STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515192	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cabell Healthcare Center	30 Hidden Brook Way Culloden, WV 25510

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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 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. Based on record review and staff interview, the facility failed to provide a Pre-admission Screening (PAS) which included all psychiatric diagnoses for Resident #10. This was true for one (1) of one (1) resident reviewed during the survey process. Resident Identifier: #10. Facility Census: 86. Findings Include:a) Resident #10On 08/07/25 at 9:00 AM, a record review was completed for Resident #10. The review found the PASARR dated 02/22/24 did not include all psychiatric diagnoses. The diagnoses not included were Generalized Anxiety Disorder documented as of 02/08/17 and Hallucinations which was documented as of 01/02/25. The resident is being treated with Klonopin (antianxiety) and Seroquel (antipsychotic) for bipolar disorder, which includes hallucinations.On 08/07/25 at 10:41 AM, the Social Services Director (SSD) #48 confirmed all the diagnoses were not listed on the PAS.

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 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 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.

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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 interview, the facility failed to identify and provide needed care and services for two (2) of eight (8) residents. Resident #4 did not have a follow-up appointment after a hospitalization. One (1) of eight (8) residents did not have follow up care after blood glucose readings were crticially low. Resident Identifier: #4 and #70. Facility Census: 86. Findings include: a) Resident #4 On 08/05/25 at 2:00 PM, a record review was completed for Resident #4. The review found the resident was discharged from the acute care facility on 07/01/25 with the diagnoses of prostatitis, urinary tract infection with hematuria, hydronephrosis and hydroureter. On 08/05/25 at 3:00 PM, the Director of Nursing (DON) was asked when the resident's urology follow up appointment from discharge from the hospital was. The DON stated, Let me find out. On 08/05/25 at 4:05 PM, the resident was observed with a urinary foley catheter in place. The urinary drainage bag was noted with dark tea-colored bloody urine. On 08/05/25 at 4:10 PM, the nursing staff at the nursing station, was asked about this observation. The nursing staff at the desk stated, the resident pulled the foley catheter out with the balloon intact last night (08/04/25). On 08/05/25 at 4:10 PM, the DON stated, The office is closed .we have tried to call three (3) times, and we haven't gotten an answer. The resident was discharged from the acute care facility on 07/01/25. No follow up appointment was scheduled until after Surveyor intervention. On 08/06/25 at 9:15 AM, the DON stated, I don't know what happened with the communication. We have a call into the urologist. They show no follow up needed. The Surveyor asked the DON, Do you think the resident needs a follow up appointment, especially since he pulled out the urinary foley catheter with the balloon intact? The DON responded, Let me see what the office says. On 08/06/25 at approximately 11:00 AM, the DON stated, The follow up appointment is scheduled on 08/08/25 at 11:30 AM. b) Resident #70 On 08/07/25 at 11:10 AM record review shows that on 07/28/25 at 9:55 PM Resident #70 had a blood glucose documented as twenty nine (29). Further review shows no progress notes or communication with the Physician they were contacted. There was no glucose recheck documented on the level. There is no documentation that the resident was given anything to increase her blood glucose level. It was documented on the Vitals Summary as well as the Medication Administration on 07/28/25 as 29. The Care Plan shows the resident is at risk for hypoglycemia. Upon conversation with the Director of Nursing on 08/07/25 at 1:10 PM, she stated she recalled the incident and had spoken with the nurse on duty that documented the level of 29. She stated that the nurse stated I must have forgotten to add the zero on the end of it making it 290 and not 29. There is no documentation availabel to confirm this. There was no error documented with the corrected blood (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sugar. From the documentation available it appears the resident had the low glucose level and nothing was performed to increase it. This was confirmed with the Director of Nursing (DON) on 08/07/25 at 1:30 PM at which time she agreed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to ensure all residents were provided with services and assistance to ensure they had no complications of vision loss. Resident #21 was wearing glasses which were in poor repair. She had seen the eye doctor in December, but the facility failed to follow through to ensure she received new glasses. This was true for one (1) of one (1) resident reviewed for the care area of Vision/hearing during the long term care survey process. Resident identifier: #21. Facility Census: 86. Findings Include: a) Resident #21 An observation of Resident #21 at 4:03 PM on 08/04/25 found the right lens of her eyeglasses was either scratched or broken near the center of the lens. A review of Resident #21's medical record found the resident was seen by the eye doctor in house on 12/18/24. A review of the consult found the following, History of Present Illness: 1. Decreased vision The [AGE] year old client presents for evaluation of Decreased vision in the right > left. It affects both near and far vision. The condition is significant. History of trauma with a BB gun per resident od. The consultation contained a prescription for new glasses. Below the prescription the following was written, New glasses will be ordered pending insurance/payer approval.An interview with the Business office manager on 08/05/25 at 12:35 PM confirmed she had not had a remedial (an adjustment the facility can request for the resident to lower her Medicaid resource amount to allow her to pay for the glasses) adjustment for glasses.An additional observation of Resident #21 glasses at 12:45 pm on 08/05/25 with the Regional Director of Clinical Observations #91 confirmed the resident's glasses were in poor repair and needed replacement. An interview with the Director of Nursing (DON) on the afternoon of 08/05/25 found the eye doctor's office sent an invoice for Resident #21's glasses in 12/2024. She stated they had talked to the son, and he did not want to pay for them at the time. The DON was asked if the facility had explained to the son that a Remedial Adjustment could be made to her Medicaid resource amount to cover the amount of the glasses and she stated she did not know what that was and would have to check with the business office. An interview with Resident #21's son Via Telephone on 08/05/25 at 1:31 PM confirmed, no one ever called him about his mom being seen for glasses and he wanted her to have anything she needed, and he would not have said no to that. He stated, I would like her to have new glasses.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation and staff interview the facility failed to ensure personal food items were stored at the correct temperature and not expired. This was true for one (1) of five (5) personal refrigerators observed. Resident Identifier: #14. Facility Census: 86 Findings Include: a) Resident #14On 08/04/25 at 12:50 PM it was observed that Resident #14 had a personal refrigerator in her room. Upon observation it was noted that it had not had the temperature checked since 08/02/25. Further observation found that two packages of yogurt expired on 07/20/25. Both findings were confirmed with Registered Nurse #59 on 08/04/25 at 12:55 PM who agreed that they were not in compliance. According to facility policy for storage of resident food it states Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for > or + to 7 days . The dietary staff will monitor refrigerator contents for food safety and reserve the right to dispose of expired, unsafe foods . On 08/04/25 at 1:15 PM it was confirmed with the Director of Nursing and the Corporate Regional Nurse that the refrigerator should have had the temperature checked and recorded daily and the expired food items disposed of.

