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	01/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and staff interview, the facility failed to develop and/or implement residents' comprehensive care plans. This deficient practice affected four (4) of 33 residents reviewed in the long-term care survey sample. Resident identifiers: #93, #43, #15, and #1. Facility census: 138. Findings included: a) Resident #1 On 01/07/26 at 2:19 PM, a record review was completed for Resident #1. The review found the care plan did not include the diagnosis of Major Depressive Disorder, single episode moderate. On 01/07/26 at 2:25 PM, Corporate Nurse #222 confirmed the diagnosis was not included in the care plan. b) Resident #43 Review of Resident #43's comprehensive care plan showed a focus initiated on 12/06/24 related to the resident's behaviors, including refusal of hygiene care. On 04/09/25, the intervention Resident prefers bed baths was initiated. Further review of Resident #43's comprehensive care plan showed a focus initiated on 10/30/24 related to a deficit in the resident's ability to perform activities of daily living. On 05/29/25, the intervention Resident prefers showers 2x week [twice a week] on nightshift was initiated. On 01/13/2026 at 10:39 AM, Resident #43 was interviewed regarding her preferences for hygiene. She stated she prefers bed baths in the evening after supper. On 01/13/2026 at 11:09 AM, Corporate Nurse #220 confirmed the conflicting care plan interventions regarding Resident #43's hygiene preferences. She stated she would clarify the matter and revise the care plan as needed. No further information was provided through the completion of the survey process. c) Resident #15 Observations of Resident #15 on the following dates and time found the following: 01/05/26 lunch meal: Resident #15 was served his meal around 12:30 pm. At approximately 3:00 PM this surveyor observed Resident #15's lunch meal still sitting on his over the bed table. The food was hardly disturbed and at least 90 % remained on his tray. (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
	515086	A. Building B. Wing	01/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse (RN) #115 was asked if Resident #15 needed help with his tray as it was still on his bedside table sitting in front of him. She replied, He sometimes does that I'll have to check. I'll go check on him. 01/06/26 and 01/07/26 Noontime Meal: Resident #15 was served his tray at approximately the same time each day. The staff was observed sitting his tray up for him on his over the bed table and then exited the room and provided no feeding assistance to him. 01/12/26 -- Noontime Meal - Resident #15 was served his tray at approximately 12:30 pm. About 15 to 20 Minutes later the surveyor entered the resident's room to see how he liked his lunch. His right hand was covered with chocolate pudding, and his food was barely disturbed. Resident #15 then asked this surveyor if she could help him eat because he could not get it. The surveyor alerted RN #115 of the observation immediately and asked her if she could help the resident. 01/12/26 - Supplement - Between 2:00 pm and 3:00 pm this surveyor entered Resident #15's room to see if the facility had provided him with his frozen nutritional supplement. The resident had the supplement and was attempting to eat it a spoon. The resident was obviously struggling and when he saw the surveyor he again asked her if she could help him eat his supplement because he could not get it. RN #115 was alerted to Resident #15's request for help. She stated, I will go help him now. A review of Resident #15's medical record found the following: A review of the resident's care plan found, and intervention related to Resident #15's need for help with ADL's which read: EATING totally dependent X1 (times one) assist. This was initiated on 11/13/25. A review of Resident #15's ADL flow sheets related to assistance with eating from 11/14/25 through 11/12/26 found out of 177 meals Resident #15 was dependent with assistance (meaning a staff member fed him his meal) as directed by the care only 74 times or 41.8 % of the time. On all other occasions Resident #15's care plan was not implemented and he did not get the assistance needed with eating he required. During an intrview with Corporate Registered Nurse (CRN) #220 at 10:10 am on 01/13/25 the above findings were discussed. She agreed that according to the observations and the ADL flow sheet documentation Resident #15 did not always receive the assistance he needed with eating. d) Resident #93 A review of Resident #93's care plan found an intervention which said, Bed in lowest position. This was added to care plan on 11/18/25 as an intervention for the following focus statement: The resident had a fall with fracture related to gait balance problems muscle weakness reduced mobility history of falls An observation with Corporate Registered Nurse (CRN) #220 on 01/05/26 at 1:55 pm found Resident #93 resting in bed. Her bed at the time of this observation was not in the lowest position. CRN #220 agreed the residents care plan had not been implemented.

