STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515174	A. Building B. Wing	06/05/2025

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. . Based on observation, staff interview, and resident interview the facility failed to ensure residents were treated with respect and dignity, by passing medications, and doing blood pressures in the dining room in a group setting and by not ensuring Resident Council Meeting was conducted with no interruptions. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Facility Census 71. Findings include: a) Resident council meeting During the Resident Council Meeting on 06/04/25 between 2:30 PM and 3:00 PM, the following staff opened the closed door and entered with residents, or was looking for someone: Registered Nurse (RN) #31 Nursing Assistant (NA) #80 and NA #35 The Resident Council in its entirety said that staff come in all the time while they are doing activities to give them medicine, and check their blood pressure. Resident Council [NAME] President, Resident #19, stated, I don't understand why they can't take us out to do that. During an interview on 06/04/25 at 3:05 PM, confidential employee #1 stated, Yes, they come into activities and give out medications and have checked blood sugars. During an interview on 06/04/25 at 3:30 PM, confidential employee #2 stated, I am not sure what to do about it. Sometimes they are in activities all day so the nurses just come in there to give them their medications. I did forget to put the sign on the door for the Resident Council Meeting, but the door was shut. (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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Confidential employee #1 and # 2 confirmed that medications were being passed in the dining room and that the Resident council meeting was disrupted.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. . Based on observation, staff interview and resident interview the facility failed to ensure resident grievance forms were easily accessible to residents. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Facility Census 71. Findings include: During the Resident Council Meeting on 06/04/25 at 2:40 PM, Resident Council members as a whole said that they did not know where to find a form to file a grievance. An observation on 06/04/25 at 3:20 PM, of the front lobby area and the nurses station revealed no grievance forms were out and accessible to residents. During an interview on 06/04/25 at 3:25 PM, The Licensed Social Worker (LSW) stated, We keep them in a box behind the nurses station. The LSW confirmed, the grievance forms were not accessible to residents. .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the Facility failed to ensure the PASRR Preadmission Screening and Resident Review) was current and coordinated with the MDS. This was true for one (1) resident of five (5) reviewed during the annual survey process. Resident identifier: #2. Facility census: 71. Findings included: a) Resident #2 Resident #2 was admitted on [DATE]. Resident #2 had a diagnosis of major depressive disorder dated 03/30/16. The resident received medications for depression. There were physician orders for: Quetiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate) (Seroquel) Give 1 tablet by mouth two times a day for Episodes of mania and depression r/t Bipolar Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) (Zoloft) Give 1 tablet by mouth two times a day for Depression Pharmacy Active 1/23/2 . The PASRR was completed by facility on 12/26/16. Major depression was not listed on the PASARR. The resident had the diagnosis prior to the PASARR being completed. This was reviewed with the DON on 06/05/25 at approximately 1:10 PM. She had nothing to add. On 06/05/25 at the exit conference, the facility administrator stated that the diagnosis of major depression occurred before the PASARR was completed, and he did not feel the PASARR needed to be updated especially since a Level II screening was not required.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. . Based on medical record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. The facility failed to collaborate with Hospices services. This was true for one (1) of one (1) resident reviewed for hospice services. Resident identifier #30. Facility Census: 71. Findings Included: a) Resident #30 A medical record review revealed Resident #30 was receiving Hospice Services starting on 03/31/25. A continued record review of physician's orders showed an order: --Order Summary: Resident is on hospice care related to: End of life care due to advanced dementia. Review of Resident # 30's Hospice documentation showed it did not contain an active care plan or collaborating documentation from Hospice Services. During an interview with the Director of Nursing #30 on 06/05/25 at 1:13 PM, she verified that Resident #30 was receiving Hospice Services and had no current coordinated plan of care with the Hospice on her medical record with the provider responsible for performing each or any specific services/functions that have been agreed upon. She stated that she downloaded the documentation from the cloud today. She verified the care staff did not have access to the documentation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff interview and observation the facility failed to ensure the environment in which it had control of, was free from accidents and hazards. This failed practice was a random opportunity for discovery and had the potential to effect more than a limited number of residents. Resident identifier #40. Facility census 71. Findings include: a) Resident #40's room An observation on 06/03/25 at 11:25 AM, revealed a gallon jug of Ecolab Lime-A-way underneath Resident #40's sink. The sink did not have an enclosure. During an observation with the Administrator on 06/03/25 at 11:35 AM, The Administration confirmed that the jug of Ecolab Lime-A-way was under the sink and should not be there. The Administrator then stated, I can only assume that the sink was stopped up and they accidently left it in here. I will have maintenance do a house wide sweep to make sure there is nothing else. b) Resident #40 A record review on 06/03/25 at 12:30 PM, revealed that Resident #40 has a diagnosis of Alzheimer's. Further record review revealed a care plan focus that reads as follows: (Resident #40 named) is at risk for falls: generalized weakness, lack of safety awareness, psychotropic medication use. c) Safety Data Sheet for Lime-A-way A review of the Safety Data Sheet (SDS) on 06/03/25 at 2:00 PM, for the Lime-A-way reads under section 2 Hazards identification as follows: Causes severe skin burns and eye damage. Section 4 First aid measures reads as follows: In case of eye contact, rinse immediately with plenty of water, also under eyelids, for at least 15 minutes. Get medical attention immediately. In case of skin contact, wash off immediately with plenty of water for at least 15 minutes. Use a mild soap if available. Wash clothing before reuse. Thoroughly clean shoes before reuse. Get medical attention immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If swallowed, contact the Poison's Information Center. Rinse mouth with water. Do not induce vomiting. Never give anything by mouth to an unconscious person. Seek medical attention immediately. If inhaled, remove to fresh air. Treat symptomatically. Get medical attention.