STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515125	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cameron Healthcare Center	20 Wilson Drive Cameron, WV 26033

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50795 Based on record review, and resident and staff interviews, it was determined that the facility staff failed to treat residents with respect and dignity, and to allow the residents the right to exercise his or her rights as a resident of the facility. This finding was true for one (1) of two (2) residents reviewed for the dignity care area during the survey. Resident Identifier #4. Facility Census: 52. Findings Included: a) Resident #4 During an interview on 08/12/24 at 2:57 PM, Resident #4 stated that she prefers to use a bedpan when voiding. Resident is non-ambulatory. Her diagnoses include fibromyalgia, acute and chronic respiratory failure, muscle wasting and atrophy of right and left upper arms, generalized muscle weakness, and morbid obesity. Resident is on oxygen, and requires substantial assistance, including the use of a lift for transfers. Resident stated that when Nurse Aide (NA) #53 was on duty, he refused her request for a bedpan, stating You call for a bedpan more than anyone else in the facility. Instead, NA #53 insists that resident use the bedside commode. Resident stated that it takes time for the staff to assist her to the bedside commode, and that by then she has usually voided into her brief. She further stated that the lift causes her pain due to her fibromyalgia. A review of resident's care plan reveals a note that states Toilet transfer: Totally dependent of 2 = 2 or more helpers do all the effort. Resident does none of the effort. Date Initiated: 02/18/24. Another note in the care plan states: Resident is incontinent of urine. Resident will remain free of skin break down due to incontinence. Date Initiated: 05/30/23 Revision on: 04/24/24. During an interview with the Director of Nursing (DON) #52 on 08/13/24 at 1:52 PM she stated that NA #53 was not available for interview because he worked at the facility on a part time basis. She further stated that it was possible that NA #53's refusal to offer resident a bedpan at her request was because getting Resident #4 out of bed would allow her to more fully void her bladder. Resident #4 was not given the opportunity to exercise her right to make a choice in the provision of her care. 50801 (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: 515125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Cameron Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Wilson Drive Cameron, WV 26033	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F Tag 550 Based on observation and staff interview, the facility failed to have the ombudsman information posted easily assessable to residents. This failed practice had the potential to affect more than a limited number of residents who are not tall enough or in wheel chairs Facility census: 52. Findings include: A) Resident Council Meeting During a resident council meeting on 08/14/24 at 9:30 AM, the residents stated they were aware of their rights and knew where the ombudsmen phone number was, but they did stated the board is not low enough for them to read it. They went on to state the board is too high for them to get the number with out asking for assistance. On 8/14/2024 at approximately11:35 AM, the Social Worker confirmed the Board for resident rights and ombudsman information was too high for the residents in wheel chairs to read.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 50801 Based on observation and staff interview, the facility failed to have the Ombudsman information posted that was easily accessible for residents. This failed practice had the potential to affect more than a limited number of residents who are not tall enough or in wheel chairs. Facility census: 52. Findings included: a) Resident Council Meeting During a Resident Council meeting on 08/14/24 at 9:30 AM, the residents stated they were aware of their rights and knew where the Ombudsmen phone number was located. They further stated that the board was not low enough for them to read it. They went on to state that the board is too high for them to get the number without asking for assistance. On 8/14/2024 at approximately 11:35 AM, the Social Worker confirmed the Board for resident rights and Ombudsman information was too high for the residents in wheel chairs to read.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50795 Based on observations and staff interview, facility staff failed to provide the housekeeping services necessary to maintain a safe, clean, comfortable, and homelike environment, by not maintaining the water temperature at a comfortable level for residents, and not ensuring that the shower rooms, and residents bathrooms were free of any accumulated dirt, grime, or other substances, and foul odors. Resident Identifiers: #4, #10, and #13. Facility Census:52. The findings included: a) Resident #4: During an interview with Resident #4 on 08/12/24 at 1:22 PM, she stated that the water was always cold when she was given a shower. An inspection of the resident's hand sink revealed no hot water, even after the water was left running for over three minutes. NA #8 confirmed that water temperature was cold. b) Resident #10 During an inspection of Resident #10's bathroom on 08/12/24 at 1:44 PM, a black substance was noted between the floor tiles. NA #8 responded to this surveyor's request and confirmed the