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	03/04/2026

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 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. Based on observation, resident interview, staff interview and policy review the facility failed to provide a comfortable home like environment in the communal 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 Long-Term Care Survey Process. Resident identifier: #42. Facility census: 54.Findings Include:a) Communal Shower RoomDuring the initial interview on 03/02/26 at 12:40 PM, Resident #42 stated, The shower room is cold. That is why I wash myself off at the sink a lot of days.An observation on 03/02/26 at 1:00 PM, revealed the shower room felt cool. There was no thermometer in the shower room to get the actual temperature.A further observation of the communal shower room at 1:05 PM, with The Director of Maintenance (DOM), confirmed the room felt cool and noted there was no thermometer to get the actual temperature. The DOM took the room temperature with the water temperature thermometer, which read 71 degrees Fahrenheit. The State Agency (SA) asked if he had a wall thermometer he could place in the room so the actual temperature could be determined.A wall thermometer was placed in the communal shower room by the DOM at approximately 1:10 PMAn observation on 03/02/26 at 2:00 PM with the DOM revealed the actual temperature of the shower room to be 67.7 degrees Fahrenheit. The DOM confirmed the temperature was not comfortable for the shower room.During an interview on 03/02/26 at 2:10 PM, Nursing Assistant (NA) stated, I myself have given one shower in there today. That is the only shower room we use for residents.b) PolicyA review on 03/03/26 at 9:30 PM of the policy titled {Extreme Cold Temperature Protocol}, under policy, reads as follows: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The purpose of this policy is to provide direction when when internal environmental temperatures drop below the minimum comfort of 71 degrees Fahrenheit

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, review of clinical records, facility documentation, and staff interviews the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases, to help prevent cross-contamination and infections including Covid-19 in regard to, follow CDC (Centers for Disease Control) guidelines for use of PPE (Personal Protective Equipment) and ensure staff donned appropriate personal protective equipment (PPE) prior to wound care for a resident on (Enhanced Barrier Precautions) and provide appropriate wound cere. The facility also failed to ensure the laundry area had bags of trash and dirty laundry in receptacles. These failed practices had the potential to affect every resident currently residing in the facility. Resident identifier:# 2. Facility census: 54. Findings included: a) Resident #2A record review revealed Resident #8 was in Enhanced Barrier Precautions (EBP) due to wound care.On 03/02/26 at 2:00 PM, Licensed Practical Nurse (LPN) #35 with assistance from Nurse Aide (NA) #56 was observed providing wound care on Resident #2's pressure Ulcer without proper PPE. They were only wearing gloves.During continued observation, the surveyor noted that LPN #35 removed packaging from wound supplies and cleaned the wound bed. She then removed additional supplies and placed a clean 4x4 and gauze around the wound without performing hand hygiene.Observation of the EBP sign on the door Resident #2's room revealed a sign titled Enhanced Barrier PrecautionsThe sign stated: Attention: Caregivers, Staff, and Visitors -Wear Gown and Gloves prior to these activities: During high contact resident care activities.- Dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (i.e. central line, urinary catheters, feeding tube, tracheotomies, ventilators), and wound care: any skin opening requiring a dressing.- Face protection may also be needed if performing activity with risk of splash or spray.-See the care plan for additional information.During an interview, with LPN #35 on 03/02/26 at 2:15 PM, she stated that she should have worn a gown during wound care. She also acknowledged that she should have changed her gloves after touching any dirty area of the wound and before touching any clean areas during the treatment. During the laundry tour on 03/03/26 at approximately 11:30 AM, the surveyor observed bags of trash and bags of dirty laundry on the floor. The laundry receptacles were overflowing with dirty clothing. During the tour the Maintenance Director confirmed that no items should be placed on the floor.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interview and record review the facility failed to ensure medical assessments regarding the frequency of falls were completed accurately.This deficiency was identified in one (1) out of two (2) records reviewed. Resident identifier: #6. Facility census: 54. Findings include:a) Resident #6Review of Resident Assessment Instrument (RAI) manual for Minimum Data Sheets (MDS) Section J1800 reads in part, Any falls since admission/entry or reentry or prior assessment, whichever is more recent. Section: J1800 of the MDS, with an Assessment Reference Date (ARD) of 08/18/2025 revealed the MDS registered nurse (RN) marked the answer as (no) to the question Any falls since admission/entry or reentry or prior assessment, whichever is more recent. Record review revealed Resident #6 had fallen on 05/12/25, 06/07/25, 06/08/25. During an interview on 03/03/26 at around 11:30 AM with MDS RN #27, the RN reviewed observations and reported, I may have missed these, as they should have been answered yes. It could be an error on my end. I will go back and review and return to verify the answer. On 03/03/26 at 12:00PM MDS RN #27 returned and explained that, indeed I missed two, I have modified these to reflect the falls.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on resident interview and record review the facility failed to provide Activities of Daily Living (ADL) care to dependent residents during meal times. This failed practice was found true for (1) one of (3) three residents reviewed for ADL care during the Long-Term Care Survey Process. Resident identifier: #11. Facility census: 54.Findings Include:a) Resident #11During the initial interview on 03/02/26 at 12:35 PM, Resident #11 stated, About a week ago, I asked to have my brief changed about 15 minutes before supper and was told by the nurse aide that I would have to wait until after the meal.A record review on 03/04/26 at 9:30 AM, revealed an ADL care plan for Resident #11 that had an intervention that read as follows:Toileting Hygiene: Totally dependent of 1, 1 helper does all the effort. Resident does none of the effort.During the Resident Council meeting with the State Agency (SA) on 03/03/26 at 10:15 AM, The Resident Council as a whole said they are being told they have to wait until after meals to be changed or taken to the restroom.During an interview on 03/04/26 at 12:03 PM, the Director of Nursing (DON) acknowledged that the Resident Council and Resident #11 told the SA staff were not providing ADL care during meal times.