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. . Based on observation, resident interview, and staff interviews, the facility failed to post menu timely and adequately. This has the potential to affect a limited number of residents. Facility census: 71. Findings included: a) Menu Posting During an observation of the dining process on 06/02/25 at 11:35 AM, found the posted menu fried chicken, green beans, and potato wedges. During an interview with Resident #51 on 06/02/25 at 11:38 AM she stated, they never get what is on the menu. An observation of Activities assistant going around the dining room with a copy of the posted menu informing the residents in the dining room they were having fried chicken, green beans, and potato wedges. An observation at 06/02/25 at 12:35 PM of the meal served was chicken, potato wedges and okra. During an interview on 06/02/25 at about 12:50 PM the Dietary Manager stated that she never noticed the mistake on the posted menu. When asked how she notifies residents of changes to the menu, she stated that she tells the staff that ask. During an observation on 06/03/25 at about 8:40 AM found no breakfast menus posted. An observation found most residents had completed their meal and had left or were leaving the dining area. During an interview on 06/03/25 at about 8:45 AM the Administrator verified the menus should be posted prior to the meal service.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on Observation, resident interview and staff interviews, the facility failed to honor residents drink preferences. This has the potential to affect a more than a limited number of residents. Resident Identifiers #32 and #40. Facility census: 71. Findings included: a) Resident preferences During an observation and interview of dining services on 06/02/25 at 12:45 pm Resident #32 had consumed his coffee and asked this Surveyor if he could have another cup. During an interview with the Activities Assistant (AA) 06/02/25 at 11:46 AM he stated that he was out of coffee and Resident #32 would have to wait until the coffee cart came out in about 15 minutes or so. Continued observation found Resident #32 table mate trying to pour her coffee in his cup. Subsequent observation at 12:05 PM of Resident #40 ask (AA) if he could have a second cup of coffee. AA stated he would have to wait until the drink cart came out. An observation at 12:25 PM found that Residents #32 and #40 had still not received a second cup of coffee. At this time, I ask the Dietary Manager if the residents could have coffee. An observation on 06/03/25 at 11:52 AM found residents in the dining area with empty cups. An interview on 06/04/25 at 12:15 PM the Activities Director stated there is no reason the residents could not have a cup of coffee or other drinks at any time, she stated that they just have to let the kitchen staff know and they would get it.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and equipment manual review the facility failed to keep the ice machine in safe operating condition. This has the ability to affect all Residents that get their nutrition from the kitchen, also residents that attend food related activities. Facility Census: 71. Findings Included: a) Ice Machines On 06/05/25 at 9:40 am the tour with the Maintenance Director found the ice machines located in the Kitchen area had a drain pipe running on the floor to a drain and the nutrition room on had no required air gap on the ice machine drains. The drain pipes were touching the drains. On 06/05/25 throughout the tour, the Maintenance Director confirmed the drain pipes / tubing should not be down in the drain or touching the drain. He states that he would get them fixed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 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 (1) one of (5) five residents reviewed for unnecessary medications during the Long-Term Care Survey Process. Resident identifiers #48, and #61. Facility census 71. Findings Include: a) Resident #48 A record review on 06/05/25 at 11:55 AM, of Resident #48's orders, revealed an order for Trazodone oral tablet 50 Milligrams (MG) to give (1) one tablet by mouth one time a day for Depression. Further record review of Resident #48's active diagnosis, revealed that Depression was not listed as a diagnosis. During an interview on 06/05/25 at 1:11 PM, Registered Nurse Unit Manager, (UM) stated, It's on the order, but I could not find it in the diagnosis. She confirmed that the diagnosis of Depression was not there as indicated for the Trazodone medication. B) Resident #61 A review of Resident #61's medical record found a physician order for a dysphagia advanced diet. There was a Speech and Language Pathologist evaluation completed on the resident on 04/01/25. This evaluation provided the following diagnoses: Displaced intertrochantric fracture of right femur, subsequent encounter for closed fracture with routine healing Vascular dementia, severe, without behavioral disturbance, mood disturbance, and anxiety Gastro-esophageal reflux disease without esophagitis Cognitive communication deficient Dysphagia, oral phase. A review of the list of active diagnosis contained in Resident #61's medical record found it was void of the Dysphagia diagnosis. On 06/05/25 at approximately 1:12 PM, this was reviewed with the DON. She acknowledged this omission.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to maintain a sanitary environment related to a hole in the dining room counter top that would allow garbage into a storage cabinet. Facility census 71. Findings include: a) On 06/02/25 at approximately 12:00 p.m., this surveyor observed a hole in the counter top located in the back of the dining room. Observed in the counter top hole into the cabinet below what appeared to be a a used plastic utensil and opened salt and pepper paper packets located in the hole. b) Interview with the facility's Guest Services director on 06/02/25 at12:10 p.m. verified the finding. The finding was also acknowledged by the facility administrator on 06/02/25 at 12:15 p.m and upon exit on 06/05/25 at approximately 3:00 p.m.