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	01/13/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and staff interview the facility failed to ensure a resident who was dependent on staff for Activities Of Daily Living received the care they needed to maintain and/or attain the highest practicable physical, mental and psychosocial well being. Resident #15 was not provided assistance with eating as required. Resident #51 did not receive the assistance with bathing they required This was true for two (2) of four (4) residents reviewed during the long term care survey process. Resident Identifier: #15 and #51. Facility Census: 138. Findings include: a) Resident #15 Observations of Resident #15 on the following dates and time found the following: 01/05/26 lunch meal: Resident #15 was served his meal around 12:30 pm. At approximately 3:00 PM this surveyor observed Resident #15's noon time meal still sitting on his over- the- bed table. The food was hardly disturbed and at least 90 % remained on his tray. Registered Nurse (RN) #115 was asked if Resident #15 needed help with his tray as it was still on his bedside table sitting in front of him. She replied, He sometimes does that I'll have to check. I'll go check on him. 01/06/26 and 01/07/26 Lunch Meal - Resident #15 was served his tray at approximately the same time each day. The staff was observed sitting his tray up for him on his over- the- bed table and then exited the room and provided no feeding assistance to him. 01/12/26 Lunch Meal - Resident #15 was served his tray at approximately 12:30 pm. About 15 to 20 Minutes later the surveyor entered the residents room to see how he liked his lunch. His right hand was covered with chocolate pudding and his food was barely disturbed. Resident #15 then asked this surveyor if she could help him eat because he could not get it. The surveyor alerted RN #115 of the observation immediately and asked her if she could help the resident. 01/12/26 - Supplement - Between 2:00 pm and 3:00 pm this surveyor entered Resident #15's room to see if the facility had provided him with his frozen nutritional supplement. The resident had the supplement and was attempting to eat it with a spoon. The resident was struggling and when he saw the surveyor he again asked her if she could help him eat his supplement because he could not get it. RN #115 was alerted to Resident #15's request for help. She stated, I will go help him now. A review of Resident #15's medical record found the following: A review of the residents care plan found an intervention related to Resident #15's need for help with ADL's which read: EATING totally dependent X1 assist. This was initiated on 11/13/25. A review of Resident #15's ADL flow sheets related to assistance with eating from 11/14/25 through 11/12/26 found out of 177 meals Resident #15 was dependent with assistance (meaning a staff member fed him his meal) as directed by the care plan 74 times or 41.8 % of the time. On the other occasions Resident #15's care plan was not implemented and he did not get the assistance needed with eating he required. During an interview with Corporate Registered Nurse (CRN) #220 at 10:10 am on 01/13/25 the above (continued on next page)

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	01/13/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	findings were discussed. She agreed that according to the observations and the ADL flow sheet documentation Resident #15 did not always receive the assistance he needed with eating. b) Resident #51 On 01/05/2026 at 12:23 PM, Resident #51 stated, I don't always get showers. Sometimes it can be every two (2) weeks. Review of Resident #51's shower and bathing task report for the last 30 days showed the resident received showers on 12/18/25, 01/01/26, and 01/08/26. The resident received bed baths on 12/21/25, 12/24/25, 12/27/25, and 01/04/26. No refusals were documented in the task report or in the progress notes. Resident #51's comprehensive care plan stated the resident preferred showers twice a week on night shift. The care plan also stated the resident was totally dependent for assistance with showering and bathing. On 01/13/26 at 10:58 AM, Corporate Nurse #220 confirmed the documentation failed to show Resident #51 received twice weekly showers. She stated she was unable to locate any further documentation of showers or any documentation of refusals of showers during the time period. No further information was provided through the completion of the survey sample.

