

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Cabell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Hidden Brook Way Culloden, WV 25510	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review and staff interview, the facility failed to assist a dependent resident with activities of daily living (ADLs). This was true for one (1) of four (4) residents reviewed during the survey process. Resident Identifier: #10. Facility Census: 85. Findings Include: a) Resident #10 On 08/04/2025 at 4:14 PM, the resident was observed lying in bed in the resident's room and appeared to be unkempt. On 08/06/25 at 2:00 PM, the facility provided a shower schedule for Lifesteps Hall. The shower schedule indicated the resident was to have scheduled showers on Tuesdays and Fridays during day shift. The review found the resident did not receive a shower or bed bath from 07/25/25 through 08/01/25. This was a total of seven (7) days. On 08/06/25 at 2:30 PM, the Director of Nursing (DON) was asked, Do the nurse aides (NAs) follow the shower schedule? The DON replied, We don't go by that .it's more for the unit managers. However, Regional Registered Nurse (RN) #91 looked in the computer and confirmed Resident #10 should be receiving showers on Tuesday and Fridays, on dayshift. On 08/06/25 at 3:15 PM, the Regional RN #91 confirmed Resident #10 did not receive a shower or bed bath for seven (7) days.</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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