

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: 515123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Wellsburg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Valley Haven Dr Wellsburg, WV 26070	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation resident interviews, staff interviews and record review, 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 the resident's personal products and unsanitary practices. Resident identifiers: #7, #31, #18, and #52. Facility Census: 52. Findings Included: a) Resident #7: During a facility walkthrough and resident interviews on 06/08/26 at 12:59 PM, it was observed that Resident #7's wheelchair had rips and tears on the edge of the seat and a round hole on each corner of the back rest by the handles exposing the inner padding. b) room [ROOM NUMBER]: Residents #31 and #18: During a facility walk through and resident interviews, on 06/09/26 at around 10:15AM, It was observed that Resident #31's wheelchair was located at the end of her bed with a tear in the right side of the backrest, with the inner padding protruding outward. Also upon observation, the left footrest for her wheelchair, located on the counter next to the shared sink, had a tear approximately 1/2 inch long in the outer padding exposing the inner padding. Further investigation of room [ROOM NUMBER], found the guest chair near Resident #18's bed. The plastic covering on the end of the left arm rest, had an approximate 6 inch tear with 4 puncture holes, causing the plastic covering to hang loose off the sides, also exposing the inner padding. Also exposing the inner padding. c) Resident #52: During an interview with Resident #52, on 06/10/26 at around 2:05 PM, the surveyor observed that the back stabilizer pad on her electric wheelchair had 1/4-inch holes around the top edge, both corners of the shoulder pads, down the backrest, and in both corners of the seat pad. Infection Preventionist Interviews: On 06/08/26 at 1:10PM the infection preventionist confirmed the issues in Resident #7's wheelchair and stated she would have it replaced. On 06/10/26 at approximately 2:15 PM, during a facility walk through and interview with the Infection Preventionist, she confirmed that Resident #31's and #52's wheelchairs and #18's guest chair had rips, tears, and holes. She stated she would recheck all wheelchairs in the facility for repair and/or replacement.		

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
--	-------	-----------

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: 515123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Wellsburg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Valley Haven Dr Wellsburg, WV 26070	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, and staff interviews, the facility failed to ensure resident's call lights were within reach. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #15 Facility Census: 52. Findings included: a) Resident #15 During resident interviews and a facility walkthrough on 06/08/26 at 12:25 PM it was observed that Resident #15's call bell was under the resident's bed not within her reach. CNA #57 was interviewed on 08/08/26 at 12:30 PM. She verified the call bell was under the resident's bed, not within reach of the resident and stated, I'm sorry. It must have fallen under there when we repositioned her for her lunch tray. We didn't realize it. In an interview with the DON on 08/08/26 at 12:38 PM, she acknowledged Resident #15's call light was not within reach and stated, Thank you for letting me know.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Wellsburg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Valley Haven Dr Wellsburg, WV 26070	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents in room [ROOM NUMBER]. This was a random opportunity for discovery. Resident #33, #42. Facility census: 52. Findings included: a) room [ROOM NUMBER] During a facility walk-through on 06/08/26 in room [ROOM NUMBER]'s bathroom, a brownish substance was around the toilet base and debris had built up under the seat, accompanied by yellow and brown dried liquid marks down the toilet base. On 06/10/26 at 11:50 AM, a recheck of room [ROOM NUMBER]'s bathroom was conducted. It was observed that Housekeeping Supervisor (HS) #81 had just left the room. Further observation found a brownish substance approximately the size of a nickel on the toilet bowl, yellowish debris buildup on the rim of the toilet bowl and under the plastic raised toilet seat, with dried yellow and brown splashes down the sides and front of the base from the toilet bowl to the floor. During an interview with the Housekeeping Supervisor (HS) #81 on 06/10/26 at 11:55 AM, HS #81 confirmed she had just finished cleaning room [ROOM NUMBER] and the bathroom. Upon showing her the findings of the buildup of debris under the raised toilet seat and brown spot on the outside of the toilet bowl and dried splashes down the sides of the base, she confirmed and stated she had missed them.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Wellsburg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Valley Haven Dr Wellsburg, WV 26070	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Resident interviews, and staff interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible in regard to an unlocked med cart in 100 hall, also a loose countertop and sink. this failed practice was a random opportunity for discovery that could effect a limited number of residents. Resident Identifier #16. Facility Census: 52. Findings Included: a) 100 hall med cart observation: On 06/09/26 at 9:15 AM the med cart was observed outside room [ROOM NUMBER] in the 100 hall unlocked and unattended while RN #56 was administering medications in another resident's room. An interview was conducted with RN #56 on 06/09/26 at 9:18 AM. She confirmed she had not locked the med cart before leaving it to administer meds in a resident's room on the 100 hall and apologized. In an Interview with the Nurse manager on 06/09/26 at 9:25 AM, she acknowledged the med cart was left unlocked in the 100 hallway and stated, She's new and has been very nervous here and learning a new facility with state . In an interview with the DON on 06/09/26 at 9:35 AM she acknowledged the med cart was left unlocked in the 100 hall and stated, Thank you for letting me know. b) Resident #16 On 06/09/26 at around 11:30 AM, during observation of Resident #16's room, the surveyor observed that the caulk along the sink edges&mdash;under the mirror and along the side wall to the right&mdash;was cracked and loose. When leaning against the countertop, the surveyor observed the sink was loose. Resident #16 reported, I noticed it being loose, I hope it doesn't come too loose and I fall when I wash my hands. On 06/09/26 at around 1:30 PM, during a follow-up observation of the sink in the room, the surveyor again observed that the caulk along the sink edges on the wall under the mirror and along the side wall to the right remained cracked and loose. The sink countertop remained loose. The resident reports, It's loose; I hope I don't fall. During an observation the Administrator was with the surveyor, and the administrator verified that this was loose and could cause injury. The Administrator reported, I will let our maintenance director know so he can get it corrected. This was true for one (1) of 32 rooms observed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Wellsburg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Valley Haven Dr Wellsburg, WV 26070	
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 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 upon observation, record review and staff interview, the facility failed to maintain accurate medical records for Resident #6 wearing Ulnar Gutter Splint on the right hand every day. Resident identifier: #6. Facility census: 52. Findings included: a) Resident #6 An observation of Resident #6 on 06/09/26 at 10:00 AM (dining room during activity), 12:20 PM (dining room for lunch), and 2:00 PM (sitting by nurse station getting ready to go to an activity) revealed the resident was not wearing Ulnar Gutter Splint per physician's orders. During the 10:00 AM observation one surveyor made the observation. At 12:20 PM observation was made by two (2) surveyors, and the 2:00 PM observation was witnessed by Staff Member #40. A review of the Treatment Authorization Record (TAR) shows Employee #32 signed off for the day section of Resident #6 wearing the splint when observation proved otherwise. The surveyor discussed this with the Director of Nursing (DON) on 06/09/2026 at 2:15 PM. Her response was, We probably need to talk to the doctor because she may be able to discharge this now.		