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	01/13/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and resident interview the facility failed to ensure Resident #15 received care to enable them to maintain and or attain acceptable parameters of hydration and nutrition status. The facility failed to ensure Resident #15 had access to water and/or fluid of his preference at bedside and accessible at all times. In addition the facility has failed to provide Resident #15 with assistance with meals to ensure the best possible meal consumption. This is true for one (1) of six (6) residents reviewed for the care areas of hydration and/or nutritional status during the long term care survey process. Resident Identifier: #15. Facility Census: 138. a) Resident #15 a1) Hydration On 01/05/26 at 3:00 pm Resident #15 was observed in his bed with his lunch tray still present. No additional fluid other than what was on his tray was observed. The three (3) cups on his tray were empty. On 01/06/26 during the course of the day from 8:30 am to 4:00 pm multiple observations of Resident #15 were made. The only fluids observed were delivered on his breakfast and lunch tray. The resident was observed multiple times laying in his bed with his over the bed table at bedside but no fluids were observed on the over- bed table or anywhere else accessible to the resident. On 01/07/26 at 9:00 am an observation found the resident in his room. His bedside table was cleared off and no breakfast or drinks remained. The nurse aide was asked if the resident ate his breakfast and he said yes and showed the surveyor the tray. There were 3 drink cups on the tray and all were empty. An observation and Resident interview on 01/07/25 at 10:45 am revealed the resident had no drink or cups in his room. When asked if the staff brought him drinks between his meals he indicated they did not. He stated that he was thirsty right now and would like to have two (2) cups of apple juice. Immediately after this observation and interview the Nursing Home Administrator was asked to accompany this surveyor to the residents room. The resident again was asked if they brought him drinks between his meals and he stated they did not. When asked if he had to wait until his next meal to get a drink, he replied, Yes He was asked if he was thirsty and he said that he was and he would like some juice and he wanted two (2) cups. While interviewing the resident prior to requesting the NHA come to the resident room the Nurse Practitioner came by and then left stating she would come back. After we left the room with the NHA another nurse was seen taking the resident a cup of juice. The NHA then told him to take him two (2) cups since he had asked for them. A later interview with the NHA on 01/07/26 indicated the nurse was taking him a cup of juice and the nurse aide said he had three (3) cups with breakfast and three (3) cups right after breakfast. He further stated they do not leave them at bedside because the consistency can change. During an interview with Nurse Aide (NA) #10 at 2:45 pm on 01/07/26 when asked about Resident #15's fluid today the Nurse Aide stated, he had those four (4) on the tray I showed you then he had another on his table he spilt and I cleaned it up and then they brought two (2) more later on. He stated, He used to have one of those little pitchers. And motioned hands in a manner to demonstrate the size which was smaller than other pitchers observed in the facility. Then he said we had to take that because he kept spilling it in his bed. So now we just take him cups in. An observation of the other residents found most residents had larger blue water pitchers which all contained ice water. The five (5) other residents who receive thickened liquids like Resident #15 all had a small blue water pitcher at their bedside with the exception of Resident #73 who had a two handled cup at bedside with thickened water in it. The smaller pitchers were the size NA #10 described while speaking with the surveyor earlier. After the interview with NA #10 and the observations of the other residents who were ordered thickened liquids, another interview was conducted with the NHA. When asked why the other five (5) residents who receive thickened liquids had fresh water at bedside, he stated, I misspoke earlier the thickened liquids can be left at bedside we just recently switched to pre thickened drinks which can be left at bedside. The NHA was made aware of the statement NA #10 made about taking Resident #15's water pitcher. The NHA stated, Let me clarify that with him under no circumstances should we (continued on next page)

