STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515086	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interview the facility failed to notify Resident #114's attending physician of a urine culture which identified the resident of having ESBL in her urine. This was true for one (1) of five (5) residents reviewed for the use of a catheter during a complaint survey. Resident identifier: #114. Facility Census: 145. a) Resident #114 A review of Resident #114 medical record found since 01/01/25 Resident #114 had two (2) urine cultures ordered. The first was ordered on 02/26/25 and was obtained on 02/28/25 as directed by the order. A review of the results for this urine culture found the following, .ATTN. ESBL !!! Follow Contact Precautions. The results of this culture were verified on 03/03/25 and had a print date and time of 03/04/25 at 6:03 am. Handwritten on the lab result was the following, 03/18/25 5:30 PM DR. (Last Name of attending physician) notified order to change F/C (foley catheter) tonight and obtain UA and C and S. This note was written by Registered Nurse (RN) #52. Further review of the medical record found the following progress notes related to this lab result: 03/01/25 - Awaiting blood. urine test results. Not available at this time. 03/18/25 5:30 PM - Dr. (Last name of local physician) office called at 4:55 PM and reported to this nurse that they could not do patients surgery tomorrow because they had received urine culture results from 03/03/25 that showed ESBL <100, 000 colonies and they were not sure if it had been treated or not. This nurse reviewed the chart and confirmed that it had not been treated. Dr. (last name of Attending Physician) notified gave order for F/C to be changed tonight and obtain UA C And S d/t (due to) other specimen being over two weeks ago. Patient Notified. This note was entered by RN #52. Resident #114 was scheduled for a Ureteroscopy with stone removal on 03/19/25. This procedure was canceled because of the failure to follow up on the lab work and treat the ESBL. The second order was entered on 03/18/25 and the results were received on 03/24/25 and the physician was notified at 4:20 PM and gave an order for Invanz 1 gram IV every day for 10 days. . (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the record found Resident #114 had the left ureteroscopy with stone removal which as originally scheduled for 03/19/25 on 04/16/25. The failure of the facility to follow up on and treat the initial lab result caused a delay in treatment from 03/19/25 to 04/16/25. An interview with the Nursing Home Administrator in the morning of 06/18/25 confirmed the above findings. He stated, I think we notified the physician, but we did not document it and I cannot prove it.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview the facility failed to thoroughly investigate all allegations of neglect thoroughly. This was true for one (1) of 10 reportable incidents reviewed. Resident Identifier: #19. Facility Census: 144. Findings Include: a) Resident #19 A review of a facility reported incident dated 05/22/25 revealed Resident #19's sister had alleged the resident left the facility for a medical appointment and was dirty (socks had not been changed for several days and he was not cleaned up for his appointment). The facility reported the incident involving Resident #19 immediately when it was brought to their attention by the resident's sister. The investigation was reviewed. Statements were taken from the staff who were working with the resident prior to him leaving for his appointment. They indicated the resident was clean and dry when he left the facility. The facility indicated the allegation was no not verified due to the statements taken from the resident, the resident's sister, and the facility staff. The statement taken by the facility indicated the sister was trying to defend the facility to the outside facility When this surveyor spoke with the resident's sister, she indicated she had brought this to the attention of the facility before and they never took her seriously and now they blew it because staff at the other healthcare facility saw it and reported it to the surveyor agency. She indicated she was glad they did. An interview with Social Worker #104 indicated when the resident returned from his appointment the sister brought her the clothes he was wearing when he left the facility. She indicated the clothes were moist but not dried. She stated the resident did have accidents all the time and this was likely what happened in this case. She indicated the resident did not like to wear a brief and would take it off when they put it on him. Resident #19's sister confirmed this and stated she had tried to explain to him that it will give him some protection and keep his penis from getting irritated, but the resident consistently does not wear a brief. An interview with Social Worker #10 stated that she completed the investigation in conjunction with the Nursing Home Administrator she stated she did not call the ambulance because her staff indicated that the resident was clean and dry when he left, and they did not think about calling the ambulance company. The NHA had indicated he thought social services had contacted or spoke with the ambulance company. Both Social Worker #10 and #104 both confirmed on the afternoon of 06/17/25 they had not spoken to the ambulance company prior to the surveyor bringing it to their attention. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, the facility failed to reach out to the health care facility in which the resident went to the appointment. The surveyor aske the facility to get the consult from the appointment. When the facility obtained the information and provided it the following was found, Resident received from outside nursing home (Name of this facility) via ambulance for excision of cyst above left eye eyebrow. When the patient arrived at Same Day Surgery, he smelled very strongly of urine. When we removed his shoes, his white tube socks appeared to be covered with dried urine, and the socks were even somewhat stuck to patients' feet. Patient's shoes and pants also smelled strongly of dried urine . The NHA stated he had requested this information, but it was not provided to them prior to the surveyor requesting it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and staff interview the facility failed to ensure Resident #114's lab work was addressed and acted upon timely. In addition the failure to treat the Urinary Tract Infection (UTI) identified by the lab testing caused a delay in Resident #114 receiving a required procedure to remove kidney stones. This was true for one (1) of five (5) residents reviewed for the use of a catheter during a complaint survey. Resident #114. Facility Census: 145. a) Resident #114 A review of Resident #114 medical record found since 01/01/25 Resident #114 had two (2) urine cultures ordered. The first was ordered on 02/26/25 and was obtained on 02/28/25 as directed by the order. A review of the results for this urine culture found the following, .ATTN. ESBL !!! Follow Contact Precautions. The results of this culture were verified on 03/03/25 and had a print date and time of 03/04/25 at 6:03 am. Handwritten on the lab result was the following, 03/18/25 5:30 PM DR. (Last Name of attending physician) notified order to change F/C (foley catheter) tonight and obtain UA and C and S. This note was written by Registered Nurse (RN) #52. Further review of the medical record found the following progress notes related to this lab result: 03/01/25 - Awaiting blood. urine test results. Not available at this time. 03/18/25 5:30 PM - Dr. (Last name of local physician) office called at 4:55 PM and reported to this nurse that they could not do patients surgery tomorrow because they had received urine culture results from 03/03/25 that showed ESBL <100, 000 colonies and they were not sure if it had been treated or not. This nurse reviewed the chart and confirmed that it had not been treated. Dr. (last name of Attending Physician) notified gave order for F/C to be changed tonight and obtain UA C And S d/t (due to) other specimen being over two weeks ago. Patient Notified. This note was entered by RN #52. Resident #114 was scheduled for a Ureteroscopy with stone removal on 03/19/25. This procedure was canceled because of the failure to follow up on the lab work and treat the ESBL. The second order was entered on 03/18/25 and the results were received on 03/24/25 and the physician was notified at 4:20 PM and gave an order for Invanz 1 gram IV every day for 10 days. . Further review of the record found Resident #114 had the left ureteroscopy with stone removal which as originally scheduled for 03/19/25 on 04/16/25. The failure of the facility to follow up on and treat the initial lab result caused a delay in treatment from 03/19/25 to 04/16/25. An interview with the Nursing Home Administrator in the morning of 06/18/25 confirmed the above findings. He stated, I think we notified the physician, but we did not document it and I cannot prove it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, and staff interview the facility failed to ensure they implemented their infection control policy to prevent the spread of disease. This was found during the investigation of a complaint and had the potential effect more than an isolated number of residents currently residing in the facility. Resident Identifier: #32. Facility Census: 45. Findings Include: a) Resident#32 At approximately 3:15 PM on 06/16/25, Nurse Aide #1 and Nurse Aide #3 was observed entering the room of Resident #32. Nurse Aide #1 was overheard telling Resident #32 they were going to assist her to bed. On Resident #32's door was a sign which indicated someone in the room was ordered enhanced barrier precautions. Beside Resident #32's name on the name plate of the room was a yellow sticker. The yellow sticker identified which of the two residents in the room was ordered EBP. This was confirmed with the Nurse Practice Educator. The signage on the door indicated if the staff were performing care such as a transfer the should wear gloves and a gown. The surveyor obtained permission from Resident #32 to observe the nurse aides transferring her to bed. During the transfer Nurse Aide #1 and #3 donned gloves but did not wear an isolation gown. When the nurse aides exited the room after completing the transfer Nurse Aide #1 was asked why he did not wear a gown while performing the transfer. He stated, We don't need to with her. When asked what the yellow sticker by her named indicated he stated, That means she is a fall risk she has fall mats. Nurse Aide #3 then approached, and Nurse Aide #1 asked her if they should have worn a gown. Nurse Aide #3 stated, No I don't think so. When she was asked what the sign on the door and the yellow sticker by the resident's name meant she stated, That means they have special stuff like at risk for falls and she has oxygen too. The Nurse Practice Educator was immediately made aware of the observation and the interviews. She stated, I am going to start additional education now. A review of Resident #32's medical record found the following physician order dated 02/13/25 which read as follows, Enhanced Barrier Precautions related to: PEG Tube, wound when dressing bathing showering transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs, or assisting with toileting.