

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Beckett House		STREET ADDRESS, CITY, STATE, ZIP CODE 1280 Friendship Drive New Concord, OH 43762	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on record review and interview, the facility failed to ensure residents received showers per their preferences. This affected two (Resident #31 and #34) of six residents reviewed for activities of daily living. The facility census was 67.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #31 admitted to the facility on [DATE] with diagnoses including paraplegia, neuromuscular dysfunction of bladder, hyperlipidemia, congestive heart failure, and need for assistance with personal care. Review of a minimum data set (MDS) quarterly assessment completed on 03/14/24 revealed Resident #31's cognition remained intact and it was very important for him to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>Review of a shower preference sheet completed on 05/01/24 revealed Resident #31 prefers showers but is okay with bed baths. Review of shower sheets revealed Resident #31 received showers on Tuesday and Friday nights. Resident #31 received a bed bath on 05/10/24, 05/14/24, 05/17/24, 05/21/24, 05/24/24, 05/28/24, 05/31/24, 06/04/24, and 06/07/24.</p> <p>Interview on 06/13/24 at 9:21 A.M. with Resident #31 revealed he prefers to take showers but was in the process of trying to find a way to shower safely and has been getting bed baths.</p> <p>Interview on 06/13/24 at 1:17 P.M. with Director of Nursing (DON) revealed there was no reason Resident #31 could not safely shower because they do have a bariatric shower chair for him. The DON confirmed Resident #31 was receiving bed baths instead of showers per resident preference.</p> <p>2. Record review revealed Resident #34 admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, hypothyroidism, acquired absence of right leg above knee, and chronic kidney disease stage 3. Review of the annual MDS completed on 03/04/24 revealed Resident #34's cognition remained intact and it was very important for her to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>Review of a shower preference sheet dated 11/09/23 revealed Resident #34 preferred showers. Review of shower sheets revealed Resident #34 receives showers on Mondays and Thursdays during day shift. Review of shower sheets revealed Resident #34 received a bed bath on 05/02/24, 05/06/24, 05/09/24, 05/13/24, 05/16/24, 05/20/24, 05/23/24, 06/03/24, and 06/10/24.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/13/24 at 12:15 P.M. with Resident #34 revealed she preferred to have showers but she does also receive bed baths.</p> <p>Interview on 06/13/24 at 1:17 P.M. with DON confirmed Resident #34 received bed baths instead of showers that a Resident #34 prefers.</p> <p>Review of a policy titled Activities of Daily Living dated 01/2022 revealed resident bathing/shower and other ADL preferences will be factored into daily activities as much as possible for each resident.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153926.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>47985</p> <p>Based on observation, interviews, and policy review the facility failed to maintain residents' personal living space in a comfortable, homelike manner. This affected two residents (Resident #4 and #62) of three residents interviewed for a homelike environment. The census was 67.</p> <p>Findings include:</p> <p>Interview on 06/12/24 at 1:34 P.M. with Ombudsman #100 revealed residents had been complaining since 02/29/24 that they wanted the windows cleaned but the windows haven't been cleaned and residents were also unhappy with the broken screens for the windows.</p> <p>Continuous interviews and observations with Maintenance Director (MD) on 06/13/24 at 8:26 A.M. revealed a company came in to give window estimates which would cost a fortune and since they were already renovating other things, no windows had been ordered yet. The MD stated he does have new screens for the building but has not had a chance to put them in yet.</p> <p>Interview on 06/13/24 at 8:35 A.M. with the Administrator revealed he was aware of some of the windows being in disrepair but the facility just spent a million dollars on a renovation and he could not put in a request for windows because it would cost too much and there are over 300 windows in the facility.</p> <p>Interview on 06/13/24 at 11:44 A.M. with Resident #4 revealed the screens in her windows were broken and her roommate doesn't even have a screen in her window. Resident #4 stated it bothered her because she loves fresh air and would like to have the windows open, but the last time her windows were open two wasps came in through the hole in the screen. Observation at the time of the interview revealed the bottom of both of Resident #4's screens were completely torn off and her roommate did not have a screen.</p> <p>Interview on 06/13/24 at 12:20 P.M. with Resident #62 revealed the windows in her room are dirty, the screens are broken and she could not open the window in her room. Resident #62 stated it is bothersome but it has been that way since she admitted to the facility.</p> <p>Observation and interview on 06/13/24 at 12:48 P.M. with Registered Nurse (RN) #115 confirmed a cracked window in Resident #62's room and the bottom of her roommate's screen was torn off.</p> <p>Review of an undated Resident Rights policy revealed each resident has the right to a safe and clean living environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154202.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on observation, medical record review, review of glucometer manufacturer information, policy review, and interview, the facility failed to ensure ensure glucometers used for multiple residents were cleaned/disinfected between resident use. This affected four residents (Residents #1, #4, #21, and #36) observed during medication administration. The facility identified 17 residents (Residents #1, #4, #21, #25, #28, #33, #34, #35, #36, #46, #50, #56, #61, #63, #64, #65, and #67) who had blood glucose levels monitored using facility glucometers.