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	09/11/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review and staff interview, the facility failed to ensure enteral (tube) feeding was provided in accordance with professional standards of practice. Documentation of the amount of enteral feeding infused was not accurately recorded. This deficient practice had the potential to affect (2) of (2) residents reviewed for the care area of tube feeding. Resident identifiers: #1 and #8. Facility census: 139. Findings included:a) Resident #8 Review of Resident #8's physician's orders showed the following order written on 01/31/25, Enteral Feed Order one time a day, Jevity 1.5 @ [at] 80 ml/hr [milliliters per hour] x [times] 10 hours via pump, up at 9 PM down at 9 AM or when total volume infused 800 ML to provide 1200 calories. to provide 1400 ml total volume, 2100 kcals [calories]. The administration times were 9:00 AM and 9:00 PM. The following order was also written on 01/31/25, Enteral Feed Order one time a day at 9:00 PM, confirm rate programmed at 80 m/hour, confirm total volume programmed in at 800 ml, and clear volume fed in the last 24 hours back to 0. The following order was also written on 01/31/25, Enteral Feed Order every night shift. When pump beeps that total volume has been delivered, turn pump off and document total volume fed on pump in last 24 hours. Review of Resident's Medication Administration Records (MARs) for June 2025 and September 2025 showed the following amounts of total enteral feed were documented: - On 06/03/25, n/a was documented. - On 06/07/25, 1600 ml was documented. - On 06/11/25, 984 ml was documented. - On 06/13/25, 1600 ml was documented. - On 06/16/25, 900 ml was documented. - On 06/17/25, 1600 ML was documented. - On 06/21/25, 550 ml was documented. - On 06/22/25, 550 ml was documented. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 06/23/25, 1600 ml was documented. - On 07/01/25, 881 ml was documented. - On 07/12/25, 0 ml was documented. - On 07/14/25, 1480 ml was documented. - On 07/19/25, 1600 ml was documented. - On 07/20/25, 1600 ml was documented. - On 07/21/25, 1180 ml was documented. - On 07/25/25, 1600 ml was documented. - On 07/26/25, 1046 ml was documented. - On 07/27/25, 1876 ml was documented. - On 08/02/25, 825 ml was documented. - On 08/03/25, 2828 ml was documented. - On 08/11/25, 0 ml was documented. - On 08/12/25, 100 ml was documented. - On 08/13/25, 1180 ml was documented. - On 08/14/25, 1881 ml was documented. - On 08/16/25, 813 ml was documented. - On 08/18/25, 1588 ml was documented. - On 08/23/25, 825 ml was documented. - On 08/24/25, 430 ml was documented. - On 08/27/25, 1267 ml was documented. - On 09/04/25, 1200 ml was documented. - On 09/06/25, 0 ml was documented. - On 09/07/25, 100 ml was documented. - On 09/08/25, 748 ML was documented. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 09/09/25, 0 ml was documented. - On 09/10/25, 300 ml was documented. On 09/10/25 at 4:15 PM, the Regional Director of Clinical Operations confirmed Resident #8's documented enteral feeding amounts on the aforementioned dates did not correlate with what she was ordered to receive daily. She stated she could not explain the discrepancies between the amount of enteral feeding ordered and the amount of enteral feeding recorded on the MARs. b) Resident #1 Review of Resident #1's physician's orders showed the following order written on 08/21/25, Enteral Feed Order two times a day, Jevity 1.5 @ [at] 70 ml/hr [milliliters per hour] x [times] 20 hours via pump to provide 1400 ml total volume, 2100 kcals [calories]. The administration times were 9:00 AM and 9:00 PM. The following order was also written on 08/21/25, Enteral Feed Order one time a day at 9:00 AM, confirm rate programmed at 70 m/hour, confirm total volume programmed in at 1400 ml, and clear total volume fed in last 24 hours back to 0. The following order was also written on 08/21/25, Enteral Feed Order every night shift. When pump beeps that total volume has been delivered, turn pump off and document total volume fed on pump in last 24 hours. Review of Resident's Medication Administration Records (MARs) for August 2025 and September 2025 showed the following amounts of total enteral feed were documented: - On 08/21/25, 800 ml was documented. - On 08/22/25, 1680 ml was documented. - On 08/23/25, 1680 ml was documented. - On 08/24/25, 1000 ml was documented. - On 08/25/25, 700 ml was documented. - On 08/26/25, the notation ok was made but no amount was documented. - On 08/27/25, 1400 ml was documented. - On 08/28/25, no amount was documented. - On 08/29/25, 1025 ml was documented. - On 08/30/25, 714 ml was documented. - On 08/31/25, 822 ml was documented. - On 09/01/25, 2100 ml was documented. