STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515002	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peterson Rehabilitation and Healthcare	20 Homestead Avenue Wheeling, WV 26003

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, and record review, the facility failed to document the resident's grievance, and failed to make prompt efforts to resolve those grievances. Resident Identifiers: Resident #76. Facility Census: 137. Findings Include a) Resident #76During an interview on 10/07/25, at approximately 1:15 PM, the resident indicated that she had requested a room change due to difficulties sleeping at night. When asked about the reasons for her sleeplessness, Resident #76 mentioned that her roommate often makes a lot of noise during the night.When asked if she had informed the facility about her issues, the resident replied that she had notified both the nurse and the Director of Nursing (DON) about her complaint and had requested a room change in late August. While she could not recall the name of the nurse she had spoken to, she was confident that she had communicated with the DON. She mentioned that she was still waiting for a transfer to another room and that the DON had informed her that the facility was working on moving her as soon as a bed became available.A request for the Complaint and Grievance logs, on 10/07/25 at 10:35 AM revealed that the facility maintains documents titled Concern/Grievance logs . A review of the logs for the period 08/01/25 through 09/30/25 revealed no concerns or grievances noted for Resident #76.During an interview with the DON on 10/08/25 at approximately 9:55 AM, she stated that she was unaware of Resident #76's request. The DON confirmed that the facility was experiencing some difficulties with documentation and stated that they were actively working to train staff to ensure accurate documentation.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify potential incidents of abuse, report the alleged violations, and implement interventions to prevent further abuse and mistreatment from occurring Resident Identifiers: Residents #161 and #46. Facility Census: 137. Findings Include a) Resident #161 Record review on 10/06/24 at approximately 4:25 PM revealed that Resident #161 was no longer at the facility. Further record review revealed the following: A note on 05/14/25 at 6:30 AM by Director of Nursing (DON), which stated: Resident continuing to go into Female Residents rooms while they are sleeping. Redirected with effect Another note on 05/14/25 at 3:44 PM by the DON, which stated: social services notified about resident going into other residents rooms On 05/15/25 at 9:01 AM SW #304 documented a progress note which stated: SW spoke with resident in length on 5/14/25 about his entering other resident's room at night when residents are sleeping. This SW told [Resident] he is not permitted to enter other residents' rooms at any time unless he is given permission by the resident who occupies that room. SW explained that he was violating other resident's rights and privacy. [Resident] agreed that he would not go in and out of other resident's room. Resident #161 was observed attempting to enter Resident #5's room as evidenced by this note on 05/21/25 at 12:20 AM by RN #94 which stated: [Resident #161] sitting outside 707 where female patients were sleeping (Resident #76 and Resident #26). Aide stopped patient from entering and effectively redirected patient away from bedroom. Record review of the resident's care plan on 10/06/25 at approximately 4:20 PM revealed Resident #161's Care Plan notes that state the following: FOCUS: Resident has behaviors related to inappropriate sexual behaviors Date Initiated: 11/29/2024 Created by: (MDS Coordinator) (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revision on: 06/09/2025 Revision by: (MDS Coordinator) Cancelled Date: 06/09/2025 GOAL: Resident will have no adverse effects related to behaviors through the next review. Date Initiated: 11/29/2024 Created by: (MDS Coordinator) Revision on: 06/09/2025 Revision by: (MDS Coordinator) Target Date: 08/04/2025 Cancelled Date: 06/09/2025 INTERVENTIONS/TASKS: Administer medications per physician order. Monitor for effectiveness and side-effects. Date Initiated: 11/29/2024 Created by: (MDS Coordinator) Revision on: 06/09/2025 Revision by: (MDS Coordinator) Cancelled Date: 06/09/2025 Approach resident in a calm manner to avoid frustration and behavior escalation; If resident becomes agitated and shows signs of escalation, re-approach later. Date Initiated: 11/29/2024 Created by: (MDS Coordinator) Revision on: 06/09/2025 Revision by: (MDS Coordinator) Cancelled Date: 06/09/2025 (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 10/07/25 revealed multiple reports by staff and the Social Worker, over a period of over six (6) months, stating that Resident #161 was indulging in sexually inappropriate behaviors with female residents, as evidenced by the following progress notes: A note on 11/27/24 by Registered Nurse (RN) #94, which stated: This patient (Resident #161) along with 706-2 (Resident #53) sat outside the