black substance. She stated that the floor needed to be cleaned. c) Resident #13 An interview with Resident #13 on 08/12/24 at 2:18 PM, the resident stated that the water was always cold. An inspection of the resident's bathroom revealed a foul, offensive odor. NA #8 confirmed that the bathroom smelled bad, and that it needed to be cleaned. Inspection of the resident's hand sink revealed that no hot water flowed out of the faucet, after the water had been running for at least three minutes. NA #8 confirmed that water temperatures were always cold. She stated that it was a frequent complaint from the residents. d) B-Hallway Shower Room: An inspection of the shower room on B Hallway on 08/12/24, at approximately 2:20 PM revealed two (2) shower benches with a brown substance on their legs. The whirlpool tub contained wheelchair footrests. NA #8 confirmed the observations and explained that the facility was not currently using the whirlpool bath. e) Resident Council A document review revealed a grievance log with complaints about the shower room. 1) On 03/20/24 a Resident Council attendee's complaint stated: Residents don't think shower room is clean enough, and needs to be cleaner and stocked better. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Cameron Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 20 Wilson Drive Cameron, WV 26033	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 4/17/24 Residents #18 and #46 complained that the shower room needs to be cleaned better and should have air fresheners. 3) 0n 05/22/24 a Resident Council attendee's complaint stated: Complaints about the shower room not clean enough, and odor. The grievance log further states that these issues were addressed after each complaint. During an interview with the Director of Plant Maintenance (DPM) #13 on 08/12/24 at 2:52 PM, he stated that the facility attempted to maintain hot water temperatures between 105 and 109 degrees Fahrenheit (F). A request for a temperature check of the hot water in Resident #13's room revealed a temperature of 78 degrees Fahrenheit. DPM #13 confirmed that the water temperature was not within the specified range.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on record review, facility documentation, and staff interview, the facility failed to protect residents from resident abuse. The facility failed to provide a safe environment for Residents. The deficient practice put five (5) of five (5) Residents at risk for serious injury, serious harm, serious impairment, or death. Resident Identifiers #32, #52, #14, #49, #36, and #24. Facility census: 52. The facility was notified of the Immediate Jeopardy (IJ) at 6:53 PM on 08/13/24. The facility submitted their first abatement plan of correction (POC) at 7:28 PM on 08/13/24. The POC was accepted by the state agency at 7:47 PM on 08/13/22. After observation of the implementation of the abatement POC, the IJ was abated at 3:30 PM on 08/14/24. The IJ started on 08/13/24 and ended on 08/14/24. The facility's approved abatement POC consisted of the following: Correction action for area of concern- - Education to all staff in building at current time with remaining education to all staff 8/14 - education will be on 1:1 process - Resident is 1:1 on 8/13 @ 7:1 - Monitor signs and symptoms of agitation - notify physician immediately with any increased agitation - Utilize medications appropriately - Social Services Supervisor will conduct resident interviews on all residents who are able to be interviewed - Body audits will be completed by licensed nurses to ensure no abuse or neglect - Ad hoc QAPI will be conducted on 8/14 with physician to discuss abatement plan - Additional education will be provided as needed DISCLAIMER: The preliminary findings and subsequent abatement plan are not an admission of wrongdoing, but an acknowledgement of the surveyor's preliminary findings. Findings included: a) Resident to Resident Abuse (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review during the Facility Reported Incident (FRI) surveys found Resident #32 was admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) score was 4 which indicates severe cognitive impairment. On 01/09/24 Resident #32 was noted to be physically aggressive, putting Resident #36 in a head lock. On 02/01/24 Resident #32 was reported to wrap his arm around another Resident #36's neck then placed his head on the back of his neck and squeezed. Continued review found Resident #32 was sent to Laurel Place for behavioral health treatment from 02/23/24 through 03/06/24. Discharge diagnoses from Laurel Place: Major Depressive Disorder, Anxiety Disorder, Dementia with Behavioral Disturbance, Inappropriate Sexual Behavior. Subsequent review found on 03/24/24 Resident #32 grabbed Resident #49 by the right arm, shaking him and stating he was going to kill him. On 4/3/24 Resident #32 grabbed Resident #24's left hand and wrist, squeezed and twisted, causing swelling, bruising and pain to the left wrist. 1:1 intervention -04/04/24 through 04/10/24. 05/16/24 Resident #32 becoming physical aggressive trying to take Resident #14's plate of food. 1:1 intervention -05/17/24 through 05/20/24. A Progress note on 7/23/24 Notified that Resident #32 has been agitated most of the day. He has been going into other residents' rooms with aggressive behaviors. He went into Resident #52's room to begin fighting when Resident #52 pushed Resident #32 to the floor. Resident #32 fell to the floor although continued with aggressive verbiage attempting to attack staff as well as residents. Police were notified to calm the situation although resident continues with outbursts. 