</p> <p>Findings include:</p> <p>1. On 06/13/24 at 7:40 A.M., Registered Nurse (RN) #100 entered Resident #21's room to administer medication and monitor Resident #21's blood glucose level. RN #100 carried a basket with a glucometer, alcohol wipes, glucometer strips and lancets into Resident #21's room and placed the basket on the table without a barrier. Resident #21's blood glucose was monitored using the facility's glucometer. After using the glucometer it was placed back into the basket which contained new lancets without disinfecting it. After returning to the medication cart, RN #100 removed the glucometer from the basket and placed it on top of the medication cart while placing the basket back into the medication cart. Neither the glucometer or basket was disinfected. RN #100 signed off the medications she had administered to Resident #21 then stated she was ready to prepare the next resident's medication.</p> <p>On 06/13/24 at 7:52 A.M., RN #100 stated the glucometers were wiped down in the morning then maybe around lunch. RN #100 reported she had three residents who used the glucometer and verified the glucometer was not disinfected after use.</p> <p>2. On 06/13/24 at 08:01 A.M., RN #105 entered Resident #4's room to administer medication and check her blood glucose level. RN #105 carried a basket with lancets, alcohol swabs, a container of lancets and the glucometer in it. Upon arriving at bedside, RN #105 placed the basket on top of Resident #105's cell phone which was sitting on her over the bed table. The basket fell on the floor with all the contents scattered onto the floor. RN #105 placed the items back into the basket and placed the basket on the over the bed table without a barrier. RN #105 proceeded to use the items to obtain the blood glucose level. After using the glucometer, it was placed back into the basket without disinfecting it. After the medications were administered, the basket was picked up and placed onto the medication cart without disinfecting the basket or the glucometer, RN #105 entered room [ROOM NUMBER] with the basket and checked Resident #1's blood glucose level, which was 208 milligrams per deciliter of blood (mg/dL) per the glucometer, then returned to the cart. RN #105 stated, before she administered any more medication, she liked to check all of her blood glucose levels at once so she could try to get them before the residents ate breakfast. RN #105 proceeded to Resident #36's room to check his blood glucose level using the same glucometer without disinfecting it.</p> <p>On 06/13/24 at 8:12 A.M. RN #105 was asked how frequently the glucometer, which was used for multiple residents, was disinfected/cleaned. RN #105 stated night shift cleaned glucometers. RN #105 verified she did not use appropriate infection control protocols with glucometer use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the manufacturer guidelines for the Assure Prism blood glucose monitoring system revealed to minimize the risk of transmission of blood-borne pathogens, the meter should be cleaned and disinfected after use on each patient.</p> <p>Review of the facility's policy, Cleaning and Disinfecting Glucose Meter (not dated), revealed instructions to clean and disinfect the meter after each use when glucometers were shared.</p> <p>The facility identified Residents #1, #4, #21, #25, #28, #33, #34, #35, #36, #46, #50, #56, #61, #63, #64, #65, and #67 as residents who had facility glucometers used to monitor blood glucose levels. Review of medical records for the diagnoses of those 17 residents revealed no diagnoses of a blood-borne illness.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>47985</p> <p>Based on observations, interviews, and interviews, the facility failed to ensure the windows were kept in good repair. This had the potential to affect all residents residing in the facility. The census was 67.</p> <p>Findings included:</p> <p>Observation of the 200 Hall sunroom on 06/13/24 at 6:00 A.M. revealed the windows were streaked and dirty, on both sides of the glass. On the outside of the windows, build up of grass and debris were present. Three screens were torn.</p> <p>Observation of the 300 Hall sunroom on 06/13/24 at 6:04 A.M. revealed windows were cloudy and streaked, had dirt and debris on them. One window had a crack and one window was shattered with shards of glass missing and duct tape around the edges in attempt to hold the window together. Another window had a torn screen.</p> <p>Observation of the 400 Hall sunroom on 06/13/24 at 6:08 A.M. revealed windows were dirty and streaked with dirt and cobwebs on the outside of the windows. There were four torn screens.</p> <p>Observation of the 500 Hall sunroom on 06/13/24 at 6:11 A.M. revealed windows were dirty and streaked with two cracked windows and three screens torn.</p> <p>Interview on 06/12/24 at 1:34 P.M. with Ombudsman #100 revealed residents had been complaining since 02/29/24 they wanted the windows cleaned and they haven't been and residents were also unhappy with the broken screens.</p> <p>Continuous interviews and observations with Maintenance Director (MD) on 06/13/24 at 8:26 A.M. confirmed the windows on the 200, 300, 400, and 500 Hall sunrooms were in disrepair. MD stated he was aware of the shattered window for about two to three weeks but had not taken any steps to get it replaced. MD Stated a company came in to give window estimates which would cost a fortune and since they were already renovating other things, no windows had been ordered yet. MD stated he does have new screens for the building but has not had a chance to put them in yet.</p> <p>Interview on 06/13/24 at 8:35 A.M. with Administrator revealed he was aware of some of the windows being in disrepair but the facility just spent a million dollars on a renovation and he could not put in a request for windows because it would cost too much and there are over 300 windows in the facility.</p> <p>Review of an undated Resident Rights policy revealed each resident has the right to a safe and clean living environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154202.</p>		