doorway of 704. Both patients yelling insults and curses into the room at 704-1 (Resident #119). This nurse overheard Waaaa, stick your finger up my A$$. Asked the patients to stop, unacceptable and no one wanted to hear such language. This patient threatened this nurse, Do you want to fight? Both patients refused to leave the spot outside the room, neither would move to a common area. Reported to charge nurse and social services. Will continue to monitor. A note on 12/11/24 at 4:49 PM by RN #94, which stated: Patient (Resident #161) exchanging inappropriate insults with roommate (Resident #119). A review of the Concern/grievance Log revealed that the incident was logged, but the facility did not identify this as an instance of verbal abuse between residents, failed to report it to OHFLAC, and failed to take appropriate action to ensure that the abuse would not continue. A note on 04/04/25 at 10:45 PM by (RN) #305, which stated: Resident exhibiting inappropriate behaviors with another resident. A nursing note on 04/07/25 at 11:01 PM by Licensed Practical Nurse (LPN) #303, which stated: Resident asked by staff several times to leave female residents rooms. Resident becomes agitated with staff but does leave once requested. A note on 04/08/25 at 3:56 PM by Social Worker (SW) #304, which stated: SW spoke to [Resident] this morning about the issues of him going into female resident rooms and touching them inappropriately. Staff have documented that [Resident] has these inappropriate behaviors. SW told [Resident] that he was not permitted to enter another resident's room in the facility. SW was very clear with resident about above. SW explained that if he continues to have inappropriate behaviors such as touching other females resident that this could be grounds for a 30-day notice of discharge. Resident stated that he understood. Another note on 04/17/25 10:15 PM by RN #158 which stated: Resident observed propelling in hallway attempting to go to room [ROOM NUMBER]. (Resident #51 and Resident #75) Nursing Assistant (NA) informed resident he was not to be on wing 3 stated he is an adult and can do what he wants. NA redirected resident back to wing 7 A note on 04/26/25 at 1:25 AM by LPN #168, which stated: Pt holding hands with another female pt in the center core 2nd floor (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A note on 05/10/25 at 7:19 AM by LPN #131 Resident repeatedly going into a female Residents room while they where sleeping. This nurse redirected Resident to leave and go back to his floor. Explained that he can not be in female Residents room. Supervisor made aware. A note by Nurse Practitioner (NP) #306 on 05/14/25, which stated: History Of Present Illness: [Resident] alert and oriented known to our facility status post bilateral amputations. Patient was discharged independently to his own apartment was doing well however presented to the emergency room on 10/28 with increased weakness. It is noted that patient was evicted from his apartment due to deplorable conditions. Patient has a long history of diabetes bilateral BKA's A-fib on Eliquis CVA depression. Patient was admitted into the hospital with failure to thrive alteration of self-care positive morbid obesity with a BMI of 40 to 44.9%. Possible long-term care due to inability to care for himself At this time noted patient does have a history of CKD 3 is followed by nephrology along with uncontrolled diabetes. Last A1c was 13.6, questionable compliance at this time. patient returns back to facility due to homeless at this time review of A1c (10.3) and noted continues to be on humalog 10u ac meals, sliding scale and lantus 20u bid trulicity 3mg qwk increased this week and noted continues to have elevated blood sugars non compliant with oral intake and noted blood sugars fluctuate noted patient becomes inappropriate with female patients at times. needs redirected A note on 05/14/25 at 6:30 AM by Director of Nursing (DON), which stated: Resident continuing to go into Female Residents rooms while they are sleeping. Redirected with effect Another note on 05/14/25 at 3:44 PM by the DON, which stated: social services notified about resident going into other residents rooms On 05/15/25 at 9:01 AM SW #304 documented a progress note which stated: (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SW spoke with resident in length on 5/14/25 about his entering other resident's room at night when residents are sleeping. This SW told [Resident] he is not permitted to enter other residents' rooms at any time unless he is given permission by the resident who occupies that room. SW explained that he was violating other resident's rights and privacy. [Resident] agreed that he would not go in and out of other resident's room. A note on 05/15/25 at 5:30 PM by RN #73 stated: Resident was observed entering room [ROOM NUMBER]. Bed 1 (Resident #5) was asleep and bed 2 (Resident #84) told him to leave. On 05/15/25 at 1:37 PM SW #38 noted: QCC 5/15/25: In attendance were social services, nursing, and activities. (Resident #161) was in attendance as well. Code status discussed and may change. Funeral home