STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366173	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Beckett House	1280 Friendship Drive New Concord, OH 43762

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 2. Observation on 06/09/25 at 12:13 P.M. of Resident #42 and #224's room revealed a dark yellow orange stain in front of toilet, two broken linoleum with a raised uneven floor by Resident #42's chair and one broken linoleum in bathroom and two going into bathroom. Observation on 06/09/25 at 12:17 P.M. of Resident #68's room revealed the drywall was damaged between her chair and side table. Observation on 06/09/25 at 12:19 P.M. of Resident #65's room revealed five cracked linoleum tile on the floor. Observation on 06/09/25 at 12:40 P.M. revealed Resident #62's walls were damaged with holes behind her chair and to the side of the bed. Observation on 06/09/25 at 3:39 P.M. of Resident #49's room revealed a large hole in the wall behind her bedside table. Observation on 06/09/25 at 5:14 P.M. the wall behind Resident #23's electric wheelchair and the side wall were plastered and not painted. There were six broken linoleum tiles with pieces missing on the floor and the bathroom door had two holes in it. Interview on 06/11/25 at 4:22 P.M. with the Administrator confirmed she was aware of environmental issues. She informed the company was having the maintenance men join together certain days of the week to go to each others facilities to assist with big projects. Based on resident interview, staff interview, and observation, the facility failed to provide a clean home-like environment in resident rooms. This affected twelve residents (#8, #11, #23, #26, #42, #49, #53, #54, #62, #65, #68 and #224) of 77 residents reviewed for environment. The facility census was 77. Findings include: Observation on 06/09/25 at 3:23 P.M. revealed Resident #53's wall with gouges on the wall behind the bed and a plastic phone jack with wires hanging from it. Interview with Resident #53 revealed they were from an old bed that was removed between four to five months ago. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 3:23 P.M. revealed Resident #53 and Resident #54's baseboard to the center wall between the rooms was missing. Observation on 06/10/25 at 3:53 P.M. revealed Resident #11 and Resident #26's baseboard to the center wall between the rooms was missing. Resident #11's wall with big gouges behind the bed. Resident #11 stated the staff hit the wall whenever they move her bed. Observation on 06/10/25 at 4:00 P.M. revealed Resident #8's baseboard was noted to coming off the wall. Interview on 06/11/25 at 8:00 A.M. with Maintenance Director #174 confirmed the gouges on the walls and missing baseboards in rooms. Stated he was aware of the environmental issues.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, policy review, and interview, the facility failed to ensure a psychotropic medication had a 14 day stop date. This affected one resident (#14) of five residents reviewed for unnecessary medication. The census was 77. Findings include: Review of Resident #14's medical record revealed a 05/28/21 admission with diagnoses including Alzheimer's disease, adjustment disorder with mixed anxiety and depression, dementia, hypertension, hypothyroidism, difficulty in walking, osteoarthritis, insomnia, pain in right knee, lumbago with sciatica, muscle wasting and atrophy, and abnormalities of gait and mobility. Review of the 05/07/25 quarterly Minimum Data Set (MDS) Assessment revealed the resident was severely impaired for daily decision making with disorganized thinking, that comes and goes, changes in severity. Physician orders included Compound: Ativan (Lorazepam) Gel Apply to skin topically two times a day for target behaviors: agitation, anxiety milligram (mg) per milliliter (ml), apply 0.5 ml to inner wrist and apply to wrist topically every 12 hours as needed for target behaviors ordered 12/16/24 and discontinued 05/22/25. There was not a 14 day stop for the as needed controlled medication. The medication should have been discontinued 12/20/24. The medication should have been discontinued on 12/20/24. Review of the medication administration records revealed the medication was administered 01/07/25, 01/08/25, 01/11/25, 01/13/25, 01/17/25, 01/17/25, 01/21/25, 01/26/25, 01/31/25, 02/01/25, 02/04/25, 03/23/25, 04/06/25, 04/20/25, 05/04/25, 05/09/25, 05/12/25, and 05/16/25 (all dates after the medication should have been discontinued) Review of the facility's Antipsychotic Medication Use policy (revised 04/2023) included as needed orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. Interview on 06/11/25 at 5:04 P.M. with Regional Clinical Support #186 verified the antianxiety medication did not have a 14 day stop as required. Interview on 06/11/25 at 5:43 P.M. with the Director of Nursing verified the facility did not follow the facility policy and regulations.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to clean a dependent resident's eyeglasses. This affected one resident (#23) of four residents reviewed for activities of daily living. The census was 77. Findings include: Review of Resident #23's medical record revealed a 09/30/21 admission and a 02/10/24 readmission. Diagnoses include type 2 diabetes, chronic obstructive pulmonary disease, peripheral vascular angioplasty with implants and grafts, Alzheimer's disease, weakness, cognitive communication deficit, abnormality of gait and mobility, muscle wasting and atrophy, dementia, vitamin D deficiency, osteoarthritis of left knee, neuromuscular dysfunction of bladder, hypertension, anemia, benign prostatic hyperplasia, transient ischemic attack and cerebral infarction without residual deficits, cardiomegaly, moderate protein calorie malnutrition, atherosclerotic heart disease, congestive heart failure, gastroesophageal heart disease, anxiety disorder, depressive disorder, hyperlipidemia, retention of urine, overactive bladder and history of pulmonary embolism, and venous thrombosis and embolism. Review of a 10/11/21 Alteration in Visual Function Related to Decreased Vision plan of care included the resident wore glasses and had an