STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515083	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundale Nursing Home	800 J D Anderson Drive Morgantown, WV 26505

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 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 observation, staff interview and and record review, the facility failed to implement a resident's care plan by failing to use both floor mats for Resident #79 with a a history of falls. Resident identifier: #79. Facility Census: 91. Findings included: a) Resident #79 On 05/27/26 at 12:31 PM, observed a fall mat against the air unit, a fall mat on the resident's right side of bed and the absence of a fall mat on the left side of resident's bed. At 12:32 PM Occupational Therapy Assistant (OTA) #164 was asked about the mat and went to find a nurse. He returned without nurse and observed fall mat leaning against heating/air unit and reported that usually it meant she has an order for it and he would put it back down on the left side of her bed. OTA #164 reported that he would report to the nurse. Review of resident's physician orders dated 11/11/25 stated bed side mats (low profile) on floor- at all times while in bed. Review of the care plan revealed, pages 7-8. Focus- Resident #79 is at risk for serious injury related to history of falls, impaired mobility, incontinence, diagnosis of Cerebrovascular Accident with R-sided hemiplegia, arthritis, etc. Approaches- Low profile mats on floor beside bed. Date initiated: 11/11/25.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on Observations and Staff interviews, the facility failed to store food in accordance with professional standards for food safety. The first floor south nutrition room had five (5) Glucerna drinks that were expired. This was a random opportunity for discovery during the normal Long Term Survey Process, that had the potential to effect more then a limited number of residents. Facility Census: 91. a) During the facility walkthrough and inspection of the nutrition areas on 05/27/26 at approximately 10:45 AM, five (5) expired Glucerna supplements were found in the first-floor south wing resident nutrition room. They expired on 01/03/26 and remained in the cabinet accessible to residents.During a interview with Social Worker #148 on 05/27/26 at approximately 11:15 AM, they confirmed the supplements were expired and then discarded them.

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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 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and staff interview, the facility failed to ensure Quality assessment and assurance (QAA) meetings were completed at minimum quarterly. This failed practice has the potential to affect more than a minimal number of residents residing in the long term care facility. Facility Census: 91Findings included: a) Record review completed on 06/03/26 revealed the QAA meeting for Quarter Two (2) was held on 10/29/25 along with the Quarter Three (3) meeting. During an interview on 06/03/26 at approximately 11:30 AM the Administrator stated they normally hold meetings the month following the end of the quarter to discuss all items for that quarter. However, the Doctor was unable to attend the scheduled meeting for Quarter Two (2) so they combined both the Quarter Two (2) and Quarter Three (3) meetings. This confirms there was no meeting during the second quarter.