reviewed. Diet discussed with [Resident]. Weight was discussed, as [Resident] has had a gain. Weight gain explained by nursing. Care plan reviewed and discussed. [Resident] stated he has no concerns or questions. A request was submitted to the facility on [DATE] at 10:15 AM for contact information for the following staff members: RN #73, RN #94, RN #305, and LPN #168. The facility submitted the requested contact information at 11:50 AM on 10/07/25. During an interview on 10/06/25 at approximately 4:11 PM with RN #73 stated that Resident #161 was 'social' and he would talk with female residents. She stated that he had probably gone into room [ROOM NUMBER] to speak to Resident #5. RN #73 stated that to her knowledge Resident #161 had not exhibited sexually inappropriate. Behaviors. During an interview with SW 38 on 10/07/25 at approximately 10:32 AM, he stated that he was currently responsible for submitting reports to OHFLAC and APS when necessary. He also stated that Resident #161 had been followed by SW 304, who was no longer at the facility, as she had retired about one month ago. SW #38 also confirmed that he was aware of complaints Resident #161 going into female resident's rooms and being inappropriate with them. He stated that SW #304, who had been the Director of Social Services at the time, had dealt with the complaints, and he assumed that she would have submitted a report to OHFLAC and APS if she had deemed it necessary. Upon being asked what he would have done about the complaints about Resident #161, SW #38 stated that he would have consulted with the Administrator and deferred to her judgment on filing a report. During a phone interview with LPN #131on 10/07/25 at 11:14 AM, LPN #131 stated that Resident #161 would go into the female residents' rooms, and the staff would go and try to make him leave. She stated that she knew of two female residents' rooms that he went to. Resident #5 and Resident #27. She stated that every time she attempted to make him leave, he would curse at her and call her you [NAME] bitch. LPN #131 stated that she had submitted a report to her supervisor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another phone interview on 10/07/25 at approximately 4:00 PM, with RN #94, revealed that Resident #161 frequently went into female residents' rooms while they were sleeping. She stated that Resident #161 is a bilateral below the knee amputee who uses a wheelchair for ambulation. She also added that resident was a very 'bad driver' who frequently rammed into obstacles, injuring his limbs in the process. RN #94 then stated that she assumed that Resident #161 was looking for someone to talk to, when he went into residents' rooms. RN #94 also stated that all the staff were aware that they were to watch Resident #161, and re-direct him out of the female residents' rooms. During an interview with the Administrator on 10/08/25 at approximately 10:20 AM, she confirmed that the facility had not considered interviewing female residents, or investigating the incidents because no residents had submitted any complaints. In addition, the Administrator referred to the verbal altercation between Residents #161, #53, and #119 on 11/27/24, and stated that it was an argument, and not considered reportable. Despite these multiple incidents, the facility failed to report the incidents, failed to address Resident #161's actions during the Quality Assurance (QA) meeting, and failed to investigate and report potential resident abuse. b) Resident #46 -Family interviews: -On 10/06/25 at 2:30 PM, A telephone interview was conducted with Resident # 46's daughter, She stated her mother had spoken to the staff nurse r/t her father's complaint of pain on 08/06/25. - --Then on 08/08/25, Resident #46's daughter reported her father's lack pain and anxiety management to the DON. She said the DON stated she was unaware of her mother's complaint made on 08/06/25, but would check into it. -On 10/06/2025 at 2:45 PM, a telephone interview was conducted with resident #46's granddaughter, she stated she had reported her grandfather's high pain level to staff during a visit with him on 07/26/25 at approximately 2:30PM and waited several hours for staff to give him his PRN medication. She stated she knew he was allowed to have his pain meds every hour if needed. She stated she complained several times to staff while waiting. Record Review: -During a record review on 10/07/25 at 12:35 PM, It was found that License Practical Nurse(LPN) # 34, documented a progress note dated 08/06/25, which stated: Resident # 46 called his wife twice c/o pain in his penis and his wife called this facility each time and asked for him to be given Morphine. Once LPN # 34 checked Resident's foley was in working order. She noted she did adjust location of foley, placed a leg strap on R leg and attached the foley tubing. per patient still having pain. LPN # 36 gave him morphine and methocarbamol 500 mg. and was resting comfortably. -On 08/08/2025 at It was noted a progress statement from the Director of Nursing (DON), which stated: Family spoke to me today regarding, they don't think his pain or anxiety is being controlled, placed a call to hospice/waiting on a call back regarding these concerns of the family. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/07/23 at 1:30 PM, a review of the facility's Abuse and Neglect policy revealed that an event may not be perceived by staff to constitute resident neglect; however, if a resident, family member, or visitor perceived the event to be neglect, the facility must report the event. -A review of the facility's reportable log, completed on 10/08/25 at 10:35AM, revealed the allegations of abuse on 08/06/25, 08/08/25, or 07/26/25 had not been entered on the Grievance/Concern log nor reported to appropriate state agencies. Staff Interviews: -During an interview on 10/08/25 with LPN #36, she stated she went to check on Resident #46 on 08/06/25 due to Resident #46's family member's phone call reporting Resident complaining of pain in his penis. On 10/08/25 at 11:40 AM, an interview was conducted with the DON. She acknowledged the complaints made on dates 08/06/25, 08/08/25 and 07/26/25 had not been logged on the concern/grievance logs, nor reported to the appropriate agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate potential verbal and sexual abuse, failed to implement interventions to prevent further abuse and mistreatment from occurring while the investigation was in progress; and failed to take appropriate corrective action to ensure that the abuse or mistreatment would not recur. Resident Identifiers: Residents #5, #27, #46, #51, #75, #76, and #119. Facility Census: 137. Findings IncludeRecord review revealed that Resident #161 was no longer at the facility. a) Resident #5Record review on 10/06/24 at approximately 4:25 PM revealed the following: A note on 05/10/25 at 7:19 AM by LPN #131Resident repeatedly going into a female Residents room while they where sleeping. This nurse redirected resident to leave and go back to his floor. Explained that he can not be in female residents room. Supervisor made aware. A note on 05/14/25 at 6:30 AM by Director of Nursing (DON), which stated: Resident continuing to go into Female Residents rooms while they are sleeping. Redirected with effect Another note on 05/14/25 at 3:44 PM by the DON, which stated:social services notified about resident going into other residents rooms On 05/15/25 at 9:01 AM SW #304 documented a progress note which stated: SW spoke with resident in length on 5/14/25 about his entering other resident's room at night when residents are sleeping. This SW told [Resident] he is not permitted to enter other residents' rooms at any time unless he is given permission by the resident who occupies that room. SW explained that he was violating other resident's rights and privacy. [NAME] agreed that he would not go in and out of other resident's room. A note on 05/15/25 at 5:30 PM by RN #73 stated:Resident was observed entering room [ROOM NUMBER]. Bed 1 (Resident #5) was asleep and bed 2 (Resident #84) told him to leave. During a phone interview with LPN #131 on 10/07/25 at 11:14 AM, LPN #131 stated that Resident #161 would enter the female residents' rooms, and the staff would attempt to make him leave. She stated that she knew of two female residents' rooms that he went to. Resident #5 and Resident #27. She stated that every time she attempted to make him leave, he would curse at her and call her you [NAME] bitch.LPN #131 stated that she had submitted a report to her supervisor. b) Resident #27During an interview with Resident #27 on 10/07/25 at approximately 10:20 AM, Resident #27 stated that Resident #161 would try to be 'sexual' with her by rubbing her arms and legs. She said that she had made a complaint on 04/05/25, and the facility had investigated the incident. She stated that Resident #161 was no longer in the facility. A record review revealed that resident #161 had discharged himself from the facility on June 6, 2025. Upon being asked whether Resident #161 had raped or performed any sexual act on her, Resident stated that that did not happen!Further record review on 10/07/25 revealed that the resident had called 911 from her cell phone, and EMS had come in and taken her to the hospital for evaluation. Skin assessment revealed no redness, no bruises to the groin, buttocks, stomach, or breasts. Evaluation results showed an elevated blood pressure and Troponin level. During another interview on 10/07/25 at approximately 1:35 PM, upon being asked whether Resident #161 had touched her under her clothes, she stated, No, he touched my arms and legs. Upon being asked about the statement she had given on 04/05/25, Resident #27 stated that she did not say that she had been raped. She stated that she did not feel well and felt that there was something inside me that needs to come out. She further stated that the Nursing Assistant (NA) had told her that there was blood around the room. Resident stated that Resident #161 had been in her room, and she was aware that Resident #161 frequently hits his stumps while ambulating around in his wheelchair and bleeds.The resident was re-directed to the incident on 04/06/25 and asked why she had called 911. She