

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
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)		
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and policy review, the facility failed to ensure all residents seated at the same table were served their meals at the same time, leaving one resident without food while the other residents ate their meal. This affected one (#29) of three residents reviewed for dining. The facility census was 73. Findings include: Record review revealed Resident #29 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, depression, and anxiety disorder. Review of a minimum data set (MDS) dated [DATE] revealed Resident #29's cognition was intact. Observation of the lunch meal in the dining room on 06/16/26 starting at 11:32 A.M. revealed Resident #29 was seated at a table with five other residents. Each of the other five residents were served their lunch meals and Resident #29 was not. After serving Resident #29's table, three other tables, located in the dining room, were given their meals for a total of 15 residents being served before Resident #29. Resident #29 was interviewed and stated she usually had her food and wondered where it was since the others had been served their meal. Interview on 06/16/26 at 11:55 A.M. with Licensed Practical Nurse (LPN) #216 confirmed all meal trays had been passed in the dining room and Resident #29 still did not have a tray. LPN #216 requested the resident's meal tray from the kitchen so she could be served her lunch. Review of a policy titled Dignity, Respect, and Privacy dated 01/2026 revealed care should be provided to residents while maintaining their dignity and privacy. Residents should always be treated with respect and cared for in a manner that protects their privacy. This deficiency represents non-compliance investigated under Complaint Number 3034800.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to develop and implement care plans for behaviors and dementia care for Resident #28. This affected one resident (#28) of two reviewed for a facility reported incident. The facility census was 73. Findings include: Review of Resident #28's medical record revealed an admission date of 07/30/25 and diagnoses including unspecified dementia with behavioral disturbance, other symptoms and signs involving appearance and behavior (aggressive behaviors), COPD, anxiety disorder, restlessness and agitation, chronic pain syndrome, hypertension, and major depressive disorder. Review of Resident #28's significant change Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of five indicating the resident had severe cognitive impairment. Further review of the MDS revealed Resident #28 utilized a walker and a wheelchair for mobility, was independent with bed mobility, required supervision with transfers, partial/moderate assistance with toileting hygiene and had two or more falls without injury since the previous MDS was completed. Further review of the MDS revealed Resident #28 was receiving hospice services. Review of Resident #28's progress notes revealed a note written on 06/02/26 at 6:56 P.M. by Licensed Practical Nurse #225 This nurse is made aware that patient was involved in a patient to patient altercation down 200 hall. This patient was asked by another patient what is his name. This patient becomes agitated & the physical altercation is heard by a family member & staff is quickly alerted. Patients are separated & distracted. Both patients have new skin tears as a result. Family & on call physicians are notified. Review of Resident #28's care plan revealed no behavior or dementia care plans were in place prior to 06/03/26. In an interview on 06/16/26 at 1:30 P.M. Regional Nurse #300 verified there was not a care plan for behaviors or dementia care prior to 06/03/26. Review of the policy titled Care Plan Policy, revised 02/2022, revealed an individual care plan will be developed to identify the physical, mental, psychosocial needs of each resident in a manner that will promote each resident feeling of well-being, self-worth and self-esteem. Care plans will address diagnoses, physician orders, dietary needs, medications, treatments, general care, devices and interventions, behaviors, advanced directives, choices, cultural preferences, and other needs and preferences specific to the resident. The care plan will be used by the care team to coordinate and manage the resident's goals, preferences, choices, past trauma care, and services that will be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This deficiency is an incidental finding discovered during the complaint investigation.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility assessment review, job description review, staff schedule review and interview the facility failed to ensure a registered nurse was scheduled for eight consecutive hours, seven days per week. This had the potential to affect all 73 residents residing in the facility. The facility census was 73. Findings include: Review of the facility assessment dated [DATE] revealed Registered Nurses (RNs) are part of nursing services and are needed to provide support and care for facility residents. Review of the nursing services schedule revealed there was not an RN scheduled for 05/23/26. In an interview on 06/15/26 at 11:00 A.M. the Administrator verified there was not an RN scheduled/who worked on 05/23/26. Review of the Registered Nurse Employee Job description, revised 09/01/25, revealed the primary purpose of the RN job position was to provide direct nursing care to residents and to supervise day-to-day nursing activities. Further review revealed RN job duties include directing the day-to-day functions of the nurses and nursing assistants in accordance with current rules, regulations, and guidelines that govern the long-term care facility. This deficiency represents non-compliance investigated under Complaint Number 3024730.