

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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 and staff interview the facility failed to provide a clean comfortable, homelike environment. This was a random opportunity for discovery and had the potential to effect more than a limited number of residents during the Long-Term Care Survey Process. Resident identifiers: #5, #8, #50. Facility Census: 106. Findings include:</p> <p>a) Resident #5 Packaged Terminal Air Conditioner (PTAC) unit</p> <p>An observation on 02/09/26 at 1:03 PM, of the Packaged Terminal Air Conditioner (PTAC), unit in Resident #5's room revealed both filters in the PTAC unit to be fully covered in approximately (2) two inches of dust/debris.</p> <p>During an interview on 02/09/26 at 2:00 PM, Housekeeper (HK) #53 stated, The person in charge of this department is out right now. I am filling in for her from the building across the road. HK #53 confirmed the PTAC units filters were dirty and needed cleaned.</p> <p>During an interview on 02/09/26 at 3:20 PM, The Director of Maintenance (DM) stated, I don't have a policy or a schedule written down but we clean them monthly. We will get them cleaned.</p> <p>b) Resident #50</p> <p>On 02/09/2026 at 12:30 PM , during the initial resident interview process the following was observed in Resident #50's room:</p> <p>Twall behind the bed and on the right side of the had multiple scratches with paint missing. At 1:05 PM, Licensed Practical Nurse #32 confirmed the walls were missing paint and had multiple scratches.</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 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>Based on record review, staff interview and observation, the facility failed to ensure an effective infection prevention and control program. was maintained. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #33, #106, #90, #96, #57, #65, #51 and #78. Facility Census: 106.</p> <p>On 02/09/26 at 2:24 PM, it was observed Activities Assistant #49 enter Resident #78's room with droplet precautions sign on door and a red stop sign draped across the front of the door. Activities Assistant walked into room and handed her a package without wearing Personal Protective Equipment PPE. During this time, other staff was in the room wearing PPE.</p> <p>On 02/09/26 at 2:30 PM, during an interview with Activities Assistant #49 when asked if Resident #78 was under precautions, she reported, She doesn't have anything. She has been going to dining room with no mask. When the sign was pointed out on the door and nurse aide whispered this resident had COVID, Activities Assistant #49 stated, Then yes, I should have been suited up.</p> <p>02/09/26 1:25 PM the Hall 200 Tray Delivery and Meal Set up was observed. During this time It was observed that the Admissions Coordinator did not offer proper hand hygiene to Resident #96 and #106 when she delivered and assisted in the meal set up.</p> <p>On 02/09/26 at 1:28 PM, It was observed that Employee #24 did not offer proper hand hygiene to Resident #90 on the 200 Hall during lunch tray delivery and meal set up</p> <p>On 02/09/2026 1:25 PM, in an interview with the Admissions Coordinator, she acknowledged she did not offer hand sanitizer to Resident #96, and #106.</p> <p>ON 02/09/26 1:28 PM, during an interview with Employee #24, she acknowledged she forgot to offer the proper hand hygiene. She stated she usually was very good at remembering that.</p> <p>On 02/10/26 at 1:45 PM, during dining room observation, it was observed that Employee #47 carried Resident #33's plate with his thumb resting in the inside of the plate's food's barrier.</p> <p>In an interview with Employee # 47 he acknowledged he had placed his thumb too far into the plate's food barrier while carrying Resident # 33's plate.</p> <p>In an interview with the Corporate Coordinator, on 02/10/26 at 2:25 PM, she acknowledged the staff's lack of proper hand hygiene in the 200 hall on 02/09/26 and the dining room on 02/10/26.</p> <p>Findings included:</p> <p>a) The facility's policy and procedure for Exhaust System Inspection stated that exhaust fans for soiled and clean laundry rooms should be inspected monthly and ensure that air flow is sufficient enough to hold a piece of paper to the vent when operating.</p> <p>On 02/11/2026 at 2:20 PM, an investigation of the laundry room was initiated with the Life Safety Surveyor and the Maintenance Director. It was observed that the air was not pulling from clean side to the soiled side of the door with the tissue test.</p> <p>(continued on next page)</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>The facility's policy and procedure for Special Contact and Droplet Precautions stated, 2. Keep the patient's door to the room closed unless doing so would endanger the patient. Multiple doors to covid positive resident rooms were observed to be open on two halls on 12/09/2026 during the initial survey process. On 02/10/2026 at 11:30 AM, the state surveyor and the Infection Preventionist Registered Nurse observed two covid positive room doors opened. In one, the nurse reported the resident wears a mask and leaves his room. In the other room, the door was closed by the nurse during the 200 hall observation.</p> <p>c) The facility's policy and procedure for Special Contact and Droplet Precautions stated, 4. Wear proper PPE including respiratory protection (N95 respirator), gown, and gloves prior to entering the room of those who require Special Contact and Droplet Precautions. Eye Protections is highly recommended for encounters with positive patients, and is required for use during aerosol-generating procedures (AGP).</p> <p>On 02/09/2026 at 12:40 PM, the Occupational Therapist was observed with no eye protection on while inside a covid positive patient's room When asked if they had a face shield or glasses, the Occupational Therapist stated, No, I don't have it.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on record review and staff interview, the facility failed to ensure education was offered for all staff for Covid-19 vaccines. The failed practice had the potential to affect more than a limited number of residents. Facility Census: 106. Findings included: a) The federal guidelines stated that education must be provided for all staff for the risks and benefits of the vaccine and the Covid-19 vaccine should be offered by the facility or the facility should offer information on how to obtain the vaccine. b) HealthStream education system provided to staff was reviewed for five nursing assistants by the surveyor assigned staffing. No documentation was found for education on the covid vaccine. On 02/11/2026 at 12:00 PM, the Infection Preventionist Registered Nurse reported she only gives information to staff if they request it for the Covid-19 vaccine. On 02/12/26 at 10:42 AM, the Infection Preventionist Registered Nurse stated, there was Nothing in HealthStream.</p>		