

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Inn of Steubenville		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, manufacturer guideline review, facility policy review and interview, the facility failed to ensure Resident #7 was comprehensively assessed and appropriate interventions were in place to prevent a burn from a hot liquid. In addition, the facility failed to ensure care planned/physician ordered fall interventions were in place to decrease the resident's risk of falls. This affected one resident (#7) of four residents reviewed for accidents. The census was 78. Actual Harm occurred on 09/19/2025 when Resident #7, who had severe cognitive impairment, required staff assistance with activities of daily living and received occupational therapy for identified upper extremity weakness, sustained large second degree burns to her left thigh requiring pain medication and treatments to the areas after the resident was provided hot tea in a Styrofoam cup that spilled on her lap. Findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM), dementia, dysphagia, secondary malignant neoplasm of brain, anxiety, Alzheimer's, atrial fibrillation, history of falls, malignant neoplasm of bronchus or lung, and traumatic subdural hemorrhage. Review of Resident #7's most recent OT evaluation and plan of treatment dated 08/28/25 revealed a goal to increase bilateral upper extremity (BUE) strength. The resident's baseline BUE strength was a 3/5. For functional skill of eating, Resident #7 required set up or clean up assistance. Resident #7's mobility function score (ranges from 0 to 12; 12 being the highest function). Resident #7's mobility score was a 0. Per the OT assessment, therapy needs were identified through weakness of the resident's upper extremities. Review of Resident #7's physician orders revealed an order for acetaminophen oral tablet 325 mg by mouth three times a day for pain. Review of Resident #7's annual Minimum Data Set (MDS) completed 09/02/25 revealed the resident had severe cognitive impairment and exhibited no behaviors. The resident required set-up or clean-up help for eating and partial to moderate assistance with oral hygiene. The resident was dependent on staff assistance with toileting, personal hygiene, lower body dressing and showers. She required maximal assistance from staff with upper body dressing and partial/moderate assistance for mobility and transfers. The resident wore corrective lenses and utilized a wheelchair for mobility. The resident had no impairments to her upper or lower body. Review of Resident #7's quarterly care plan completed 09/02/25 revealed Resident #7 had impaired activities of daily living (ADL) function related to requiring assistance to perform and complete ADL care. Interventions included allowing time for the resident to complete tasks; Allow for rest breaks if the resident tires. Observe for frustration or inability to complete tasks, and intervene to assist as indicated to complete care, and to meet mobility needs. Assist with meal intake. There were no assessments within the medical record to identify the resident's safety with hot liquids. There was no care plan regarding the resident's ability to safely consume hot liquids or interventions to decrease the likelihood of burns from hot liquids. Review of Resident #7's progress note revealed a note authored by Registered Nurse (RN) #86 on 09/19/25 at 12:40 P.M that stated Resident #7 spilled a cup of tea onto (her) lap. (The resident's) left thigh was red and (a) blister formed and burst almost immediately. Cold water was applied to the area, clothes were changed, and (the resident's left) leg was assessed. Director of Nursing (DON), Primary care physician (PCP) and family was notified. Waiting on new orders from (the) provider. Resident reporting some discomfort to (the) left thigh. (The pain was rated a 1 on a scale of 0-10 (0 represents no pain and 10 represents the worst pain ever reported by the resident). Review of Resident #7's progress note dated 09/19/25 at 6:14 P.M., authored by RN #86, revealed Resident #7 had complaints of increased pain due to a beverage burn. Ibuprofen 400 milligram (MG) oral (PO) three times a day (TID) as needed (PRN) ordered. (There was no assessment of the resident's pain at this time). Record review revealed a wound assessment completed 09/19/25 revealed Physician #1004 was notified of a burn in house acquired to Resident #7's left upper thigh, pink epithelia present and wound appeared moist. Small amount of serosanguinous drainage was noted. The wound was 15 centimeters (cm) in length, nine cm in width, peri wound was red with irregular edges. Treatment plan for Silver sulfadiazine External Cream 1.0 % Apply to left thigh topically every shift for burn to left thigh, cleanse with normal saline, apply cream, telfa pads and kerlix. Review of Therapist #6's statement dated 09/19/25 revealed she had just prepared hot tea for the resident and another (unidentified) resident. As she was sitting beside Resident #07 and preparing for the