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	01/13/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take his pitcher because he spills it. Later in the afternoon the NHA advised the surveyor that NA #10 was just trying to convey he was having a hard time drinking from the blue pitcher, so they started not giving him one and began giving him the smaller cups of fluid when he needed them. The NHA further stated, We are getting him a two handled cup for him to keep at his bedside with fresh water in it. Observations of Resident #15 on the following dates and time found the following: 01/05/26 Noontime meal: Resident #15 was served his meal around 12:30 pm. At approximately 3:00 PM this surveyor observed Resident #15's noon time meal still sitting on his over- bed table. The food was hardly disturbed and at least 90 % remained on his tray. Registered Nurse (RN) #115 was asked if Resident #15 needed help with his tray as it was still on his bedside table sitting in front of him. She replied, He sometimes does that I'll have to check. I'll go check on him. 01/06/26 and 01/07/26 Noontime Meal: Resident #15 was served his tray at approximately the same time each day. The staff was observed sitting his tray up for him on his over-bed table and then exited the room and provided no feeding assistance to him. 01/12/16 Lunch Meal - Resident #15 was served his tray at approximately 12:30 pm. About 15 to 20 Minutes later the surveyor entered the resident's room to see how he liked his lunch. His right hand was covered with chocolate pudding, and his food was barely disturbed. Resident #15 then asked this surveyor if she could help him eat because he could not get it. The surveyor alerted RN #115 of the observation immediately and asked her if she could help the resident. 01/12/26 - Supplement - Between 2:00 pm and 3:00 pm this surveyor entered Resident #15's room to see if the facility had provided him with his frozen nutritional supplement. The resident had the supplement and was attempting to eat it with a spoon. The resident was obviously struggling and when he saw the surveyor he again asked her if she could help him eat his supplement because he could not get it. RN #115 was alerted to Resident #15's request for help. She stated, I will go help him now. A review of Resident #15's medical record found the following: A review of the resident's care plan found an intervention related to Resident #15's need for help with ADL's which read: EATING totally dependent X1 assist e. This was initiated on 11/13/25. The following Weights were recorded: 09/23/25 -- 176.8 Lbs. (pounds) 09/30/25 - 175.Lbs. 10/03/25 -- 176.2 Lbs. 10/14/25 -- 173.3 Lbs. 10/21/25 -- 176 lbs. 10/27/25 -- 178.2 lbs. 11/07/25 -- 170.1 lbs. 11/12/25 -- 164.8 lbs. 11/18/25 -- 164.2 lbs. 11/24/25 -- 163 lbs. 12/01/25 -- 163.8 lbs. 12/09/25 -- 164.6 lbs. 01/05/26-- 154.5 lbs.01/07/26 -- 154.8 lbs. Based on the weights obtained the resident had suffered a 5.95 % weight loss in 30 days based on his most recent weight. This was considered a severe weight loss. Resident #15 lost 12/15 percent in the last 90 days based on his most recent weight. This is also considered a severe weight loss. Further review of the weight record found the resident suffered the largest losses between 12/09/25 and 01/05/26 and 10/27/25 and 11/12/25. A comparison of the activities of daily living (ADL) flow sheet for the task of eating found between 10/27/25 and 11/12/25 Resident #15 was coded as being dependent for eating only 56 % of the time. From 12/09/25 to 01/05/26 resident #15 was coded as being dependent only 48 % percent of the time. A further comparison of Resident #15's ADL assistance coding and the percentage of his meals consumed found the following: The review period from 09/21/25 through 01/07/25 revealed when the resident was provided feeding assistance and was marked as being totally dependent for feeding the resident consumed 76- 100 % of his meals 75% of the time. When the resident was marked as being independent with his meals (meaning he received no assistance from staff) he consumed 0- 25 % of his meal 69 % of time. During an interview with Corporate Registered Nurse (CRN) #220 at 10:10 am on 01/13/25 the above findings were discussed. She stated the resident was in the hospital with an adrenal crisis and returned to the facility on [DATE]. CRN #220 said, We have changed his medication for hyperthyroidism twice. We were attributing his weight loss to that. She confirmed she did not know he was not being provided the assistance he required for meals. She provided the surveyor with the two (2) medication orders. Resident #15 started 10 mg of methimazole on 10/08/25 and this was decreased on 12/17/25 to 5 mg. An additional record review of the registered dietician notes and assessments found that she had entered a note and/or an assessment on 11 occasions since the resident's readmission to the facility (continued on next page)

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	01/13/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on [DATE]. A review of this documentation found the dietician did not note anything attributing the weight loss to Resident #15's diagnosis of Hyperthyroidism. She never mentioned the medication changes or that he was on medication to treat hyperthyroidism. She mentioned his antidepressant in every assessment but failed to mention the methimazole which the facility attributed his weight loss to.

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	01/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on Record review and staff interview, the facility failed to ensure medications were administered in accordance with physician orders. Specifically, a resident was ordered lorazepam 0.5 mg every six (6) hours; however, the resident received lorazepam 2 mg per dose on seven (7) occasions. The facility failed to identify and correct the medication administration error in a timely manner. This failed practice represented a pattern of noncompliance and had the potential for more than minimal harm, as the resident received a dosage of lorazepam significantly greater than ordered on multiple occasions. The incorrect administration placed the resident at risk for adverse effects including excessive sedation, altered mental status, and respiratory depression. Although no actual harm was identified, the repeated nature of the medication error demonstrated a pattern that could compromise resident safety. Resident Identifier: #149 Facility Census: 138Findings include:On 01/07/26 at approximately 9:00 AM, Corporate Nurse #220 informed the surveyor that while reviewing Resident #149's medication orders and controlled substance administration record, a medication error was identified involving Lorazepam. Corporate Nurse #220 stated, The order is for lorazepam 0.5 mg every six hours; however, the resident received lorazepam 2 mg per dose.Record review completed on 01/07/26 revealed Resident #149 had a physician order for Lorazepam 0.5 mg, give one tablet by mouth every six (6) hours as needed for end-of-life care, anxiousness, and shortness of breath for 14 days.Further review of the Controlled Substance Administration Record revealed Lorazepam 2 mg, one tablet by mouth every four (4) hours as needed for anxiety, was administered to Resident #149 on the following dates and times:01/01/26 at approximately 5:16 AM, 12:23 PM, and 10:30 PM01/02/26 at approximately 8:23 AM and 10:09 PM01/05/26 at approximately 7:30 PM01/06/26 at approximately 10:40 AMThis resulted in the resident receiving four times the ordered dose of a benzodiazepine medication on seven (7) occasions over multiple days.During an interview on 01/07/26 at approximately 10:00 AM, Corporate Nurse #229 confirmed that Lorazepam was administered at 2 mg instead of the ordered 0.5 mg on seven occasions.The facility failed to ensure medications were administered in accordance with physician orders, placing the resident at risk for oversedation, respiratory depression, and other adverse outcomes, and failed to identify and correct the error timely.