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 09/02/25, 1400 ml was documented. - On 09/03/25, 1088 ml was documented. - On 09/04/25, 850 ml was documented. On 09/05/25, the order was changed to the following, Enteral Feed Order every shift for Nutrition Enteral nutrition via pump of Jevity 1.5 at a rate of 70 mls per hour for a total of 2100 kcal intake. Start time 1 pm and run until 1400 mls has been infused. May turn off at 9 am if total of 1400 ml has infused. Review of Resident's Medication Administration Records (MARs) for August 2025 and September 2025 showed the following amounts of total enteral feed were documented: - On 09/05/25 200 ml was documented for night shift. - On 09/06/25 0 ml was documented for day shift and 1400 ml was documented for night shift. - On 09/07/25 1400 ml was documented for day shift and 1397 ml was documented for night shift. - On 09/08/25 1400 ml was documented for day shift and 1397 ml was documented for night shift. - On 09/09/25 0 ml was documented for day shift and 1120 ml was documented for night shift. The order was discontinued on 09/10/25. On 09/11/2025 at 9:12 AM, the Regional Director of Clinical Operations confirmed Resident #1's enteral feeding amounts had not been documented accurately on the MARs. She stated she could not explain the discrepancies between the amount of enteral feeding ordered and the amount of enteral feeding recorded on the MARs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, the facility failed to ensure that baking pans were stored in a sanitary manner by stacking them while still wet (wet nesting). This practice had the potential to contaminate food-contact surfaces and cause foodborne illness. This failed practice had the potential to affect more than a minimal number of residents residing in the facility. Facility census: 139.Findings include: On 09/08/2025 at 10:29 AM, during a kitchen observation with the Dietary Manager, two (2) baking pans were observed stacked while wet. Wet nesting creates an environment that can support bacterial growth and contaminate food prepared in the pans.On 09/08/2025 at 10:42 AM, the Dietary Manager confirmed the pans should have been completely dried prior to storage and stacking. The pans were removed and rewashed at that time.

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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 safe infection control practices were followed to prevent the spread of diseases and infections. This was a random opportunity for discovery and has the potential to affect more than a limited number of residents. Facility Census: 139. a) Ice Chest On 9/08/25 at 3:30 PM an observation of the ice chest on F wing of the facility found the scoop for the Ice was stored in the chest with the clean Ice. An immediate interview with Registered Nurse #300 confirmed the scoop was not stored properly to prevent the spread of infection.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure Resident #151's physician orders reflected her wishes concerning the end of life care. This was true for one (1) of five (5) residents reviewed for the care area of advance directives during the long term care survey process. Resident identifier: #151. Facility census: 139. a) Resident #151 A review of Resident #151's medical record on [DATE] found a Physician Orders for Scope of Treatment (POST) form which was completed by the resident on [DATE] and signed by the Nurse Practitioner on [DATE]. On this form Resident #151 indicated she did not want Cardiopulmonary Resuscitation (CPR) should her heart stop. She also indicated she would want full intervention prior to her heart stopping. Further review of the medical record found a physician's order dated [DATE] which read CPR. This order directed nursing staff to perform CPR on the resident should her heart stop. This order did not align with the resident's directive contained on the post form. An interview with the Regional Director of Clinical Operations (RDCO) #207 at 12:45 PM on [DATE] confirmed the order in the resident's electronic medical record needed to be updated to reflect the residents wishes regarding CPR.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review the facility failed to implement their Abuse Prohibition policy in regards tot he reporting of neglect. This was a random opportunity for discovery and was true for Resident #145. Resident Identifier: #145. Facility Census: 139. a) Policy Review A review of the facility's policy titled, Abuse, Neglect, and Misappropriation found the following pertaining to the identification and reporting of abuse: IV Identification of Incidents and allegations 1. The accurate and timely identification of any even which would place our residents at risk is a primary concern of the facility. 