Infection (UTI) and was soiled. She said they (nurse aides) had taken people out to smoke and no one was answering her call light. Resident #19 confirmed that her call light was on. During the 52-minute phone call the only staff member who came in was from dietary and they were asking about her preferences for the lunch and dinner meal. After approximately 45 minutes Program Manager II had Health and Human Resource Associate (HHRA) call the facility to try and get help for this resident. During the first call the receptionist transferred the HHRA to the nursing station and there was no answer. During a second call the HHRA was sent to the administrator with no success. During a third call HHRA announced to receptionist that he was from OHFLAC and that (Resident #19 name) had called and that she had been requesting incontinence care assistance for over 45 minutes. During that call an employee came to Resident 19's room and offered to change her. That employee was identified as Registered Nurse Supervisor (RNS) #59. Resident #19 later confirmed this employee was an RN who never answers call lights. Resident #19 said that RNS #59 told her they only had two nurse aides on shift. Resident #19 was very upset about this and how this was going to impact her care for the day and night.d) Resident #49During an interview on 12/15/25 at 2:00 PM, Resident #49 stated, I have only been here for three (3) weeks, and already I have had to wait for (3) three hours to be changed. I waited that long with poo on me. My NA was told (4) four times. She would come in and turn the light off and then leave.During an interview on 12/15/25 at 2:10PM, Restorative Aide (RA) #66 stated, I am a Restorative Aide, I have not been here very long. They pulled me to work over here today because they was short.During an interview on 12/15/25 at 2:15 PM, (NA) # 65 stated, I worked 19 hours yesterday. I am here today because my daughter called me and asked if I could please come in and help her because she was by herself. I stay over a lot for call ins. We work doubles consistently. I try my best, but I am tired. The State Agency (SA) asked NA #65 how many residents she is typically responsible for? NA #65 stated Around 20 but when there is just (2) two of us here I have had 30 before e) Resident</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview, the facility failed to provide an accurate and complete documentation for three (3) of 11 residents. Resident #60, #17 and #2. Facility Census: 59. Findings Include:a) Resident #60On 12/15/25 at 1:00 PM, a record review was completed for Resident #60. The review included a complaint dated 12/04/25 as well as a facility-reported incident (FRI) dated 12/02/25. The allegation was neglect; not providing incontinence care on 12/01/25 as well as 12/02/25. The facility did complete the investigation and found the resident was provided care. The NAs were not documenting each time care was provided to Resident #60. No documentation was found for the following dates and times:--12/01/25 at 12:53 PM--12/02/25 at 9:30 AM--12/02/25 at 2:44 PM--12/02/25 at 3:38 PM--12/02/25 at 3:59 PMOn 12/16/25 at 9:05 AM, an interview was held with the Administrator and the Director of Nursing (DON). The Administrator stated, This was a documentation error .the care was provided .we aren't taking credit for the care we provide.b) Resident #17On 12/15/25 at 3:00 PM, a facility-reported incident (FRI) was reviewed. The FRI was dated 12/02/25 regarding incontinence care not being provided for more than two (2) hours. This initial allegation of neglect was given to the Ombudsman. An investigation was completed by the facility and found the resident did receive incontinence care. The NAs were not documenting each time care was provided to Resident #17. No documentation was found for the following dates and times:--12/02/25 at 5:00 AM --12/02/25 at 7:45 AM--12/02/25 at 3:00 PM On 12/16/25 at 9:05 AM, an interview was held with the Administrator and the Director of Nursing (DON). The Administrator stated, This was a documentation error . the care was provided .we aren't taking credit for the care we provide.c) Resident #2On 12/16/25 at 11:00 AM, a record review was completed for Resident #2. The review found meal percentages were not documented for 10/28/25 breakfast, morning snack, lunch, and afternoon snack. On 12/16/25 at 4:00 PM, the DON was notified and confirmed the meal percentages were not documented. The DON stated, I couldn't find any documentation for that day .I think the meals were not documented.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to maintain an infection control program. Staff were observed transporting soiled linen through the 100 Hallway while wearing soiled gloves. Trash Barrells sitting in resident a hallway full of soiled briefs were unable to be closed due to being so full. In addition, the 100 Hall Shower Room had a soiled washcloth, candy wrapper and open bottle of shampoo present. These were random opportunities for discovery that had the potential to affect more than an isolated number of residents. Facility Census: 59. a) 100 hall shower room On 12/15/25 at 11:44 AM, a tour of the shower room in 100 hall was completed. The tour found a soiled washcloth under the sink, a used hand wipe and candy wrapper on the floor, and an open bottle of soap sitting on the shower bar. On 12/15/25 at 11:45 AM, the Administrator was notified and entered the shower room. The Administrator began picking up the objects throughout the shower room. b) Soiled linen and soiled gloves On 12/15/25 at 1:45 PM, an interview was held with Resident #17. The resident stated, They leave those barrels in the hallway without emptying them and the smell comes into my room and it makes me sick at my stomach. On 12/15/25 at 1:47 PM, Restorative Aide #66 was observed carrying soiled linen with soiled gloves down the 100 hall to the soiled linen [NAME]. Restorative Aide #66 was asked, Is this how you are supposed to transport soiled linen while wearing soiled gloves? Restorative Aide #66 stated, I'm sorry I didn't know .I'm filling in because of low staffing today. On 12/15/25 at 1:49 PM, an interview was held with Nurse Aide (NA) #65. NA #65 stated, The soiled linen should be bagged up before bringing it into the hall and soiled gloves should not be worn in the hall. On 12/15/25 at 1:56 PM, the Administrator was notified and confirmed the soiled linen should be bagged up before bringing it into the hall and soiled gloves should not be worn in the hall. c) Three compartment barrels On 12/15/25 at 1:50 PM, three (3) barrels were noted in the hallway. One for soiled linen, One for personal clothing and one for trash. The barrel lid could not be closed completely due to the barrel being full of dirty briefs. NA #65 confirmed the barrel could not be closed completely due to being to full. On 12/15/25 at 1:56 PM, the Administrator was notified and confirmed the barrel lids were not completely closed. We will get this taken care of.</p>		