1:1 intervention -07/08/24 through 07/12/24. 1:1 intervention -07/23/24 through 07/23/24. During an interview on 08/13/24 about 5:00 PM the Administrator verified all noted incidents. She stated that they have tried everything with Resident #32.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50795 Based on record review, and staff interview, the facility failed to report a fall with serious injury to the required agencies within the specified time period. This failed policy had the potential to affect an isolated number of residents that reside in the facility. Resident Identifier: #37. Facility census:52. Findings Included: a) Resident #37 Review of records on 08/13/24 at 11:32 AM revealed a note dated 7/22/2024 at 1:33 AM by Licensed Practical Nurse (LPN) #43. The note stated: Resident fell and hit head in her bathroom large knot and laceration above the left eye. (name) MPOA notified. Telehealth called and gave orders to transfer resident to local hospital. Resident complains of neck pain and some bruising to right hand and left knee. Another note on 7/22/24 at 5:11 AM by LPN #35 stated: Nurse at (local hospital) said resident is being transferred to (area trauma center). She has a laceration to forehead, contusion to (L)chest wall, contusion to face, CT showed cervical fracture. During an interview with the Social Worker on 08/14/24 at 1:58 PM she produced a Facility Reported Incident (FRI) that had been submitted to the Office of Health Facility Licensure and Certification (OHFLAC). Review of the report revealed that the staff had become aware of the fall at 1:23 AM on 07/22/24. The Administrator had been notified of the fall at 7:00 AM on 07/22/24. Further review of the report revealed that no other agencies were notified of the fall, and that the report had been submitted to OHFLAC on 07/22/24 at 11:17 AM. The facility was not in compliance with this requirement because the fall had been reported over six (6) hours after facility had knowledge that a serious injury had occurred, and no notification had been submitted to Adult Protective Services (APS) and Ombudsman.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to ensure that the resident's Pre-Admission Screening (PAS) reflected pre-admission diagnoses for one (1) of one (1) residents reviewed for the category of PASARR (Pre-Admission Screening and Record Review), during the Long-Term Care Survey process. Resident identifier: #39. Facility census: 52. Findings included: a) Resident #39 A record review, completed on 08/13/24 at 7:30 PM, revealed Resident #39 had been admitted to the facility on [DATE] with an admitting diagnosis of Major Depressive Disorder. The admitting PASARR, dated 12/09/21, did not identify Resident #39 had a major depressive disorder on Section III, Question 30 of the PAS. A continued record review also revealed there was never a new PAS completed that revealed resident's major depressive disorder diagnosis in order to address whether or not specialized services were needed. During an interview on 08/14/24 at 9:45 AM, the Social Worker acknowledged the admitting PAS failed to identify resident's major depressive disorder diagnosis and that there was never a new PAS completed that revealed resident's major depressive disorder diagnoses. The Social Worker then stated she would complete a new PASARR for Resident #39 to reflect the major depressive disorder diagnosis.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43340 Based on record review and staff interview, the facility failed to ensure residents who experienced weight loss of five (5) pounds or more were re-weighed to verify weight was correct. This was true for one (1) of one (1) resident's reviewed under the nutrition pathway during the Long-Term Care Survey Process. Resident Identifier: #38. Facility census: 52. Findings included: a) Resident #38 A record review, completed on 08/13/24 at 2:02 PM, revealed there was a physician order for resident to have weekly weights. The review also revealed the following weights for Resident #38: -On 02/12/2024 at 1:01 PM, Resident weighed 90.0 Lbs. -On 02/21/2024 at 2:38 PM, Resident weighed 81.4 Lbs. -On 03/01/2024 at 9:10 AM, Resident weighed 81.0 Lbs. A review of the facility's Resident Height and Weight policy, completed on 08/13/24 at 2:33 PM, revealed the following guidelines for obtaining a resident's weight: --Compare weight to previous weight obtained. If a variance of 5 pounds or more is noted, Reweigh resident to verify weight. --Documentation: In EHR (Electronic Health Record) During an interview on 08/14/24 at 11:23 AM, the Director of Nursing (DON) acknowledged a reweigh had not been recorded in the electronic medical record after staff weighed Resident #38 on 02/021/24 and there was a weight loss of 8.6 lbs. The DON stated she would review the dietician's notes and follow-up with surveyor if she found any documentation about resident being reweighed. No further information was provided prior to surveyor's exit from the building.