

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Peterson Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. This was a random opportunity for discovery of a medication left at bedside unattended Resident Identifier #11. Facility census 131. a) Resident #11An observation, on 06/22/26 at 12:23 PM, found two (2) pills in a 30 ml medication cup at Resident #11's bedside, unsecured and unattended and allowing access to this medication by wandering residents, unauthorized staff, or visitors. During an interview on 06/22/26 PM at 12:29 PM , Licensed Practical Nurse (LPN) #120 verified the two (2) Renvela pills (a prescription phosphate binder used to lower high blood phosphorus levels in adults with chronic kidney disease) should not be left out in the room. LPN #120 removed the 30ml medication cup at this time.A medical record review revealed, Resident #11 did not have physician's order for medication self-administration.		

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, record review, and staff interview, the facility failed to ensure meals were palatable and served at a safe and appetizing temperature. This was found during the Long-Term Care Annual Survey Process and had the potential to affect more than a limited number of residents. Resident Identifiers, #2, #11, #13, #17, #18, #44 and #84. Facility census: 131. Findings included: a) Policy Review Review of the facility's policy for food temperatures, read in part, 8.15.4.d At the time of receipt by the resident, foods shall be at a temperature of no less than 120 degrees Fahrenheit (F) for hot foods and at no more than 50 degrees F for cold foods. b) Resident Council Minutes Review of resident council meeting minutes over the last year revealed six (6) of 12 months reviewed had complaints of cold foods. c) Test Tray Results On 06/24/26, tray line service began at approximately 12:05 PM. The meal cart left kitchen at approximately 1:15 PM. The meal cart arrived at Wing 600 at approximately 1:35 PM. Test tray temperatures were obtained by the Dietary Manager at around 1:55 PM. The food temperatures were:-Regular roast beef-101 degrees F-Puree roast beef-100 degrees F-Puree carrots-100 degrees F-Mashed potatoes-104 degrees F-Pudding- 60 degrees F Review of meal service temperatures identified the following dates that did not have documented temperatures:- 06/18/26 for breakfast and lunch- 06/23/26 for lunch The Dietary Manager, on 06/24/26 at approximately 1:35 PM, verified temperatures were not documented and reported, I will educate them. d) Resident Interviews During interviews on 06/23/26 at approximately 2:00 PM: -Resident #17 reported, The food is usually cold. Sometimes I have the gals warm it up, that helps.-Resident #13 reported, It takes a good bit to get our food, usually it's cold.-Resident #13 reported, The food is ok, cold a lot though.-Resident #84 reports, I think if we got our food earlier it would not be cold-Resident #2 reported, The food is usually cold when we get it.-Resident #11 reported, We get our food late usually. It is almost always cold; I have them reheat at times.-Resident #44 reported, The flavor was good today, but the food was cold.-Resident #17 reported, The meal would have been good if it was warm. I asked them to heat it back up, that helped. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 06/24/26 at approximately 2:30 PM:-Resident #13 reported, I liked the flavor, but it was cold.-Resident #84 reported, The meal was pretty cold today, the flavor was good though.-Resident #2 reported I would have liked it better if it was warmer.-Resident #11 reported, It was pretty cold today, I needed it re-heated.-Resident #18 reported, The meal was really cold, so I ordered something else.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to distribute and serve food in accordance with professional standards for food service safety. The facility did not ensure all equipment used for meal deliveries was clean, that hotel pans were not air dried prior to storage, and that proper hair restraints were being utilized. The facility also failed to ensure any plastic items with large chips were removed from service. This was found during the annual Long-Term Care Survey Process and had the potential to affect more than a limited number of residents. Facility census 131. Findings include. A) review of Sanitization policy Statement reads- The food service area is maintained in a clean and sanitary manner. Policy interpretation and implementation reads in part. 2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. 7. Food preparation equipment and utensils that are manually washed are allowed to air dry. 12. Plastic ware, China, and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. Damaged or broken equipment cannot be repaired and is discarded. B) review of policy for preventing foodborne illness-Employee hygiene and sanitary practices. Statement reads - Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy interpretation and implementation reads in part. Hair nets: Hair nets or caps and/or beard guard are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. C) Initial tour of kitchen revealed. On 06/22/2026 at around 12:00 PM tour of kitchen with dietary manager, observed in the dry stock room three (3) cases of oil on floor, Dietary Manager verified it should be up off the floor. On 06/22/2026 at around 12:00PM during initial tour of kitchen with Dietary Manager, observed in the dry stock room moderate amount of food and trash debris on the bottom shelves, dried food debris under the shelves, Dietary Manager verified the area needed swept and cleaned. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed in the reach in refrigerator that is located in the dry stock room, empty, however observed moderate amount of dried liquid debris on the inside of the refrigerator where empty milk crates were being housed. Dietary Manager verified needing cleaned. Reports, We only use this for overages from the walk-in. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed in the freezer walk-in, under the shelves that are placed against the wall, moderate amount of food debris, dried liquid, the shelves with build up of debris dried white, and crumbs, the fan with moderate amount of dust and debris blowing outward. Dietary Manager verified area needing cleaned and that Maintenance would be informed to clean fan. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed the food delivery carts six (6) of six (6) with dried liquid debris, on inside and dried food debris on outside at handle. Dietary Manager verified these carts were ready for service and that they did need cleaned. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed on the stove back splash having a moderate amount of dried, sticky debris, the tray under the stove top with moderate amount of debris. Dietary Manager verified needing cleaned, reporting They usually clean these at end of shift, however the backsplash does need deep cleaned to remove the greasy, sticky debris. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed the can opener with moderate amount of thick build up dark brown debris, Dietary Manager verified it needed to be cleaned. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed the floor (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under the prep tables with moderate amount of build up dark brown debris and paper debris. Dietary Manager verified needing cleaned. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed wet nesting to eight (8) of (10) hotel pans. Dietary Manager verified they were wet when stored. On 06/22/2026 at around 12:00PM during the tour of kitchen with Dietary Manager observed moderate amount of food debris inside the clean hotel pans found true for four (4) of six (6) pans observed. Dietary Manager verified they were not clean and removed the pans, then instructed staff to ensure all items are air dried and or clean prior to putting up. On 06/24/2026 around 11:00 AM follow up rounds in kitchen observed Dietary aides (62) and (124) in food prep areas without beard guard, manager verified and instructed placement. Food Delivery carts six (6) of eight (8) per dietary aide (62) verified they were cleaned and ready for use, however, noted food debris, dried liquid substance on inside of doors, and along outside. Dietary aide (62) verified they needed to be wiped down again. On 06/24/2026 at around 12:30PM, during observation of meal service (28) of (125) bases with large cracked and missing pieces sharp edging. Dietary manager verified needing replaced. On 06/29/2026 at around 11:50 AM during follow up walk through of the kitchen wet nesting was observed observed in (22) of (22) soup bowls, Dietary Manager verified these were not allowed to be air dried, then removed them and instructed staff to wash and allow to air dry. On 06/29/2026 at around 11:50AM during follow up walk through of the kitchen, wet nesting observed in four (4) of eight (8) hotel pans. Dietary Manager verified and education given to staff. On 06/29/2026 at around 11:50AM during follow up walk through of the kitchen, observed the Ice machine having moderate amount of dried white debris on side, to lid a moderate amount of food debris, along the floor surrounding the ice machine and wall behind a moderate amount of debris build up, dark brown in color. Dietary Manager verified cleaning needed done.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based upon record reviews and staff interviews, the facility failed to ensure proper documentation of medical procedures. Blood pressures were documented for the wrong locations of dialysis patients. This was true for two (2) of two (2) residents reviewed under the Dialysis Pathway throughout the Long-Term Care Survey Process. Resident Identifiers: #8 and #11. Census 131. Findings include: a) Resident #8 During record review, conducted on 06/25/2026, it was identified that blood pressures (BPs) were being documented as taken in the resident's right arm a total of nine (9) times between 03/30/26 and 06/25/26. Resident #8's orders specifically stated not to take blood draws (lab work) or BP in the right arm due to an A/V Fistula (dialysis access) being present at that location. During an interview with the Director of Nursing (DON) and the Administrator, on 06/25/2026 at approximately 11:30 AM, they confirmed the documentation error. We realized we had an issue when we did a mini audit and did staff education and training. We did a whole plan of correction. The plan of correction provided was dated for 06/22/26 and included a training for all nursing staff about BPs and proper documentation for dialysis patients. All medical staff signed the training between 06/22/26 - 06/23/26. During a subsequent interview, Resident #8 stated they don't allow staff to take their BP in that arm ever. I have not had BP's or anything else done to that arm. b) Resident #11 A record review of dialysis care revealed Resident #11 had a physician order for no blood draws / injections / blood pressures from right upper arm. A medical record review found documentation of blood pressures being obtained in the right arm. During an interview on 06/29/26 at about 9:10 AM Resident #11 stated that he would not allow anyone to take blood pressures from his right arm. He stated that he protects his right arm. During an interview on 06/29/26 at 9:15 AM, the Director of Nursing (DON) confirmed the documentation was inaccurate.		

