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	07/01/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 and staff interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections with regards to resident hand washing, and unsanitary practices with trash storage. These were random opportunities for discovery. This practice had the potential to affect all residents that reside in the facility. Facility census: 131. Findings included: a) Soiled Utility An observation, on 06/22/26 at 12:37 PM, of the soiled supply rooms on 500 and 600 halls revealed three (3) large bags of trash on both wings laying on the floor. During an interview on 06/22/26 at 12:45 PM with the Assistant Director of Nursing (ADON) verified the bags of trash should not be stored on the floor. b) Lunch Pass Hand Sanitation for Residents On 06/22/26 at 1:16 PM, during observation of lunch pass on the hallways there was no hand sanitation being completed for residents. This affected Resident #59. Nursing assistant #162 verified not washing residents hands. c) Lunch Pass Hand Sanitation for Staff On 06/22/26 at 1:32 PM, there was no hand sanitation or hand washing being completed by Licensed Practical Nurse (LPN) #98. LPN #98 verified this by stating she had her own hand sanitizer, which was on the desk, and that she didn't normally help with trays, LPN #98 stated she was just helping real quick. This affected Resident #53. d) 100 Wing On 06/22/2026 at around 1:30 PM, during observation of meal services, no resident or staff hand hygiene was completed. Nursing Assistant #11 reported, We usually just wash their hands in their rooms, and we use hand wash or hand sanitizer. Resident #124, #126, and #122 were in the day room for 100 wing eating their meals.

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