therapy session, the resident began to take a drink (of the hot tea). The therapist believed the resident attempted to balance the cup on her lap, on the dish she had also been holding, resulting in the cup spilling on her leg. Immediately she was able to intervene, nulling the</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, the facility failed to ensure a resident at risk for dehydration had water maintained at her bedside. This affected one (Resident #7) of three residents reviewed for dehydration. Findings include: Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease with a late onset, unspecified dementia, adult onset diabetes mellitus, personal history of malignant neoplasm of the pancreas, malignant neoplasm of an unspecified part of an unspecified bronchus/ lung with metastasis to the brain, chronic kidney disease, unsteadiness on feet, and a history of falls. Review of Resident #7's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was severely impaired. She was not indicated to have displayed any behaviors and was not known to reject care. She required a partial to moderate assist with transfers and ambulation. The resident was coded as having received a diuretic medication during the seven day assessment period. Review of Resident #7's care plans revealed the resident had the potential for fluid imbalance related to kidney disease and diuretic use. The goal was for the resident to demonstrate adequate hydration as evidenced by laboratory values within normal range for the resident. The interventions included the need to maintain water at the resident's bedside. On 10/14/25 at 2:31 P.M., an observation of Resident #7 noted her to not have any water made available to her in her room as per her plan of care. There was no evidence of her being provided a Styrofoam cup, with a lid and straw, as was noted in other residents' rooms providing them with ice water. Her room was absent of any cups or other sources of a beverage for her to drink to help keep her hydrated per her plan of care. Findings were verified by Certified Nursing Assistant (CNA) #104. On 10/14/25 at 2:40 P.M., an interview with CNA #104 revealed she had provided Resident #7 with ice water earlier that morning, when they were getting residents up for the day. She denied she had assisted Resident #7 with getting up that morning, as she was already up when she came on duty at 6:00 A.M. She reported night shift got Resident #7 up that morning. She was not able to locate a Styrofoam cup for the resident in her room or any other beverage for the resident to drink when she wanted. She suspected that maybe housekeeping had thrown it away when they were in the resident's room cleaning it earlier. She acknowledged housekeepers were in other residents' rooms cleaning their rooms without throwing their Styrofoam cups away. She further acknowledged Resident #7's plan of care indicated the staff were to maintain water at her bedside at all times. On 10/15/25 at 8:40 A.M., further observations of Resident #7 noted her to be lying in bed in her room. She was noted to have a Styrofoam cup dated 10/15/25 that had water in it, but the Styrofoam cup was sitting on the overbed table that was placed near the entry door to the room and out of the resident's reach. On 10/15/25 at 8:43 A.M., an interview with CNA #26 confirmed Resident #7's water that was in a Styrofoam cup on her overbed table was not left in the resident's reach. She further confirmed with the placement of the overbed table away from the resident's bed, the resident would not be able to reach her Styrofoam cup if she wanted or needed a drink. This deficiency demonstrates non-compliance investigated under Complaint Number 2630029.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure an effective antibiotic stewardship program was implemented, when a resident returned from the hospital on an antibiotic for the treatment of a urinary tract infection, and the facility's infection preventionist failed to ensure an appropriate antibiotic was ordered to adequately treat the infection. This affected one (Resident #7) of three resident's reviewed. Findings include: Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease with late onset, unspecified dementia, and chronic kidney disease. Review of Resident #7's nurses' progress notes revealed the resident was sent to the emergency room (ER) on 08/26/25 at 5:00 P.M. for complaints of chest pain. She complained of mid-sternum burning and heaviness. She returned to the facility on [DATE] at 1:40 A.M. with the diagnoses of a urinary tract infection (UTI). She returned to the facility with a new order for Keflex 500 milligrams (mg) by mouth every eight hours for seven days for the treatment of a UTI. Review of Resident #7's hospital records for her emergency room (ER) visit on 08/26/25 revealed the resident was seen for complaints of chest pain not relieved by gastroesophageal reflux disease (GERD) medications. She was diagnosed with a UTI and was started on Keflex 500 mg by mouth every eight hours for seven