2. The following procedures will assist the staff in the identification of incidents and direct them to the appropriate steps of intervention. a. Each occurance of resident incident, bruise, abrasion or injury of unknown source, or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive director of the incident or allegation immediately. Required notification of agencies, physician, and resident representative will be completed as required. c. The executive director or designee with direct the investigation VII. Reporting of Incidents and Facility Response 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported to the Executive Director immediately. 2. The executive Director/designee will report appropriate incidents to OHFLAC, APS, the regional ombudsman and other local authorities including but not limited to local law enforcement if appropriate and required by state law b) Resident #145 Resident #145 was selected as a closed record review for the care area of hospitalization during the long term care survey process. A record review completed during the investigation of this care area found the resident was sent to the emergency room (ER) on 07/18/25. The transfer form completed by the facility indicated the resident was sent to the local hospitals ER at 1:10 pm on 07/18/25. The reason for the transfer was listed as, unresponsive. Further review of the medical record found an Emergency Department Record from the local hospital in the scanned documents in the medical record. A review of the document found it was faxed to the facility on [DATE] at 8:30 am. This document had been scanned into the electronic medical record prior to the beginning of this survey. A review of this document found the following, -- Resident Arrived at the ER at 1:38 PM.-- . [AGE] year old female presents to ER via EMS with complaints of Unresponsive -- . [AGE] year old female from nursing facility arrives as a sepsis with hypotension., tachycardia, altered mental status, there was differentiating stories from the nursing facility a CNA reportedly said she had been this way since 7:00 am. EMS had nurses told her it was just since about 10:00 am. An interview with the Director of Nursing (DON) at approximately 12:00 pm on 09/09/25 confirmed she had not read the report which indicated the resident had been unresponsive since 7:00 am or 10:00 am. She indicated she knew this was not the truth. She was able to show with the Medication Administration Record (MAR) that resident had drank some of her mighty shake at 10:43 am on this day. She agreed that they had not looked into this being true and no investigation was done because she knew it was not true because she was here that day and had seen the resident. An interview later in the afternoon on 09/09/25 with the Nursing Home Administrator (NHA) and Regional Director of Clinical Operations (RDCO) confirmed this was not reported. The NHA stated, We knew this was not the case so we did not report it or investigate it. We talked about her decline in the morning meeting an knew she was not doing well.' They both agreed this was not reported as neglect.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to identify and report a situation of potential neglect. This was a random opportunity for discovery found during the long term care survey process. This was true for Resident #145. Resident Identifier: #145. Facility Census: 139. a) Resident #145 Resident #145 was selected as a closed record review for the care area of hospitalization during the long term care survey process. A record review completed during the investigation of this care area found the resident was sent to the emergency room (ER) on 07/18/25. The transfer form completed by the facility indicated the resident was sent to the local hospitals ER at 1:10 pm on 07/18/25. The reason for the transfer was listed as, unresponsive. Further review of the medical record found an Emergency Department Record from the local hospital in the scanned documents in the medical record. A review of the document found it was faxed to the facility on [DATE] at 8:30 am. This document had been scanned into the electronic medical record prior to the beginning of this survey. A review of this document found the following, -- Resident Arrived at the ER at 1:38 PM.