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Food and Drug Administration Medication Information review, and interview the facility failed to ensure residents were free of unnecessary medications. This affected on resident (#28) of two reviewed for a facility reported incident. The facility census was 73. Findings include: Review of Resident #28's medical record revealed an admission date of 07/30/25 and diagnoses including unspecified dementia with behavioral disturbance, other symptoms and signs involving appearance and behavior (aggressive behaviors), COPD, anxiety disorder, restlessness and agitation, chronic pain syndrome, hypertension, and major depressive disorder. Review of Resident #28's significant change Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of five indicating the resident had severe cognitive impairment. Further review of the MDS revealed Resident #28 utilized a walker and a wheelchair for mobility, was independent with bed mobility, required supervision with transfers, partial/moderate assistance with toileting hygiene and had two or more falls without injury since the previous MDS was completed. Further review of the MDS revealed Resident #28 was receiving hospice services. Review of Resident #28's progress notes revealed a note written on 06/02/26 at 6:56 P.M. by Licensed Practical Nurse #225 This nurse is made aware that patient was involved in a patient to patient altercation down 200 hall. This patient was asked by another patient what is his name. This patient becomes agitated & the physical altercation is heard by a family member & staff is quickly alerted. Patients are separated & distracted. Both patients have new skin tears as a result. Family & on call physicians are notified. Review of Resident #28's physician's orders revealed an order dated 06/03/26 for depakote oral tablet delayed release 250 MG (Divalproex Sodium) give one tablet by mouth two times a day for target behaviors: agitation, anxiety related to unspecified dementia, unspecified severity, with behavioral disturbances. In an interview on 06/16/26 at 1:30 P.M. Regional Nurse #300 verified the depakote was ordered for agitation, anxiety related to unspecified dementia, unspecified severity, with behavioral disturbances and those were not approved diagnosis for administration. Review of the United States Food and Drug Administration labeled uses for depakote revealed the medication was approved for use in patients who had seizures, manic episodes of bipolar disorder and for migraine prevention. This deficiency is an incidental finding discovered during the complaint investigation.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure residents received the correct texture diet. This affected one (#6) of three residents observed for correct diet texture. The facility census was 73. Findings include: Record review revealed Resident #6 admitted to the facility on [DATE] with diagnoses including other sequelae of other cerebrovascular disease, vascular dementia, and anxiety disorder. Review of an order dated 10/10/25 revealed Resident #6 required a regular diet with mechanical soft texture, thin liquids, a divided scoop plate, and a spout cup. Review of a care plan dated 12/04/25 revealed Resident #6 had a nutritional problem or potential nutrition problem related to cerebrovascular disease, dementia, metabolic encephalopathy, a mechanically altered diet, and hospice services. The goal was for Resident #6 to tolerate the least restrictive diet texture without difficulties. Interventions included but were not limited to determine likes and dislikes and provide diet as ordered. Review of a minimum data set (MDS) completed 06/04/26 revealed Resident #6's cognition was severely impaired, he was dependent on staff for eating assistance, and was on a mechanically altered diet. Observation on 06/15/26 at 11:29 A.M. revealed Resident #6 was in the dining room with his lunch. His meal ticket revealed he needed a mechanical soft diet including soft breads. Resident #6 received a biscuit with his meal. Licensed Practical Nurse (LPN) #216 stated she would ask the kitchen if he received the correct bread. At 11:40 A.M. kitchen staff brought out buttered bread and removed the biscuit from Resident #6's plate. Interview on 06/15/26 at 11:47 A.M. with Regional Nurse (RN) #300 confirmed Resident #6 was given a biscuit as part of his mechanical soft diet and it was removed. Interview on 06/16/26 at 12:01 P.M. with Speech Therapist (ST) #301 revealed each building is different regarding what is or is not considered mechanical soft. Some buildings would say no to a biscuit and some would say yes. ST #301 stated she was aware if biscuits sat long enough or by the time they were delivered to resident's they could get hard. Voicemail received from ST #301 on 06/16/26 at 1:12 P.M. revealed she had reviewed her professional dysphagia (difficulty swallowing) diet guidelines and a biscuit was considered to be a regular diet, not mechanical soft. Review of a policy titled Pureed and Mechanical Soft Foods Production dated 09/08/21 revealed a mechanical soft diet consists of foods that are in an easy to chew form for residents with chewing difficulty, teeth loss, poor fitting dentures, mouth pain, or residents that require extensive time to complete a meal. Regular menu items should be mechanically altered, chopped or ground, so it can be consumed by a resident with chewing difficulty. Food characteristics include: can be eating with a spoon, fork or chopsticks; can be mashed/broken down with pressure from spoon, fork or chopsticks; a knife is not required to cut food; chewing is required before swallowing; soft, tender and moist throughout; and bite sized pieces (half an inch or less). This deficiency represents non-compliance investigated under Complaint Number 3034800.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and policy review, the facility failed to maintain a clean environment. This had the potential to affect 73 of 73 residents in the facility. Findings include: Observations on 06/15/26 from 8:27 A.M. to 8:38 A.M. during the initial tour of the facility revealed in the sunroom at the end of each hallway there were dust accumulations and dead bugs on the floors along the edges of the walls. Observations and interview on 06/15/26 at 4:09 P.M. with Housekeeping Supervisor (HS) #200 revealed in sunrooms at the end of each hallway there was an accumulation of dust and dead bugs as well as behind all fire doors on each hall. HS #200 confirmed findings. Review of a policy titled Housekeeping Policy dated 11/2025 revealed the facility will be cleaned on a regular basis. The hallway floors are to be clean and dry, corners and edges of the floor are to be clean and free of wax buildup. This deficiency represents non-compliance investigated under Complaint Number 3024730.		