stated that she had not felt well, and They were watching me. She also stated that They were trying to kill me, I felt there was something inside me and it needed to come out! Resident stated that after she visited the hospital, she felt better. Resident #27 is diagnosed with Huntington's Disease, Unspecified Mood (Affective) Disorder, Anxiety Disorder, Depression, Legal Blindness and Hypertension. During a phone interview on 10/07/25 at approximately 8:55 AM, with the resident's mother, who is her Medical Power of Attorney (MPOA), she stated that she lives about an hour and a half away from the facility. She went on to state that her daughter has paranoia and is also blind. Upon being asked whether Resident #27 had expressed any complaints or concerns, MPOA stated that her daughter had not mentioned anything to her. MPOA was aware of the incident at the facility, and that Resident #27 had 'panicked' and called 911 and had been taken to the hospital. MPOA stated that she usually tries to take her daughter home with her for at least a few days every other month. MPOA stated that if her daughter had any concerns, she would usually bring them up. Upon

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to revise and update the resident's care plan, and implement interventions to ensure that residents at the facility were free from abuse. Resident Identifier: #161. Facility Census: 137.Findings Include a) Resident #161Record review on 10/06/24 at approximately 4:25 PM revealed that Resident #161 was no longer at the facility.Record review on 10/07/25 revealed multiple reports by staff and the Social Worker, over a period of over six (6) months, stating that Resident #161 was indulging in sexually inappropriate behaviors with female residents, as evidenced by the following progress notes:[Typed as Written]A note on 11/27/24 by Registered Nurse (RN) #94, which stated:This patient (Resident #161) along with 706-2 (Resident #53) sat outside the doorway of 704. Both patients yelling insults and curses into the room at 704-1 (Resident #119). This nurse overheard Waaaa, stick your finger up my A$$. Asked the patients to stop, unacceptable and no one wanted to hear such language. This patient threatened this nurse, Do you want to fight? Both patients refused to leave the spot outside the room, neither would move to a common area. Reported to charge nurse and social services. Will continue to monitor.A note on 12/11/24 at 4:49 PM by RN #94, which stated:Patient (Resident #161) exchanging inappropriate insults with roommate (Resident #119). A review of the Concern/grievance Log revealed that the incident was logged, but the facility did not identify this as an instance of verbal abuse between residents, failed to report it to OHFLAC, and failed to take appropriate action to ensure that the abuse would not continue. A nursing note on 04/07/25 at 11:01 PM by Licensed Practical Nurse (LPN) #303, which stated:Resident asked by staff several times to leave female residents rooms. Resident becomes agitated with staff but does leave once requested. A note on 04/08/25 at 3:56 PM by Social Worker (SW) #304, which stated:SW spoke to [Resident] this morning about the issues of him going into female resident rooms and touching them inappropriately. Staff have documented that [Resident] has these inappropriate behaviors. SW told [Resident] that he was not permitted to enter another resident's room in the facility. SW was very clear with resident about above. SW explained that if he continues to have inappropriate behaviors such as touching other females resident that this could be grounds for a 30-day notice of discharge. Resident stated that he understood. A note on 05/14/25 at 6:30 AM by Director of Nursing (DON), which stated: Resident continuing to go into Female Residents rooms while they are sleeping. Redirected with effect Another note on 05/14/25 at 3:44 PM by the DON, which stated:social services notified about resident going into other residents rooms On 05/15/25 at 9:01 AM SW #304 documented a progress note which stated: SW spoke with resident in length on 5/14/25 about his entering other resident's room at night when residents are sleeping. This SW told [Resident] he is not permitted to enter other residents' rooms at any time unless he is given permission by the resident who occupies that room. SW explained that he was violating other resident's rights and privacy. [Resident] agreed that he would not go in and out of other resident's room. Resident #161 was observed attempting to enter Resident #5's room as evidenced by this note on 05/21/25 at 12:20 AM by RN #94 which stated: [Resident #161] sitting outside 707 where female patients were sleeping (Resident #76 and Resident #26). Aide stopped patient from entering and effectively redirected patient away from bedroom. Record review of the resident's care plan on 10/06/25 at approximately 4:20 PM revealed that the facility was aware of Resident #161's sexually inappropriate behaviors since 11/29/24 as evidenced by the following notes:FOCUS:Resident has behaviors related to inappropriate sexual behaviorsDate Initiated: 