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49751 Based on observations and staff interviews the facility failed to ensure the facility nursing staff posting was completed for the day shift. This was a random opportunity for discovery during the revisit survey. Facility Census: 53 Findings include: On 10/02/24 at approximately 9:32 AM a surveyor observed the Nursing staffing sheet hung at the end of C - Hall was not completed for the Day shift. During an interview with Licensed Practical Nurse (LPN) #40 confirmed the staffing sheet should have been completed. The LPN stated, I'm doing it now we have been passing meds. An interview with the Director of Nursing (DON) was completed on 10/02/24 at 12:00PM. The interview confirmed the staffing sheet should have been completed at the beginning of day shift. Record review on 10/02/24 of the facility's policy #: NS 1091-01 under Procedure it stated, The facility will post the nurse staffing data daily at the beginning for each shift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 50801 Based on observation and staff interview, the facility failed to dispose of expired food items. This failed practice had the potential to affect more than a limited number of residents who were served food from the kitchen. Facility census: 52. Findings included: a) Initial Tour of Kitchen During the initial tour of the kitchen, on [DATE] at 11:30 AM, with the Dietary Manager revealed One (1) unopened box of muffin mix found to have an expiration date of [DATE], stamped on the container by the manufacturer. The Dietary Manager stated This should have been thrown out and immediately disposed of muffin mix. Based on observation and staff interview, the facility failed to dispose of expired food items. This failed practice had the potential to affect more than a limited number of residents who are served food from the kitchen. Facility census: 52. Findings included: A) Initial Tour of Kitchen with Dietary Manager My Observations during the initial tour of the kitchen, on [DATE] at 11:30 AM, revealed: One unopened box of muffin mix found to have an expiration date of [DATE], stamped on the container by the manufacturer. The Dietary manager stated: This should have been thrown out and immediately disposed of it

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50795 Based on observation, interviews with facility staff, and a review of facility policy and procedures, it was determined that the facility failed to follow acceptable infection control practices that controlled, or prevented, the spread of infection. This practice had the potential to affect all residents that reside in the facility. Facility Census: 52. Findings included: a) Water Management During facility record review of the water management, it was revealed that the facility did not have a Water Management Plan, or a water flow diagram which identified the facility's water systems for which Legionella control measures were needed. No documentation was maintained, or provided, describing facility's control practices to prevent growth of water borne pathogens. b) Laundry Services On 08/14/24 at 2:16 PM an inspection of the soiled laundry room, accompanied by Director of Plant Maintenance (DPM) #13 observed that the door between the soiled laundry room and clean laundry room was held open by a box of detergent. The clean laundry room contained a rack of uncovered clean clothing in close proximity to the open door. The opened door potentially caused contamination of the clean laundry. DPM #13 confirmed that the door should not have been left open. On 08/14/24 at 1:58 PM, during an interview with the DPM #13, revealed that he was unable to locate the facility's water management plan, and water system flow diagram. He mentioned that he had taken measures to control and prevent the growth of opportunistic waterborne pathogens, such as flushing unused water outlets, and shower heads. However, he admitted to having no documentation, or logs, of the measures taken. At approximately 3:48 PM on 08/14/24 DPM #13 submitted a document which stated, I typed this down word for word as I was Instructed. : TYPED AS WRITTEN Hot Water Distribution Water goes underground to main mechanical room via 6-inch water line that feeds the fire suppression sprinklers and then flows through a back flow converter, then branches into 3 hot water heaters. One (tank #3) is located in the main mechanical room that feeds laundry room and kitchen. (Washer 1, washer 2, 3 sinks. C hall sinks, showers, resident restroom, and nurses station restroom. Tank #2 does pantry, ct tub, janitor's closet dump sink, B hall sinks and med room. Cold Water Distribution (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enters main mechanical room, same as above and branches to sinks, toilets, ice machines throughout facility and hose bibs outside, then drains to local sewage plant. Facilities must be able to demonstrate their measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. Water management must be based on nationally accepted standards (e.g., ASHRAE (formerly the American Society of Heating, Refrigerating, and Air Conditioning Engineers), CDC, U.S. Environmental Protection Agency or EPA) and include: o An assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter) could grow and spread; and o Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them. Examples of an assessment include a description of the building water systems using text and flow diagrams for identification. Additionally, control measures may include visible inspections, use of disinfectant, and temperature (that may require mixing valves to prevent scalding). Monitoring such controls includes testing protocols for control measures, acceptable ranges, and documenting the results of testing. Water management should also include established ways to intervene when control limits are not met.