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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 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.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interviews, the facility failed to ensure that the resident's Pre-admission Screening (PASSAR) reflected pre-admission diagnoses for one (1) of two (2) residents reviewed for the category of PASARR, during the long-term care survey. Resident identifier #26. Facility Census 131. Findings Included: a) Resident #26A record review of the resident's electronic medical record (EMR), the resident's most recent PAS, dated 02/06/26, indicated no level II not required. Section III, Question #30 MI/MR Assessment indicated Anxiety and history of seizure diagnosis. The record also revealed indicated the resident had a diagnosis of schizophrenia on admission, 02/09/26, but did not receive a new PAS to address whether or not specialized services were needed. On 06/24/26 at 10: 00 AM, the Director of Nursing (DON) and Administrator verified Resident #26's PAS did not reveal his diagnosis of schizophrenia. The DON confirmed a new PAS was not completed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to ensure a comprehensive, person-centered care plan was in place for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD), for a resident receiving comfort care, and a resident ordered to use plastic utensils. This deficient practice was true for three (3) out of 33 sampled residents throughout the Long-Term Care Survey Process. Resident identifiers: #12, #17, and #23. Facility census: 131. Findings included: Findings included: a) Resident #23, PTSD Diagnosis Review of Resident #23's diagnosis list, on 06/25/26, revealed the resident was diagnosed with Post-Traumatic Stress Disorder PTSD), Unspecified on 05/08/26. Review of Resident #23's care plan, on 06/25/26, revealed the care plan did not specifically address PTSD. During an interview on 06/25/26 at 9:07 AM, the Director of Nursing (DON) acknowledged PTSD and potential triggers were not addressed in care plan. b) Resident #12, Comfort Measures Review of Physician note, dated 06/17/26, revealed Resident #12 was placed on comfort focused care, that resident's family was aware and in agreement. Review of Resident #12's care plan, on 06/29/26, did not address comfort focused care. During an interview on 06/30/26 at 3:37 PM, the DON acknowledged physician ordered comfort measures had not been put into care plan but would be as of that date. c) Resident #17, Use of Plastic Utensils On 06/29/26 at approximately 11:30 AM. a review of physician orders/care plan progress notes revealed an order for Resident #17 to have plastic utensils for meals. No reason given. There were no care plan interventions as to use of plastic utensils during meals. During a subsequent interview, the Administrator reported, He gets the plastic utensils because he tries to cut the wander guard off. A review of progress notes and care plan was then conducted. There was no mention of plastic utensils being used. During an interview on 06/29/26 at 1:15 PM, the DON reported, He gets these due to he tries to cut the wander guard off. When questioned if the need for these utensils were reviewed, the DON reported, Yes, we review at care plan meetings and as needed. The State Agency (SA) requested (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	copies of any care plan notes / progress notes were use of plastic utensils had been reviewed. Nothing was shared with the SA prior to completion of the survey process.		

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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. Based on medical record review and interview, the facility failed to revise a person-centered comprehensive care plan. The facility failed to revise care plans for behaviors. This practice affected one (1) of (33) resident's care plans reviewed during the Long-Term Care Survey Process (LTCSP). The failure to ensure the comprehensive care plan was reviewed and revised for the resident's highest practicable well-being placed the residents at risk of not receiving services that would meet their desires or wants and a decreased quality of life. Resident Identifier #110. Facility census: 131. Findings included:a) Resident #110On 06/22/26 an observation of Resident #110 found her sitting in the hallway eating lunch in a Styrofoam container with plastic utensils. A review of Resident #110's medical record showed the diet order, Styrofoam and plastic ware with all meals.A review of the current care plan showed there was an active care plan addressing the diet order for Styrofoam and plastic ware. There was no focus, intervention or behaviors noted for the use of plastic ware. On 06/23/26 at 12:39 PM, a second observation revealed Resident #110 eating in the hall out of a Styrofoam container with plastic ware.During an interview at 12:44 PM, Nurse Aide #165 stated that she was unsure why Resident #110 had to eat out of the containers and not allowed to have silverware.An interview on 06/24/26 at 11:45 AM with the Director of Nursing (DON) and Administrator, verified that Resident #110's care plan was not revised to reflect the resident's current status and behaviors of throwing dishes and silverware.		