STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515199	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summersville Healthcare Center	712 Professional Park Drive Summersville, WV 26651

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interview, the facility failed to perform tracheostomy care within accepted standards of care. This deficient practice had the potential to affect one (1) of one (1) residents observed for tracheostomy care. Resident Identifier: #3. Facility Census: 88. Findings included: a) Resident #3 The facility's policy titled, Tracheostomy Care, with no implementation date given, gave instructions to review the resident's medical record, noting the type and size of the tracheostomy tube. Review of Resident #3's physician's orders showed the following orders, which were written on 12/04/25: - Trach care daily and prn [as needed]. Clean stoma and flange, change drain sponge. Change disposable inner cannula. - Trach: Shiley Cuffless Size 4: 6.5 mm[millimeters] trach with 5.5 inner canula. On 04/29/2026 at 10:15 AM, Registered Nurse (RN) #83 was observed performing Resident #3's tracheostomy care. After removing the inner cannula of the tracheostomy, RN #83 cleaned around the resident's tracheostomy site repeatedly due to the resident coughing up secretions. RN #83 attempted to insert the new inner cannula, but it appeared the inner cannula would not slide fully into the tracheostomy tube. RN #83 immediately withdrew the inner cannula. She stated she felt resistance, which had never happened before. According to the inner cannula packaging, the inner cannula RN attempted to insert was size 6.5 mm. RN #83 went to the doorway of the resident's room and asked Registered Nurse #111, who was passing by, to get another inner cannula for the resident. RN #111 returned with another size 6.5 inner cannula. The surveyor asked RN #111 to go check Resident #3's physician's order for the inner cannula size. RN #111 left and returned with a size 5.5 mm inner cannula. She stated the physician's order was for a 5.5 mm inner cannula. RN #83 easily inserted the 5.5 mm size cannula into Resident #3's tracheostomy tube.

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 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 staff interviews, the facility failed to ensure residents received pain management in accordance with professional standards of practice, by not recording the pain level for as-needed (PRN) pain medication. This failed practice was found true for (1) one of (1) one residents reviewed for the care area of pain during the Long-Term Care Survey Process. Resident identifier #3. Facility Census: 88.Findings Include:a) Resident #3A record review on 04/28/26 at 2:22 PM, revealed an order for Resident #3 that read as follows:Hydrocodone-Acetaminophen Tablet 7.5-325 Milligrams (MG): Give one tablet via G-Tube every 6 hours as-needed for pain.A review of the Medication Administration Record (MAR) from 04/02/26 to the present showed that the PRN Hydrocodone-Acetaminophen Tablet was administered 43 times to Resident #3. For 27 of the 43 times the PRN medication was administered, no pain levels were indicated in the medical record. Further record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/09/26, Section C, revealed that Resident #3 has a Brief Interview for Mental Status (BIMS) of 12.During an interview on 04/28/26 at 3:00 PM, Resident #3 stated, I can tell them what level of pain I am having.During an interview on 04/29/26 at 11:48 AM, the Director of Nursing (DON) confirmed that pain levels were not indicated for Resident #3 for the administration of PRN pain medication.b) Policy A review of the Policy titled {Pain Management and Assessment}, under procedure, section II, c, reads as follows:The 1-10 pain scalei. For residents with intact cognitive abilities who can and are willing to determine their worst pain ever (10) and no pain (1) range using numbers.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure storage of medication within accepted standards of practice. A bottle of medication located in the second floor medication storage room had expired. This was a random opportunity for discovery. Resident Identifier: #3. Facility Census: 88. Findings included:a) Findings included: Review of the facility's policy titled, Stock Medications, with no implementation date given, stated medications would be discarded when out of date. On [DATE] at 8:24 AM, the second floor medication storage room was inspected with Registered Nurse (RN) #111 in attendance. In the floor stock medication cabinet, a bottle of magnesium tablets, 500 mg, had an expiration date of [DATE]. RN #111 confirmed the medication had expired.