STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewisburg Healthcare Center	979 Rocky Hill Road Ronceverte, WV 24970

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to follow a physician order for a resident to receive nothing by mouth (NPO). Resident #95 was given a soft drink by a staff member which resulted in the resident immediately coughing. This failed practice had the potential for more than minimal harm to any resident with an (NPO) order for or an order for thickened liquids. Resident identifiers #95, #13, #33, #80, #87 and #51. Facility Census 90.The citation will be cited at past non-compliance. The immediate Jeopardy occurred on 05/01/25 and was corrected on 05/03/25. Findings Include:a) Resident #95A record review on 01/14/25 at 1:30 PM revealed Resident #95 was admitted to the facility on [DATE].Resident #95 was admitted with diagnoses that included Cerebral Palsy and Autism.Further record review revealed that Resident #95 had a Peg Tube and a physician's order to have nothing by mouth (NPO) dated 04/21/25. Additionally, Resident #95 was determined to be incapacitated on 04/21/25. A review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/24/25, Section C, revealed that Resident #95 had a Brief Interview for Mental Status Score (BIMS) of (9) nine, indicating moderate cognitive impairment.A nurses note dated 05/01/25 at 2:24 PM that read as follows: Resident during activities this afternoon was given cola by staff that was not familiar with Resident. Resident coughed one time and it scared her when another staff stated that she was NPO. Resident is in no distress but was scared that she would get into trouble. MD and POA aware.A nurses note dated 05/02/25 at 5:05 PM reads as follows: Interdisciplinary Team (IDT) met to review and discuss resident recent choking episode. Resident was noted to be in the dining room post-activity, before noon mealtime. She is alert and can make needs known to staff, denies any pain, harm, or neglect and was aware of her NPO status, but still requested a Cola from staff. After she asked for the cola, resident took a drink and got choked. Resident was noted to be on a NPO diet. Cola was immediately removed from resident after choking episode noted. Staff removed resident from dining room and brought her back to the nurse for assessment and to inform of episode. MD and POA were notified with new orders for monitoring vital signs and chest Xray.Further record review revealed that the following residents currently have orders for Nectar Thick Liquids: Resident #13, #33, #80, and #87. Resident #51 had an order for Honey Thick Liquids.During an interview on 01/14/25 at approximately 6:00 PM, The Certified Nursing Assistant Instructor/Staff Educator shared she had conducted a Nurse Staff Meeting in May of 2025. The Agenda and with signatures of staff members in attendance was provided. During the nurse staff meeting, the importance of looking at the Kardex to ensure residents are getting the right diets was discussed. On 01/14/25 at 4:12 PM, the DON reported that the CNA who provided the soft drink was provided re-education and an Employee Corrective Action form documented the incident. The corrective action reads as follows:CNA gave NPO resident a can of pop (Cola) without checking her Kardex and diet orders, resulting in the resident having a choking episode.Facility administration failed to ensure staff were implementing resident-directed care consistent with the resident's comprehensive (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: 515144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessment and care plan physician orders, and professional standards of practice, placing the residents on specialized liquids or on a NPO diet at risk for aspiration pneumonia which could lead to hospitalization and possible death.Education was done with staff on 05/03/25 that read as follows: All foods and beverages requested by residents required verification of resident specific current diet orders and fluid consistencies. Do not provide residents with food or beverage until their diet order has been verified and the food or beverage is deemed appropriate per the physician order in the resident chart.The State Agency did an interview with staff on 01/15/26 at approximately 10:00 AM, that consisted of the following question: If a resident comes to you and requests something to eat or drink, what is the first thing you need to do?Dietary cook #107 replied, I would ask their name, verify the diet and inform nursing.Business Office Manager #80, replied, I would ask their name then inform them that I would let their nurse and or aide know the request.Nursing Assistant #90,replied, I would check the residents' Kardex for their dietary information.The Environmental Service Director replied, I would assist the person to a nurse or aide that could assist. The Activities Director replied, I would check the Kardex for proper diet and drink orders per resident.The Assistant Director of Nursing, replied, I would check the PCC order to the correct diet and liquid consistency before I give them anything,Therapy Staff #93, replied, Check the resident's food and drink orders before I give them anything.Maintenance Technician #37 replied, I'm not allowed to give the resident food or drinks. I would go to the CNA or nurse to have them get it for them.On 01/15/25 at 9:30 AM, The Administrator and DON presented SA with some Relias trainings that staff had completed for thickened liquids and for reading the meal tray ticket, however none of the documentation they supplied read to the fact of following the physician's order, and to check the order before given residents any food and/or liquid.