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	01/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and staff interviews, the facility failed to ensure accurate and complete medical records for the five (5) of 33 residents. Resident #73, 1:1 documentation incorrect, Resident #149's post-event form was missing, and a fall assessment time was incorrect. Resident #6's feeding and water flush entries were mixed up. Resident #12's weights recorded incorrectly, and Resident #8's readmission assessment missed the identification of wounds. This was found true for five (5) of 33 residents' medical records being reviewed during the long-term care survey process. Resident identifiers: #73, #149, #6, #12, and #8. Facility census: 138.a) Resident #73 Record Review: On 01/07/26, review of Resident #743's activity participation records showed no documentation of 1:1 visits. Further review on 01/07/26 revealed the resident's care plan indicates 1:1 visits are to occur five (5) times per week. Staff Interview: On 01/07/26 at 3:11 PM, the Activity Director stated, We only mark the 1:1 tab if the resident requires a 1:1 sitter. I didn't think to have staff mark it for the scheduled 1:1 visits. I will educate staff and get this done now. This confirms that 1:1 visits were not being documented correctly, despite being provided according to the care plan. b) Resident #149 Record Review: On 01/07/26, review revealed the following:A post-fall assessment dated [DATE] incorrectly recorded the date and time of the fall as 01/06/25 at 14:00; the actual time of the fall was 07:20 AM. Further review indicated Resident #149's code status is DNR (Do Not Resuscitate). However, the medical record did not contain the POST form, and none was available at the nurses' station. Staff Interview: Corporate RN #220 stated, The nurse who completed the admission did have an orange verification paper for the DNR order, but it has been misplaced. RN #220 confirmed that the POST form was not present in the medical record during the surveyor's review and that the post-fall evaluation did not reflect the correct time of the fall c) Resident #6 This resident receives her nutrition through a PEG (Percutaneous Endoscopic Gastrostomy) feeding tube, due to a stroke affecting her right side and a diagnosis of dysphagia. A review of the medical record documents the following orders pertaining to PEG feeding: Enteral Feed order every night shift. Change flush syringe and container daily. Verbal order. Order date 12/12/25. Enteral Feed order every shift HOB (Head of Bed) elevated at least 30 degrees while administering enteral feedings. HOB remains at 30 degrees for at least 1 hour post bolus enteral feeding and post (continued on next page)