-- . [AGE] year old female presents to ER via EMS with complaints of Unresponsive -- . [AGE] year old female from nursing facility arrives as a sepsis with hypotension., tachycardia, altered mental status, there was differentiating stories from the nursing facility a CNA reportedly said she had been this way since 7:00 am. EMS had nurses told her it was just since about 10:00 am. An interview with the Director of Nursing (DON) at approximately 12:00 pm on 09/09/25 confirmed she had not read the report which indicated the resident had been unresponsive since 7:00 am or 10:00 am. She indicated she knew this was not the truth. She was able to show with the Medication Administration Record (MAR) that resident had drank some of her mighty shake at 10:43 am on this day. She agreed that they had not looked into this being true and no investigation was done because she knew it was not true because she was here that day and had seen the resident. An interview later in the afternoon on 09/09/25 with the Nursing Home Administrator (NHA) and Regional Director of Clinical Operations (RDCO) confirmed this was not reported. The NHA stated, we knew this was not the case so we did not report it or investigate it. We talked about her decline in the morning meeting an knew she was not doing well.' They both agreed this was not reported as neglect.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review, and staff interview, the facility failed to ensure a complete and accurate Minimum Data Set (MDS) assessment in the area of dialysis for one (1) of one (1) residents reviewed for the care area of dialysis. Resident Identifier: #135. Facility census: 139. Findings included: a) Resident #135 During an interview on 09/08/25 at 4:14 PM, Resident #135 stated he was receiving dialysis treatments. Review of Resident #135's physician's orders showed the resident had been receiving dialysis treatments since admission on [DATE]. Resident #135's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 08/27/25 indicated the resident was not receiving dialysis treatments. On 09/09/2025 at 1:10 PM MDS Nurse #182 confirmed Resident #135's MDS with ARD 08/27/25 was incorrect and should have indicated the resident was receiving dialysis treatments. No further information was provided through the completion of the survey process.

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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. Based on record review, observation and staff interview the facility failed to ensure Resident #16's care plan in regards to falls was implemented. This was true for one (1) of five (5) residents reviewed for the care area of accidents during the long term care survey process. Resident Identifier; #16. Facility Census: 139. a) Resident #16 A review of Resident #16's medical record found the following care plan: Focus Statement (First Name of Resident #16) has had falls and is at risk for further falls secondary to dementia with severe impaired cognitive function, unsteadiness on feet, muscle weakness, episodes of incontinence, difficulty hearing, episodes of pain. (Resident #16) has hypertension, panic disorder, anxiety, osteoarthritis, anemia, depression, hx of CVA. She has use of medications that carry side effects that increase risk for falling. Resident has poor safety awareness. Date Initiated: 09/15/23.Goal associated with this Focus Statement: (First Name of Resident #16) will not sustain major injury related to falls through review date Date Initiated: 09/15/2023 Revision on: 05/20/2025 Target Date: 11/20/25 Interventions included: Dycem under cushion of wheelchair Date Initiated: 06/24/25 Laminated sign in room to remind resident to use call light Date Initiated: 07/03/2025 Revision on: 07/08/2025An observation of Resident #16 with the Director of Nursing (DON) at 10:05 am on 09/10/25 found the resident resting in bed. Her wheelchair was sitting to the right of her bed. There was no Dycem in her wheelchair and no cushion. Also, there was not a laminated sign reminding the resident to use her call light. The DON agreed the interventions were not in place.

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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. Based on observation, record review and staff interview, the facility failed to store medications in accordance with accepted standards of practice. A multiuse vial of Tuberculin Purified Protein Derivative was not dated when opened. Facility census: 139.Findings included: a) Medication Room On 09/09/2025 at 8:22 AM, the building 2 medication room was inspected with Licensed Practical Nurse (LPN) #84 in attendance. In the medication room refrigerator was an opened multiuse vial of Tubersol Purified Protein Derivative that had not been dated when opened. This was confirmed by LPN #84. The vial was delivered by the pharmacy on 07/09/25. Tubersol Purified Protein Derivative is used to screen for tuberculosis infection. According to the medication package insert, available on the Food and Drug Administration (FDA) Website, a vial of Tubersol which has been entered and in use for 30 days should be discarded. No further information was provided through the completion of the survey process.