intervention to ensure eyeglasses are clean. Review of the 03/18/25 quarterly Minimum Data Set (MDS) Assessment revealed the resident was moderately impaired for daily decision making with no behaviors. The resident was dependent for hygiene. Observation on 06/09/25 at 5:42 P.M. revealed the resident's eyeglasses were dirty. The lenses had white smears on them. There were debris embedded where the lenses and frame met. Observation on 06/10/25 at 3:50 P.M. revealed the resident's glasses had the same smearing and debris as the previous day. At the time of the observation, interview with Certified Nurse Aide (CNA) #154 revealed she had cleaned his glasses in the past. She stated she usually used a wipe they had at the nurse station. She used soap and water at the bathroom sink wetting and applied soap several times. She was attempting to get the dirt off around the frames where it met the lens. She verified the glasses were soiled and verified the resident would not be able to get the eyeglasses clean himself.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on the interview and resident council meeting minute review the facility failed to provide preferred resident activities including community outings to residents in the facility. This affected two residents (#17 and #37) of three residents reviewed for activities. The facility census was 77. Findings include: Interview on 06/12/25 at 11:00 A.M. Resident #37 reported she would prefer to do her own shopping and would like to go on outings in the community. She went on to say the facility does not have a working vehicle to take her. Interview on 06/12/25 at 11:11 A.M. Resident #17 reported she never gets to go on outings and would, love to go shopping Stated has brought it up many times with the facility but it was not addressed. Review of the resident council meeting minutes for 05/01/25 revealed the residents wanted to discuss future outings. Review of the Activity Calendar from January 2025 to May 2025 revealed the facility did not have any activities scheduled for outside of the facility. Review of the June 2025 activity calendar revealed on 06/19/25 the facility had an outing scheduled but it did not say what they would be doing. Interview 06/12/25 at 11:08 A.M. revealed Staff #165 did the transporting of residents in a SUV. She stated the SUV had not been used for taking residents on outings. She was the last one to drive the transport bus and it had not been working since May 2024. She reported they wanted to schedule an outing for 06/19/25 but she will not be able to transport that day due to another resident needed surgery, and she would have to take her instead. This was the first time she was aware of a facility outing being planned since the bus broke down in May 2024. Interview on 06/11/25 at 4:24 P.M. interview with Activities Aide (AA) #173 reported the facility had not had a working vehicle to transport any residents to outside activities since she had worked at the facility. Interview on 06/12/25 at 9:13 A.M. AA #172 reported the facility had not had a working vehicle to transport any residents to outside activities since she had worked at the facility. Interview on 06/12/25 at 1:23 P.M. Activity Director #171 reported she had been with the company since October 2024. She continued that the facility had not had any community outings since she had been at the facility. She stated she was aware that residents wanted community outings and believed the facility was working with another facility to borrow their van but as of now a plan had not been put in place. She stated they had something on the June calendar, but it will need rescheduled due to not having a driver available that day. Interview on 06/12/25 at 11:32 A.M. the Administrator confirmed the facility had not had a working vehicle to transport residents to outside activities in the facility. The Administrator reported they were in the process of establishing a system with another facility to borrow their vehicle.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on the review of the facility job description, personnel record review and staff interview, the facility failed to ensure the Activities Director was qualified for the position. This had the potential to affect 77 out of 77 residents. The facility census was 77. Findings include: Review of the facility Job Description for an Activity Director (AD) revealed the AD must be a qualified therapeutic recreation specialist or an activities professional who is licensed by the state and is eligible for certification as a recreation specialist or as an activities professional; must have as a minimum two years' experience in a social or recreation program within the last five years one of which was full time in a patient activities program in a health care setting or must be qualified occupational therapist or occupational therapy assistant; or must have a training course approved by the state. AD #171 signed the job description on 10/02/24. Review of the personnel file for AD#171 revealed a hire date of 10/02/24. The personnel file revealed the AD's only activity experience was from May 2023 through February 2024 at another facility. The personnel file did not have evidence where the AD met any of the qualifications to become an Activities Director. Interview on 06/11/25 at 8:35 A.M. AD #171 reported when hired Administration spoke with her about completing an approved training to be a qualified Activities Director but she declined the training stating it was not something she wants to pursue at this time. Interview on 06/11/25 at 4:24 P.M. interview with Activities Aide (AA) #173 feels like she was not properly trained for her position. She stated she is overwhelmed in the position and has several concerns. She stated she can never find AD #171, was told she isn't allowed to make substitutions if resident do not like the scheduled activity, doesn't always have enough supplies for the residents, and the AD does not always have events planned for special occasions and holidays. Interview on 06/12/25 at 9:13 A.M. AA #172 reported she did not receive any formal training by the AD when hired. She went on to say she feels as though the resident trained her. AA #172 stated communication in the activity department is not good. She stated there have been several recent events where AD #171 did not communicate what the activity was or where supplies were located. AA# 172 reported she even took the AD course on her own so she could receive training on how the activity department is supposed to function. Interview on 06/11/25 at 2:46 P.M. the Administrator confirmed AD #171 did not meet the requirements to be the Activity Director. She stated the facility has self-identified issues in the department and are working with the staff to resolve the issues.