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	01/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration. Verbal order. Order date 12/12/25. Entered Feed order every shift. Monitor for signs/symptoms or tube feed intolerance QS (every shift), abdominal distention, increase pain, shortness of breath, formula visual in saliva, diarrhea, emesis. Verbal order 12/12/25 Enteral Feed order one time a day down at 7 AM or when total volume of 1155 ml has infused (provides 1732 kcals per 24 hours). Verbal order 10/31/25 Enteral Feed order one time a day Jevity 1.5 @ 105 ml/hour x 11 hours via enteral pump, up at 8:00 PM. Verbal order 10/31/25 Enteral Feed order one time a day. Take water flush down at 7 AM or when total volume of 660 ml has infused. Verbal order 01/05.26 Enteral Feed order one time a day. Water flushes @ 60 ml/hour x 11 hours while TF is infusing to provide 660 ml per 24 hours, start at 8 PM. Verbal order 01/05/26 Enteral Feed order two times a day Flush PEG tube with 30 ml water before and after enteral feeding. Verbal order 12/12/25. Enteral Feed order two times a day Verify enteral tube placement before feeding and flushes by checking for gastric contents. Notify physician if gastric contents are not visualized. Verbal order 12/12/25. A review of the Medication Administration Report (MAR) for 01/01/26, under the order for Enteral Feed Order one time a day down at 7 AM or when total volume has infused, the number infused was reported as 660 ml. A total of 1155 ml should have been infused. On the same date under the order Enteral Feed Order one time a day down at 7 AM or when a total volume of 1155 has infused (provides 1732 kcals per 24 hours), a total of 1155 ml was documented. A review of the MAR for December, 2025 documented under the order Enteral Feed Tube Order one time a day at 7 AM or when total volume has infused, values of: 660 ml on 12/17/25 660 ml on 12/26/25 and 660 ml on 12/31/25 During an Interview with Corporate RN # 220 on 01/13/26 at approximately 10:00 AM, surveyor asked about discrepancies on 12/17/25, 12/26/25, 12/31/25 and 01/01/26 values, surveyor asked shouldn't the feeding tube amount should been 1155 ml? Surveyor pointed out the values recorded as 650 ml. RN #220 said she thought the orders were confusing to staff, and stated staff were putting in water flush amount instead of feeding amount. RN #220 stated she has gone into the medical record to define this better so that staff will not confuse the entries anymore. d) Resident #12 (continued on next page)

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	01/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial record review of this resident, the medical record documented resident weight on 01/05/26 was 151 pounds. On 12/31/25, the medical record documented the resident weighed 260 pounds, which is a loss of 109 pounds in less than a week. This was reviewed with Corporate RN #220, on 01/07/26 at 10:20 AM. She said let me go fix that, and then said she would go look at the post dialysis note from 01/05/26 to see what the recorded weight was on that documentation, and make the appropriate correction. e) Resident #8 A review of Resident #8's medical record found he was discharged from the facility to an acute care hospital on [DATE]. The record further indicated that he returned to the facility on [DATE]. According to the nursing admission assessment which was completed on 12/29/25 upon his readmission to the facility Resident #8 had no skin issues. However, a skin/wound note dated 12/29/25 found the following, readmission skin assessment performed by wound team and UM (Unit Manager). The following was noted - O2 (oxygen) via nasal cannula set at 2L (liters), scattered bruising and scabs, skin tear on left forearm, IAD (Incontinence Associated Dermatitis) to groin scrotum, DTI (Deep Tissue Injury) to bilateral heels, DTI to sacrococcygeal, orders received, care plan updated. Dr. (last name of Physician) and resident aware. An interview with Corporate Registered Nurse (CRN) #220 at 11:00 am on 01/13/26 confirmed Resident #8's readmission assessment was not accurate. She confirmed he had three (3) DTI's upon readmission and several bruises and scabbed areas as well as a skin tear. She agreed those should have been captured on the nursing assessment upon readmission.

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	01/13/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure appropriate information was communicated to the receiving healthcare institution when a resident was transferred to the hospital in order to ensure a safe and effective transition of care. This deficient practice had the potential to affect one (1) of seven (7) residents reviewed for the care area of hospitalization. Resident Identifier: #8. Facility census: 138.Findings included:a) Resident #8 The facility's policy titled Transfer and Discharge Policy, with no implementation or revision dates given, stated a transfer form would be completed and sent with a resident being transferred to the hospital. The transfer form would contain the following information: - Patient status, including baseline and current mental, behavioral and functional status- Recent vital signs - Current diagnoses, allergies and reasons for transfer- Contact information for the practitioner responsible for the resident's care at the facility- Patient representative information, including contact information - Current medications and treatments- Relevant laboratory or radiological findings - Immunization status- Special instructions or precautions for care - Special resident risks - Other information necessary to ensure a safe and effective transition of care Review of Resident #8's medical records showed the resident was transferred to the hospital on [DATE] due to unresponsiveness and low blood pressure. Further review of the resident's medical records showed no completed transfer form to communicate to the hospital the information necessary to safely and effectively assume care of the resident. On 01/13/2026 at 10:53 AM, Corporate Nurse #220 stated she was unable to locate documentation of the information conveyed to the hospital when the resident was transferred. She stated a transfer form should have been completed and sent to the hospital with the resident. No further information was provided throughout the completion of the survey process