11/29/2024Created by: (MDS Coordinator)Revision on: 06/09/2025Revision by: (MDS Coordinator)Cancelled Date: 06/09/2025GOAL: Resident will have no adverse effects related to behaviors through the next review. Date Initiated: 11/29/2024Created by: (MDS Coordinator)Revision on: 06/09/2025Revision by: (MDS Coordinator)Target Date: 08/04/2025Cancelled Date: 06/09/2025INTERVENTIONS/TASKS:Administer medications per physician order. Monitor for effectiveness and side-effects.Date Initiated: 11/29/2024Created by: (MDS Coordinator)Revision on: 06/09/2025Revision by: (MDS Coordinator) Cancelled Date: 06/09/2025Approach resident in a calm manner to avoid frustration and behavior escalation; If resident becomes agitated and shows signs of escalation, re-approach later.Date Initiated: 11/29/2024Created by: (MDS Coordinator)Revision on: 06/09/2025Revision by: (MDS Coordinator) Cancelled Date: 06/09/2025 A note on 05/15/25 at 5:30 PM by RN #73 stated:Resident was observed entering room [ROOM NUMBER]. Bed 1 (Resident #5) was asleep and bed 2 (Resident #84) told him to leave. On 05/15/25 at 1:37 PM SW #38 noted:QCC 5/15/25: In attendance were social services, nursing, and activities. (Resident #161) was in

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	515002	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peterson Rehabilitation and Healthcare	20 Homestead Avenue Wheeling, WV 26003

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that a licensed nurse completed a timely assessment and intervention in response to an acute change in condition for a resident identified as high risk for bleeding due to anticoagulant therapy. This verifies a complaint that the facility failed to provide care in noncompliance with 42 CFR S483.25 (Quality of Care - F0684).Entry: 10/06/2025 at 12:00 PMFacility Census: 137RE: FRI #2561221Status: Verified- The facility failed to ensure that a licensed nurse completed a timely assessment and intervention in response to an acute change in condition for a resident identified as high risk for bleeding due to anticoagulant therapy.Date Complaint Received: 07/12/2025 at 8:38 AMAllegation Date (per complainant): 05/12/15 at 5:38 PMAllegation Summary:Resident #160 experienced a prolonged nosebleed that was not promptly or properly treated.Staff allegedly provided only washcloths and ice.Complainant states the nurse could not respond due to excessive patient load.A staff member told the complainant that anything positive I've heard about the facility lied to me.Complainant expresses fear of the hospital returning the resident to the facility.Investigation Actions:Record review showed the resident was admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia, morbid obesity (BMI 65.8), muscle weakness, and atrial fibrillation. The resident was prescribed Rivaroxaban (Xarelto) 20 mg daily for atrial fibrillation, which placed her at increased risk for bleeding.The record showed the resident received intravenous fluids on 07/10/2025 and had a complete blood count and comprehensive metabolic panel (CBC/CMP) completed on 07/11/2025. On 07/12/2025 at 14:41, the facility generated a skilled nursing note documenting that the resident was receiving oxygen at 3 liters per minute via nasal cannula and had diminished lung sounds. Review of the facility Kardex for that date showed multiple routine CNA and nursing tasks listed as Canceled-Requires documentation.The facility's discharge summary was dated 07/12/2025 but was revised on 08/13/2025. The record did not contain contemporaneous nursing documentation or assessment corresponding to the family-reported episode of active nasal bleeding that began at approximately 17:38 on 07/12/2025. No change-in-condition assessment, vital signs, or licensed-nurse follow-up was documented related to this episode. Progress notes indicated the resident later contacted emergency medical services and was transported to the hospital.Review of the oxygen saturation log showed the resident's last documented reading was 97% on room air at 16:08 on 07/12/2025. No subsequent oxygen saturation readings or respiratory assessments were documented following the onset of the reported nosebleed at approximately 17:38. The facility failed to reassess and document the resident's oxygenation status following an acute change in condition involving active bleeding in a resident with a history of respiratory failure, while receiving oxygen therapy at three liters per minute via nasal cannula. Review of the physician order summary for 07/01/2025-10/31/2025 revealed no new orders were entered on or after 07/12/2025 related to the resident's reported nosebleed or subsequent hospital transfer. The last clinical order was for laboratory testing completed on 07/11/2025. The record contained no provider orders for nasal care, respiratory monitoring, or change-in-condition evaluation. The absence of any new physician orders during or following the reported acute event indicates the facility failed to assess, notify, and obtain medical direction in response to a significant change in condition for a resident at high risk for bleeding. Review of the