STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365271	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Inn of Steubenville	3102 St Charles Drive Steubenville, OH 43952

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 - Minimal harm or potential for actual harm 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** 28704 Based on observation, medical record review, and interview, the facility failed to notify hospice of a resident refusal of respiratory treatments. This affected one (#83) of three residents sampled. The census was 84. Findings include: Medical record review revealed Resident #83 was admitted to the facility on [DATE] with diagnosis including Parkinson's disease. Review of the significant change Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #83 was severely impaired for daily decision-making, was receiving hospice services and had two or more falls resulting in no injuries and two or more falls resulting in injuries. Review of the electronic Physician Orders dated 07/11/24 revealed Continuous Positive Airway Pressure (CPAP) machine (a treatment for sleep apnea that involves wearing a mask while you sleep that delivers mild air pressure to keep breathing airways open during sleep) to be worn at bedtime and continue home settings. Review of the hospice Physician Plan of Care dated 10/16/24 revealed physician orders including to start oxygen via nasal cannula two liters to five liters per minute continuously. On 12/17/24 at 9:32 A.M., observation revealed Resident #83 was lying in bed. An oxygen concentrator was observed beneath the window with nasal cannula (oxygen tubing that delivers oxygen through your nose) laying on the floor. The oxygen tubing was dated 11/09/24. A CPAP machine was observed sitting on the window sill. On 12/18/24 at 9:03 A.M., interview with Certified Nursing Assistant #206 stated Resident #83 uses oxygen when he gets short of breath but would need to speak to the nurse about that. On 12/18/24 at 9:22 A.M., interview with Licensed Practical Nurse (LPN) #208 verified there were no current physician orders in the computer for Resident #83's oxygen to be administered and the resident does not wear the oxygen continuously. LPN #208 also verified the CPAP order did not have the ordered settings and had been refused all but one day between 11/01/24 and 12/18/24 without notifying hospice or the physician. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency was an incidental finding discovered during the complaint investigation.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure fall interventions were implemented. This affected one (#83) of three residents sampled. The census was 84. Findings include: Medical record review revealed Resident #83 was admitted on [DATE] with diagnosis including Parkinson's disease. Review of the significant change Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #83 was severely impaired for daily decision-making, was receiving hospice services and had two or more falls resulting in no injuries and two or more falls resulting in injuries. Review of the care plan: Potential for Falls: Resident is at risk for falls and fall related injury related to impaired vision, medication use, requires assist with transfers, and history of falls revised 10/30/24 revealed interventions including to keep call light within reach, assist with wearing proper footwear, assist with wearing glasses and encourage him to wear non-skid gripper socks when not wearing shoes. Review of Resident #83's Progress Notes on 12/16/24 at 12:06 P.M. revealed Licensed Practical Nurse (LPN) #204 witnessed Resident #83 leaning to his left and appeared to be trying to get to his shoes. The resident fell to the floor and no injuries were observed. The physician and family were notified of the fall and staff were notified the resident was to be in a geri-chair at all times. On 12/17/24 at 12:16 P.M. Resident #83's fall intervention was changed from a geri-chair to keeping a grabber (reach extender that increases the range of a person's reach and grasp when grabbing objects) within reach. The resident was already utilizing a geri-chair for comfort as ordered by hospice services. Review of the Fall Risk Evaluation dated 12/16/24 revealed Resident #83 was at high risk for falls. Review of the Learning Circle In-Service dated 12/16/24 revealed a new intervention for Resident #83 was to be in a geri-chair when up. Further review of the Inservice revealed no evidence Certified Nursing Assistant (CNA) #206 was educated of the resident's fall or signed the Inservice sheet as acknowledgment of the new intervention. Review of Resident #83's fall care plan revealed no evidence the fall care plan was revised after his fall on 12/16/24 with the new intervention to have a grabber within reach or for the resident to be in a geri-chair when out of bed. On 12/17/24 at 9:32 A.M., observation revealed Resident #83 was lying in bed wearing only an incontinence product with a sheet draped across his lower abdomen. The resident was not wearing gripper socks, no gripper socks were observed in the bed, his touch pad call light was not within reach and was positioned at the end of the bed, resting against the foot board. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 9:02 A.M., observation revealed Resident #83 was lying in bed, was not wearing gripper socks or his glasses and his touchpad call light was positioned between the mattress and the footboard. Interview with Housekeeping #207 at the time of the observation verified the call light was not within reach of the resident. On 12/18/24 at 9:03 A.M., interview with Certified Nursing Assistant (CNA) #206 revealed she was caring for Resident #83 and he was a high fall risk. CNA #206 verified Resident #83's touchpad call light was not within reach and stated his fall interventions included for the call light to be within reach, wearing his glasses, in a low bed with a floor mat and the bed against the wall. CNA #206 stated the resident was to be up in his specialized tilt-n-space wheelchair when out of bed. CNA #206 stated she was not aware of any recent falls or other interventions she should be checking. On 12/18/24 at 9:11 A.M., interview with LPN #208 stated Resident #83 had a fall from his chair on 12/16/24 and the new intervention was for a grabber to be in reach to assist the resident in picking up items off the floor. LPN #208 stated after a resident fall, the nursing staff completes an investigation and starts education on the new interventions implemented to try to prevent the resident from falling again. On 12/18/24 at 9:13 A.M., observation of Resident #83's room with LPN #208 revealed there was no grabber (extended reacher) in his room for use and the resident glasses were not on. LPN #208 verified without his glasses, Resident #83 would not be able to see the posted reminder on the wall that stated Please hit call light for assistance getting up! On 12/18/24 at 10:00 A.M., interview with the Director of Nursing (DON) verified there was no grabber or reach extender available for use currently in the facility. The DON stated the grabbers were on order, had not been delivered yet and Resident #83 has not had one to use yet. The DON verified no other intervention had been implemented to prevent further falls since the 12/16/24 fall. Review of the policy: Falls and Fall Risk, Managing reviewed 12/18/24 revealed staff was to identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall risk factors included footwear that was unsafe or absent. Staff was to implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. This deficiency represents non-compliance investigated under Complaint Number OH00159914.