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	01/13/2026

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 - Few	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, observation and staff interview the facility failed to ensure Resident #9 who was fed by enteral means received the enteral feeding in accordance with the physician's orders. This was true for one (1) of two (2) residents reviewed for the care area of Tube Feeding during the long term care survey process. Resident Identifier: #9. Facility Census: 138. Findings Include: a) Resident #9 A review of Resident #9's medical record on 01/07/26 found the following physician orders: -- Enteral feed order in the morning turn off tube feeding at 8:00 am if the total volume of 1400 ml has infused, clear pump and document total. The start date of this order was 09/26/25 and was the current order at the time of this review. -- Enteral Feed order one time a day Jevity 1.5 at 70/ml/hr. via enteral pump start time 12:00 pm and run until 1400 Ml has been infused. May turn off at 8:00 am if 1400 Ml has infused. This order also had a start date of 09/26/25 and was the current order at the time of this review. -- Enteral feed order in the morning for nutrition Turn off tube feeding at 8:00 am. If the total volume of 1400 ml has been infused. Clear pump and document total. This order had a start date 09/27/25 and was the current order at the time of this review. An observation of Resident #9 on 01/07/26 at approximately 9:00 am found the resident resting in bed. His feed pump had been turned off, and the pump was not on. An additional observation of Resident #9 at 12:45 pm on 01/07/26 found the nurse had started his feeding which was due to be started at 12:00 pm. The enteral pump was on and running. The rate of feeding was programmed in the pump as 70 ml per hour as ordered. An observation of the pump found that at 12:45 PM only 45 minutes after the feeding was scheduled to start the total amount fed read 1105 ml. Corporate Registered Nurse (CRN) #220 was asked to look at the pump. She confirmed the amount fed said 1105 ml. She agreed the pump was not cleared after the resident's last feeding as directed in the order. When asked why it only read 1105 ml if the resident was to receive 1400 ml on the previous day she was unable to answer. She indicated she would have to talk to the nurses involved and see what happened. She agreed there was no way to determine when the feeding would be complete if the pump was not cleared after each feeding.

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	01/13/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interview, the facility failed to ensure oxygen was administered according to physician orders. This deficient practice was identified as a random opportunity for discovery. Resident Identifiers: #149 and #8. Facility census: 138. Findings included: a) Resident #8 An observation of Resident #8 on 01/05/26 at 3:22 PM found Resident #8 in his bed. His oxygen concentrator was on and running at two (2) liters per minute. The tubing for the residents oxygen was observed rolled up in a neat circle laying on the residents bed. It was not connected to the concentrator nor was the nasal cannula in Resident #8's nose. Registered Nurse (RN) #26 was asked to look at the oxygen and confirmed it was not connected to the concentrator or the resident. She stated that she would get him some new tubing and nasal cannula and get it hooked up appropriately. b) Resident #149 On 01/06/26 at approximately 11:09 a.m., the surveyor observed Resident #149 receiving oxygen at a rate of 4 liters per minute via nasal cannula. Record review completed on 01/06/2026 revealed a physician order indicating the resident was to receive oxygen at 2 liters per minute. An interview conducted on 01/06/26 with the Infection Prevention (IP) Nurse confirmed the physician order for Resident #149 was 2 liters per minute and acknowledged the oxygen was set incorrectly at 4 liters per minute at the time of observation.