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility pharmacist failed to identify a psychotropic medication needed a 14 day stop date. This affected one resident (#14) of five residents reviewed for unnecessary medication. The census was 77. Findings include: Review of Resident #14's medical record revealed a 05/28/21 admission with diagnoses including Alzheimer's disease, adjustment disorder with mixed anxiety and depression, dementia, hypertension, hypothyroidism, difficulty in walking, osteoarthritis, insomnia, pain in right knee, lumbago with sciatica, muscle wasting and atrophy, and abnormalities of gait and mobility. Review of the 05/07/25 quarterly Minimum Data Set Assessment revealed the resident was severely impaired for daily decision making with disorganized thinking, that comes and goes, changes in severity. Physician orders included Compound: Ativan (Lorazepam) Gel Apply to skin topically two times a day for target behaviors: agitation, anxiety milligram (mg) per milliliter (ml), apply 0.5 ml to inner wrist and apply to wrist topically every 12 hours as needed for target behaviors ordered 12/16/24 and discontinued 05/22/25. There was not a 14 day stop for the as needed controlled medication. The medication should have been discontinued 12/20/24. Review of pharmacy reviews dated 12/24/24, 01/25, 02/25, 03/09/25, and 04/25 did not identify the need for the Compound: ativan (Lorazepam) Gel to have a 14 day stop date due to being an as needed antianxiety medication. Review of the medication administration records revealed the medication was administered 01/07/25, 01/08/25, 01/11/25, 01/13/25, 01/17/25, 01/17/25, 01/21/25, 01/26/25, 01/31/25, 02/01/25, 02/04/25, 03/23/25, 04/06/25, 04/20/25, 05/04/25, 05/09/25, 05/12/25, and 05/16/25 (all dates after the medication should have been discontinued). Review of the facility's Antipsychotic Medication Use policy (revised 04/2023) included as needed orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. Interview on 06/11/25 at 4:34 P.M. with Pharmacist #185 included the nurse practitioner put the routine and the as needed antianxiety medication on the same prescription. He included when one prescription is sent in the insurance company will pay for both. When the routine and as needed dose is written as different prescriptions the insurance company will not always pay for both medications. We think of it as one prescription and a quantity so it did not trigger with the pharmacist to write a recommendation to discontinue the medication because it was all on one prescription. Interview on 06/11/25 at 5:04 P.M. with Regional Clinical Support Staff #186 verified the pharmacist did not write a pharmacy recommendation for the physician to write a 14 day stop date

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to ensure accurate documentation in the medical record. This affected one resident (#12) of one resident reviewed for edema. The census was 77. Findings included: Review of Resident #12's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included hemiparesis and hemiplegia, cerebral infarction, peripheral insufficiency, congestive heart failure, chronic ischemic heart disease, aphasia, high blood pressure, major depression, and anxiety. Review of the quarterly minimum data set assessment dated [DATE] revealed his cognition was moderately impaired. He required set up or clean up assistance for eating, oral hygiene, dependent for toileting, substantial/maximal assistance for bath/showering, personal hygiene and turning and repositioning. The resident was occasionally incontinent of urine and always continent of bowel. Review of the physician orders revealed an order dated 03/18/25 to apply compression stockings to bilateral lower legs after applying treatment. Leave on for six to eight hours every day shift, 14 days on and seven days off for skin integrity. Review of the treatment record revealed the compression hose were documented as applied when reviewed on 06/12/25 at 10:34 A.M. Observation on 06/12/25 at 8:48 A.M., 10:30 A.M. and 1:34 P.M. revealed the compression stockings were not applied. On 06/12/25 at 1:37 P.M. interview with Registered Nurse (RN) #143 revealed the resident's compression hose are usually put on in the morning before getting the resident up by the certified nurse aides (CNA's). RN #143 revealed he had not gotten to apply the resident's compression stockings but verified he had already signed off as the hose application was completed. On 06/12/25 at 2:08 P.M. interview with the Director of Nursing revealed it was her expectation treatments are not signed off until completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation of medication administration, and staff interview , the facility failed to ensure proper hand washing was completed during medication administration. This affected two residents (#50 and #57) of six residents observed for medication administration. Findings include: On 06/11/25 observation between 7:07 A.M. and 7:15 A.M. revealed Licensed Practical Nurse (LPN) #136 put on gloves and prepared medication for Resident #57, removed her gloves and put on new gloves without washing her hands and went in to the Resident #57's room and administered the medication, then removed her gloves and used hand sanitizer. LPN #136 then again put on new gloves, prepared medication for Resident #50, changed her gloves and went into the resident's room to administer medications. On 06/11/25 at 7:18 A.M. interview with LPN #136 verified she had not washed her hands between glove changes.