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to provide appropriate care for oxygen and respiratory equipment. This affected one (#83) of three residents sampled. The census was 84. Findings include: Medical record review revealed Resident #83 was admitted on [DATE] with diagnoses including Parkinson's disease, generalized anxiety disorder, pneumonia and acute respiratory failure with hypoxia. Review of the electronic Physician Orders dated 07/11/24 revealed Continuous Positive Airway Pressure (CPAP) machine (a treatment for sleep apnea that involves wearing a mask while you sleep that delivers mild air pressure to keep breathing airways open during sleep) to be worn at bedtime and continue home settings. Review of the hospice Physician Plan of Care dated 10/16/24 revealed physician orders including to start oxygen via nasal cannula two liters to five liters per minute continuously. Review of the significant change Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #83 was severely impaired for daily decision-making and was receiving hospice services. On 12/17/24 at 9:32 A.M., observation revealed Resident #83 was lying in bed. An oxygen concentrator was observed beneath the window with nasal cannula (oxygen tubing that delivers oxygen through your nose) laying on the floor. The oxygen tubing was dated 11/09/24. A CPAP machine was observed sitting on the window sill and the face mask was observed to have speckled black spots on the cushion of the face mask as it was resting on the window sill. The face mask was not covered or resting on a barrier. On 12/18/24 at 9:02 A.M., observation revealed Resident #83's oxygen tubing was laying on the floor and CPAP mask was laying on the window sill without a barrier. On 12/18/24 at 9:03 A.M., interview with Certified Nursing Assistant #206 stated Resident #83 uses oxygen when he gets short of breath but would need to speak to the nurse about that. On 12/18/24 at 9:13 A.M., interview with Licensed Practical Nurse (LPN) #208 verified Resident #83's oxygen and CPAP equipment should be kept in a bag and changed when used. LPN #208 verified the oxygen tubing was dated 11/09/24 and should be changed weekly by the nursing staff. At 9:22 A.M., LPN #208 stated there were no current physician orders in the computer for Resident #83's oxygen and the CPAP order did not have the ordered settings just to continue home settings but she did not know what those were. LPN #208 stated she would have to contact the physician for clarification. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Oxygen Administration revised 12/18/24 revealed oxygen was to be administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans and the resident's goals and preferences. Oxygen was to be administered under orders of a physician and cleaning and care of equipment shall be in accordance with facility policies. This deficiency was an incidental finding discovered during the complaint investigation.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to administer medications as ordered. This affected two (#50 and #58) of four residents observed for medication administration during 29 opportunities for error resulting in a 13.7% medication error rate. The census was 84. Findings include: 1. Medical record review revealed Resident #50 was admitted on [DATE] with diagnoses including hypertension, congestive heart failure, coronary artery disease and anxiety. Review of the electronic Physician Orders dated December 2024 revealed to administer medications including a chewable aspirin (ASA) 81 milligrams (mg), Isosorbide Dinitrate 30 mg once a day with physician parameters to hold if her systolic blood pressure (SBP) was less than 100, and Lopressor 25 mg with physician parameters to hold if her SBP was less than 100. On 12/17/24 between 9:39 A.M. and 9:48 A.M., observation of Resident #50's medication administration revealed Registered Nurse (RN) #209 assessed Resident #50's blood pressure and stated it was 108/72 millimeters of mercury (mmHg). RN #209 went back to the medication cart and dispensed medication into a medication cup including ASA enteric coated (EC) 81 milligrams. During the medication administration, RN #209 stated she was not going to administer Isosorbide or Lopressor due to the resident's blood pressure reading of 108/72 mmHg. RN #209 verified the two medications were not administered despite the resident's blood pressure exceeding the parameters to withhold the medications. 2. Medical record review revealed Resident #58 was admitted on [DATE] with diagnoses including cerebral infarction. Review of the electronic Physician Orders dated December 2024 revealed to administer medications including ASA 81 mg. On 12/17/24 at 9:50 A.M., observation revealed RN #209 administered ASA EC 81 mg to Resident #58. On 12/17/24 between 9:50 A.M. and 9:55 A.M., interview with Registered Nurse #209 verified ASA EC 81 mg was administered to Resident #58 and not an ASA 81 mg as ordered. Review of the policy: Administering Medications revised April 2019 revealed medications were to be administered as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00159914.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to maintain a complete medical record. This affected one (Resident #85) of three residents sampled. The census was 84. Findings include: Closed medical record review revealed Resident #85 was admitted on [DATE] and discharged on [DATE]. Review of the closed record revealed a handwritten Physician's Progress Notes dated 10/25/24 by Nurse Practitioner #210 and Physician's Progress note dated 10/31/24 by Physician #201. The progress note sheet was not labeled with a resident name, identification number or room number. There was no identifying information on the Physician's Progress Note sheet to indicate who the note was for. On 12/18/24 at 2:30 P.M., interview with the Director of Nursing (DON) verified the Physician Progress Note was in the closed record for Resident #85; however, with no resident information he could not verify what resident it was for without the physician and nurse practitioner to verify. The DON verified the medical record was not complete. This deficiency is an incidental finding discovered during the complaint investigation.