Medication Administration Record (MAR) showed rivaroxaban (Xarelto) 20 mg administered on 07/12/2025 at 17:00 hours by LPN C. [NAME] for atrial fibrillation. The reported onset of epistaxis occurred at approximately 17:38 hours, less than one hour after the scheduled anticoagulant dose. No PRN medications for nasal hemostasis (e.g., oxymetazoline, saline gel), oxygen humidification, or change-in-condition interventions were documented during or after the bleeding episode. The MAR contained no documentation of vital-sign reassessment, physician notification, or new treatment orders following the event.The Order Summary (07/01/2025-10/31/2025) reflected no new provider orders entered on or after 07/12/2025, and the Discharge Summary contained no contemporaneous nursing assessment or documentation of the acute episode.At 16:01 hours, the facility Administrator stated to the surveyor that the resident was only here for four days - we didn't do a change of condition. The Administrator further explained that staff do verbal shift change and that there was no log for physician communication. When asked about the duration and severity of the bleeding, the Administrator stated, I don't think it was a bad nosebleed.The surveyor explained that according to the complainant, the resident's family reported active bleeding lasting approximately one hour and that the resident was receiving anticoagulant medication, which increases the

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, and Interviews, the facility failed to ensure that PRN(as needed) pain management was provided timely for a resident who required such services, consistent with Physician Orders, and the comprehensive person-centered care plan. Resident Identifier: # 46 Facility Census:137 Findings included: a) Resident #46 and family Interviews: -During an interview on 10/07/25 at 2:10 PM, Resident #46 indicated at times he has had to wait a long period of time for staff to get his PRN Pain Medication to him. -During a phone interview with Resident #46's granddaughter, on 10/07/25 at 2:30 PM, she reported that during a visit with her grandfather on July 26, 2025 her grandfather told her he was hurting. She stated she asked staff for pain medication for him at approximately 2:30PM. After waiting over an hour, she reported to her mother and stayed on the phone with her for another couple of hours before the nurse gave her grandfather his pain medication. -During an interview with Resident #46's daughter on 10/07/25 at 250PM, She reported her father was often in pain but didn't feel the facility was giving him his pain medications when he needed them. She stated on 8/26/25 her daughter called her to report that Resident # 46 was in pain and requested pain meds for him. She stated it took at least another hour before the pain meds were given. b) Record Reviews:-During a record review on 10/07/25 at 1:20Pm, Physician ordered Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.25 ml by mouth every 1 hours as needed for SOB/pain Dated 07/17/25. Monitor: Pain Score every shift Other Active: 7/18/2025 19:00 - On 10/07/25 at 1:45PM, a record review of the Treatment Administration Request (TAR) document found the Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML was recorded administered at 18:19 PM on 08/26/25. -A record review, completed on 10/07/21at 3:00 PM, revealed Resident # 46 had the following diagnoses muscle spasms, FX 1st lumbar Vertebra, compression fracture of T11/T12, and Diabetes, muscles spasms, right hip pain. -A record review of resident #46's care plan, on 10/07/25 at 3:15PM indicated Resident # 46 has a terminal prognosis with hospice care r/t end-of-life dx Pain control the resident was at risk for pain related to end of life dx. Resident has potential for pain r/t FX 1st lumbar Vertebra, compression fracture of T11/T12, and Diabetes, muscles spasms, right hip pain. Encourage the resident to request pain medication before the pain becomes too intense or prior to activities that the resident knows there is a potential for increased pain c) Staff Interview:During an interview with the DON on 10/08/25 at 9:20 AM, she acknowledged that resident # 46 PRN pain medication was not administered timely upon resident's request 0n 08/26/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This was a random opportunity for discovery. Resident room [ROOM NUMBER]. Facility Census: 137.Findings Include a) room [ROOM NUMBER]During an interview with Resident #27 in room [ROOM NUMBER], on 10/07/25 at approximately 10:20 AM, the bathroom door was open and a ‘pool noodle' was observed taped with orange tape, to the entire length of the water pipe leading to the commode. The flush handle too was covered with foam and tape. When asked about it, Resident #27 stated, It was there when I came to this room! During an interview with the Director of Nursing (DON), on 10/07/25 at approximately 11:00 AM, she stated that it had been installed when another resident occupied the room. DON confirmed that it was an infection control issue because it could not be properly sanitized. She stated, I'll get it removed immediately!