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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, policy review and staff interview, the facility failed to provide an accurate and complete record for Resident #4's weights. This is true for one (1) of three (3) residents reviewed under the care area of nutrition. Resident Identifier: #4. Facility Census: 86.Findings Include:a) Resident #4On 08/04/25 at 3:31 PM, a record review was completed for Resident #4. The review found weights documented from 06/23/25 through 08/03/25. The following weights were documented:--06/23/25 190.8--07/02/25 156.6--07/06/25 154.8--07/20/25 176.7--07/27/25 175.5--08/03/25 173.8On 08/06/25 at 10:30 AM, the Regional Registered Nurse (RN) #91 was notified of the discrepencies in the documented weights. The Regional RN stated, Let look over the record and check and see if something was going on.On 08/06/25 at approximately 2:00 PM, the Regional RN #91 stated, I have reviewed all the weights of the residents throughout this time. I could not find any other issue with weights. I thought maybe something may have been wrong with the scales. The Regional RN #91 then stated, it does look like there was an error in documenting these weights.On 08/06/25 at 2:15 PM, the facility policy regarding weights was reviewed. The facility policy is entitled Resident Height and Weight. Number 3 states, Compare weight to previous weight obtained. If a variance of 5 pounds or more is noted, reweigh the resident to verify weight.