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	01/13/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, record review, and observations the facility failed to ensure one resident received timely, consistent, and effective pain management in accordance with physician orders, and resident assessments, This practice was found true for one (1) of two (2) resident's reviewed for pain. Resident identifier: #149. Facility Census: 138.a) Resident #149On 01/06/2026 at 9:39 AM, Resident #149 reported uncontrolled pain and stated: They don't give me my pain medication. I hurt.The resident reported having cancer and stated he may have three (3) to four (4) months left to live. The resident expressed a desire to read his Bible and get closer to the Lord, but stated his pain prevented him from doing so. He reported that when pain medication was administered, it helped and made the pain tolerable, but stated there were days he did not receive any pain medication. The resident stated he usually activated his call light 30 minutes before his pain medication was due. Resident #149 said staff respond but do not return.At the time of interview, the resident confirmed he was in pain and rated it 7/10.The resident stated his last pain medication was morphine at approximately 8:00 PM the previous evening, although it was ordered every 12 hours.During the surveyor's interview with Resident #149, LPN #148 entered the resident's room to obtain vital signs and stated the resident was on neurological checks due to a fall. The nurse did not assess the resident's pain, did not discuss pain control, and did not administer or address overdue pain medication during the encounter.Review of the Nursing admission Evaluation showed Resident #149 was admitted on [DATE] at 3:14 PM. The nursing admission assessment revealed a pain score of 9/10 on the verbal pain scale.Further record review revealed the resident did not receive pain medication until 01/01/26 at 5:15 AM. This was more than nine (9) hours after admission, despite documented severe pain.Physician Orders for Resident #149 included:Morphine 30 milligram (mg), one (1) tablet by mouth every 12 hours for intractable pain.Oxycodone 15 mg, one tablet by mouth every four (4) hours as needed for pain.Medication Administration Record Review revealed the following dates/times Resident #149 received pain medication:Oxycodone 15 mg:01/01/26: 5:16 AM, 2:45 PM, 10:30 PM01/02/26: 8:23 AM, 10:10 PM01/03/26: None01/04/26: None01/05/26: 4:46 AM, 9:26 AM, 2:55 PM, 7:30 PM, 11:40 PMMorphine 30 mg:01/05/26: 8:43 PM01/06/26: 10:16 AMThe medication administration record (MAR) demonstrated missed and delayed pain medication administration, including multiple days without PRN pain medicationDuring an interview, with LPN #148 on 01/06/26 at 10:00 AM, the LPN confirmed the scheduled morphine dose was late. The nurse stated he would need to contact the physician for a one-time order to administer the morphine.

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	01/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and staff interview, the facility failed to have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medications. This was a random opportunity for discovery. Resident identifier: #21. Facility census: 138. Findings included: a) Resident #21 The facility's policy titled Medication Administration, with no effective date or revision date given, stated narcotics would be signed out when given. On 01/12/26 at 10:26 AM, inspection was made of the F odd medication cart. Registered Nurse (RN) #29 was in attendance. The Individual Resident's Controlled Substance Administration Records were reviewed for several residents. The amount of medication remaining according to the administration record was compared to the actual amount of medication contained in the locked drawer. For Resident #21, the Individual Resident's Controlled Substance Administration Record showed 32 tablets of Tramadol were left. However, there were only 31 Tramadol tablets for Resident #21 left in the locked drawer. This was confirmed by RN #29, who was unable to explain the discrepancy. The Tramadol had last been signed out on the Controlled Substance Administration Record on 01/12/26 at 4:22 AM. Review of Resident #21's Medication Administration Record (MAR) showed the resident received Tramadol four (4) times a day for pain, at 4:00 AM, 10:00 AM, 4:00 PM, and 10:00 PM. No further information was provided through the completion of the survey process.

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	01/13/2026

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 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 ensure medications were labeled properly. A multi-dose vial of insulin had two (2) different dates to indicate when the vial had been opened and two (2) different dates to indicate when the vial would expire. This was a random opportunity for discovery. Resident Identifier: #90. Facility Census: 138. Findings included: a) Resident #90 On 01/12/2026 at 10:23 AM, the F even medication cart was inspected. Registered Nurse (RN) #29 was in attendance. A multi-dose vial of Humulin Regular insulin for Resident #90 was noted to have two (2) dates to indicate when the vial had been first accessed and two (2) dates to indicate when the vial would expire. On the box were written the opening date of 12/10/25 and expiration date of 01/07/26. An opening date of 01/04/26 and expiration date of 02/02/26 were also written on the box. These dates were also written on the vial itself. The box had been filled by the pharmacy on 11/22/25. According to the Humulin Regular insulin package insert, available on the Food and Drug Administration (FDA) Website, vials must be used within 31 days of opening or be discarded. RN #29 confirmed the two (2) different opening dates and two (2) different expiration dates written on Resident #90's Humulin Regular multi-dose insulin box and vial. She also confirmed the medication had expired according to the earlier date on the vial. No further information was provided through the completion of the survey process.

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	01/13/2026

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and staff interview, the facility failed to offer the pneumococcal vaccination to Resident #4. This was true for one (1) of five residents reviewed under the care area of infection control. Resident Identifier: #4. Facility Census: 138. Findings Include: a) Resident #4 On 01/05/26 at 2:30 PM, a record review was completed for Resident #4. The review found Resident #4 was eligible for a pneumococcal 20 vaccination in 09/2025. However, the resident was not offered the pneumococcal vaccination. On 01/06/26, at 1:30 PM, Corporate Nurse #220 confirmed the vaccination was not offered to the resident.