days for a UTI. Review of a urinalysis (U/A) with a culture and sensitivity (C&S) that was collected on 08/26/25 at 10:31 P.M., while Resident #7 was in the hospital, revealed the resident's U/A showed her urine was positive for nitrites (typically caused by a bacterial infection in the urinary tract) and was also positive for bacteria. The final culture report on 08/29/25 revealed the resident's urine had greater than a 100,000 colony count/ milliliter of heavy Enterobacter Cloacae (gram negative bacterium that's a natural part of the human gut, but could cause various infections including UTI's). The sensitivity report indicated Keflex was not one of the seven antibiotics that the organism causing the resident's UTI was sensitive to. Review of an Antibiotic Time Out report for Resident #7 dated 08/29/25 at 2:07 P.M. pertaining to the resident's use of Keflex 500 mg by mouth three times a day revealed the resident was sent to the ER for chest pain and returned with a UTI diagnosis. The resident was indicated to be showing no signs or symptoms of a UTI, but the U/A C&S returned positive for Escherichia Coli (E. coli). The Antibiotic Time Out report did not accurately reflect the organism identified on the C&S as having caused the UTI, which was Enterobacter Cloacae. The report further showed the antibiotic use was reviewed with the physician, but informed him of the incorrect organism identified as causing the infection. The physician responded on 09/02/25 (the day the seven day course of the antibiotic treatment was completed) and provided instructions to finish and complete the antibiotic, when she only had one dose of the antibiotic left to take. Review of Resident #7's medication administration record (MAR) for August and September 2025 revealed the resident received the full course of the ordered antibiotic (Keflex) for seven days between 08/27/25 and 09/02/25. The first dose was given on 08/27/25 at 2:00 P.M. and the last dose was administered on 09/02/25 at 10:00 P.M. There was no evidence of the antibiotic being changed to one of the seven antibiotics identified on the sensitivity report as being effective in treating the UTI caused by the specific organism identified on the culture report. The resident received a full seven day course of Keflex that was not effective in treating a UTI caused by Enterobacter Cloacae. On 10/15/25 at 10:35 A.M., an interview with LPN #62 revealed she was the facility's acting Infection Preventionist (IP) when Resident #7 was treated for a UTI following her ER visit on 08/26/25. She reported she was responsible for reviewing residents who were sent to the hospital and was started on an antibiotic to treat an infection as part of her IP role. She stated she reviewed to see if an antibiotic had been started and also obtained the labs to ensure an antibiotic was warranted. She claimed to have identified Resident #7 was started on an antibiotic for the treatment of a UTI, after the resident returned from the hospital on [DATE]. She reported she identified the organism causing the resident's UTI was not sensitive to the antibiotic that had been ordered at the hospital. She indicated she completed an antibiotic time-out and reached out to the resident's physician. She stated the physician wanted to continue the antibiotic as ordered even though it was not an effective treatment for the organism identified. She further indicated that particular physician, who was their prior medical director at the time, was one of the few physicians she dealt with that was not good about following the facility's ATB Stewardship program. He would often want antibiotics continued that had been ordered without supporting documentation confirming the resident had an active infection. He also did not always change the antibiotic that had been previously ordered when it was made know that antibiotic was not effective in treating the</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, interview, and review of maintenance work orders the facility failed to maintain a safe and comfortable home like environment. This had the potential to affect one (Resident #07) of five residents rooms observed. the census was 78. Observation on 10/15/25 at 10:02 A.M. revealed a hole in the wall behind the head of Resident #7's bed. The hole was observed to be located behind the head of the resident's bed, near the baseboard. The hole was approximately eight inches by eight inches. Review of facility maintenance work orders for the past six months revealed no documentation of an order to repair the hole in the wall of Resident #7's room. Interview on 10/15/25 at 10:48 A.M. with Certified Nurses Assistant (CNA) #42 and Licensed Practical Nurse (LPN) #18 confirmed there was a larger hole in the wall of Resident #7's room. The hole was located behind the head board near the bottom of the wall. CNA #42 and LPN #18 stated they had not noticed the hole in the wall prior to it being pointed out. This deficiency demonstrates non-compliance investigated under Complaint Number 2630029.</p>		