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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 record review and staff interviews, the facility failed to provide care and services in-accordance with professional standard of practice in regards to adverse drug consequence, Adverse consequence is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. The resident had not yet experienced side effects from the medication. This was true for one (1) of five (5) reviewed for unnecessary medications. Resident identifier #9. Facility census: 54.Findings included:a) Resident #9Adverse consequence is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. The resident had not yet experienced side effects from the medication. A review for Unnecessary Medication regarding Resident #9 identified that Acetaminophen was added to the drug allergy list on the admission date of 12/24/25.Continued medical record review revealed an order: Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 650 mg by mouth every four (4) hours as needed for Pain. Order date 02/02/26.A review of Resident #9s medication administration record found Acetaminophen 650 mg was given on 02/20/26, 02/21/26 and 03/04/26.Subsequent review of Resident #9s Medication Regimen Review (MRR) for February 2026 discovered, Acetaminophen was not noted as an Adverse Consequence.On March 4, 2026, at approximately 10:00 AM, the Director of Nursing (DON) verified the Acetaminophen was given to Resident #9 the facility nor the pharmacist identified the potential for adverse consequences regarding the administration of Acetaminophen to Resident #9.

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F 0756 Level of Harm - Minimal harm or potential for actual harm 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. Based on record review and staff interviews Medication Regimen review (MRR) failed to evaluate and report on the potential adverse consequences for a resident to receive a medication in which they had a listed drug allergy. This was true for one (1) of five (5) reviewed for unnecessary medications. Resident identifier #9. Facility census: 55.Findings included:a) Resident #9A review for Unnecessary Medication regarding Resident #9 identified that Acetaminophen was added to the drug allergy list on the admission date of 12/24/25.Continued medical record review revealed an order: Acetaminophen Oral Tablet 325 MG (Acetaminophen): Give 650 mg by mouth every four hours as needed for Pain. Order date: 02/02/26.A review of Resident #9's medication administration record found Acetaminophen 650 mg was given on 02/20/26, 02/21/26 and 03/04/26.Subsequent review of Resident #9's Medication Regimen Review (MRR) for February 2026 revealed that Acetaminophen was not noted as an Adverse Consequence.On 03/04/26 at approximately 10:00 AM, the Director of Nursing (DON) verified that neither the facility nor the Pharmacist identified the potential for adverse consequences when administering Acetaminophen to Resident #9.