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	04/06/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, maintenance ticket reviews, and staff interviews the facility failed to maintain safe flooring when it did not repair an area of flooring that was uneven and cracked on the transition care unit (TCU) utilized by residents. This affected nine mobile residents (#1, #9, #13, #25, #34, #42, #62, #95, and #105) of 20 residents residing on TCU. The facility census was 95.Findings include:Observation on 03/30/26 at 7:35 AM during the initial tour of the transition care unit (TCU) in front of the nurses' station door revealed a dip in the flooring and a piece of the flooring cracked with a hole starting. This was verified by certified nursing assistant (CNA) #481 who reported she would fill out a ticket to let the maintenance department know of concern. CNA #481 confirmed that the dip in the floor and crack have been there for a while. Observation and interview on 04/02/26 at 9:32 A.M. during a return tour of the TCU in front of the nurses' station door revealed a dip in the flooring and a piece of the flooring cracked with a hole starting. This was verified again by registered nurse (RN) #255 who reported that the maintenance department was aware of the concern, and she had told them that the physical therapy team was concerned as residents walk through that hallway during treatments and are having to walk around the area to the side of the hallways to prevent falls. RN #255 further reported that non-emergent maintenance issues are put on handwritten tickets and placed at the nurses' station and they come around daily to get tickets and address concerns. Urgent issues would be called immediately to the maintenance supervisor. RN #255 reported it's been that way for a while.Interview on 04/02/26 at 10:20 AM with Maintenance Director (MD) #148 reported he received a ticket dated 03/30/26 concerning the flooring issues on TCU. The MD #148 further reported that all of the flooring is needing to be replaced but this would require a contractor and they are in the process of getting estimates. The MD #148 was not able to produce records of estimates or tickets prior to 03/30/26 regarding flooring issues on TCU.Interview on 04/02/26 at 1:40 P.M. with the Administrator revealed she was just made aware of the flooring concern on TCU today and maintenance was currently fixing the floor. During interview the MD #148 came into the Administrator's office and reported he had fixed the flooring issues on TCU.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview and observation, and staff interview the facility failed to ensure a call light was accessible and within reach to meet resident needs. This affected one resident (#95) of 20 residents residing on the transitional care unit. The facility census was 95.Findings include:Review of the medical record for Resident #95 revealed admission to the facility on [DATE] with diagnoses including sepsis (a whole-body infection), venous ulcers to bilateral lower legs, severe peripheral vascular disease (narrowing of the vessels in the arms and legs decreasing blood circulation), diabetes, heart failure, heart disease, and acute kidney failure. Further review of the medical record for Resident #95 revealed a minimum data set (MDS) comprehensive assessment was completed on 03/25/26 and revealed Resident #95 required supervision and hands on assistance with dressing lower body, supervision with transfers from bed to wheelchair, and was dependent on staff for mobility of his wheelchair. The MDS assessment also revealed that Resident #95 had no cognitive impairment with a brief interview for mental status score of 15/15.Observation and interview on 03/31/26 at 9:53 A.M. revealed the door of Resident #95's room was closed. Resident #95 was found to be sitting up in a wheelchair, with bilateral footrest present, in the middle of his room. Further observation revealed the call light was not within reach of Resident #95 and was attached to the bedside dresser. The dresser was behind Resident #95 and there was not enough space to move the wheelchair into the area to retrieve the call light. Resident #95 then reported I am glad you came in when you did the nurse left me a while ago to get something for my bed and my dressings are falling off my foot and I can't reach my call light and the door was shut. Interview on 03/31/26 at 9:55 A.M. with registered nurse (RN) # 255 verified that Resident #95 could not reach his call light and she would get someone to change Resident #95's foot dressing. Review of the policy titled Call lights: Accessibility and Timely Response, dated 12/08/25, revealed staff will ensure the call lights are within reach of residents and secured as needed.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure an appropriate diagnosis was indicated for the use of an antipsychotic medication. This affected one resident (#2) of five residents reviewed for unnecessary medications. Findings include: Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, non-Alzheimer's disease, unspecified fracture of right lower leg, osteomyelitis of right ankle and foot, diabetes mellitus, cirrhosis of liver, chronic obstructive pulmonary disease, and muscle wasting. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 10/01/25, revealed Resident #2 had severe cognitive impairment, a diagnosis of non-Alzheimer's dementia, and received an antipsychotic medication. Review of the physician order, dated 10/02/25, revealed the order for Risperdal (antipsychotic medication) oral tablet 0.5 milligrams (mg) one tablet by mouth two times a day for agitation. Review of the Monthly Regimen Reviews (MRR), dated 10/08/25, revealed the pharmacist recommended an appropriate diagnosis to support the use of the antipsychotic medication, Risperdal. Further review revealed the physician did not timely address the recommendation until 11/20/25, and at that time, changed the diagnosis to dementia with mood disturbance. Interview on 04/02/26 at 7:59 A.M with the Director of Nursing (DON) confirmed Resident #2's October 2025 MRR was not addressed timely by the physician and the resident received Risperdal 0.5 mg by mouth two times per day, an antipsychotic, without an appropriate diagnosis. Review of facility policy titled, Addressing Medication Regimen Review Irregularities, dated 12/05/25, revealed it is the policy to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. The report should be submitted to the Director of Nursing within 10 working days of the review.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and facility policy, observation of medication administration, and staff interviews the facility failed to properly administer medications through a feeding tube for Resident #8. This affected one resident (#8) of one resident reviewed for tube feeding management and care. The facility census was 95.Findings include:Review of the medical record for Resident #8 revealed admission to the facility on [DATE] with diagnoses including high blood pressure, paraplegia (unable to use lower legs), aphasia (inability to speak), seizure disorder, depression, gastrotomy tube (for tube feeding and medications), and anoxic brain damage (lack of oxygen to brain leading to death of brain cells). Further review of the medical record for Resident #8 revealed a quarterly assessment of the minimum data set (MDS) completed on 02/13/26. The MDS revealed Resident #8 was unable to speak and communicate needs, was dependent for all cares and mobility, and was unable to complete an evaluation for mental cognition. The MDS also revealed Resident #8 required a feeding tube for nutrition and medication administration. Observation on 04/01/26 at 8:02 AM of the medication administration for Resident #8 with registered nurse (RN) # 466 revealed several medications crushed by registered nurse (RN) # 466 for administration through Resident #8's feeding tube. The medications included Baclofen (a muscle relaxer) 20 milligrams (mg), lisinopril (for blood pressure control) 10 mg, Vitamin D (supplement for bone health) 25 mg, and a multivitamin (supplement for general health) 1 tab. Continued observation revealed RN #466 added the powdered mixture of crushed medications to a cup of approximately 180 milliliters (ml) of water and then immediately used a large syringe to pull up approximately 60 ml of fluid into the syringe to be administered through the feeding tube. RN #466 did not mix the crushed medications in the water and did not allow time for the medications to be completely dissolved into the water. There was a residual layer of medication on top of the water remaining in the cup after RN #466 pulled up the water with the crushed medications. RN #466 then repeated drawing up another 60 ml of water with crushed medications. The medications were still not completely dissolved, and a layer of powder remained on top of the water. RN #466 began to administer the second 60 ml syringe of water and crushed medications when he met residence and the fluid stopped going through the feeding tube. RN #466 assessed the three-way stop cock attached to the end of the feeding tube and visualized undissolved medication particles sitting at the base of the stop cock blocking the flow of the fluid through the feeding tube. RN #466 then attempted to remove the blockage and was able to eventually remove the buildup of undissolved medications from the stop cock to resume flow of fluids. RN # 466 then returned to the cup of water with crushed medications which still had a residual film on top of water of undissolved medications and removed the last 60 ml of fluid and administered the water with crushed medications through the tube feed. RN #466 then made a comment that he would add additional water to cup to rinse it and administered it. RN #466 then added approximately 120 ml of water to the cup which had residual crushed medication attached to the inside of the cup. The cup of water turned a yellow tinted color as the remain crushed medication dissolved into it. RN #466 then administered the remaining fluids and then flushed the feeding tube with an additional 30 ml of water. RN #466 verbalized that he must not have crushed up the medications as good as he thought and verified there was a clog in the three-way stop cock of crushed undissolved medications. Review of the facility policy titled Medication Administration via Enteral Tube, and dated 12/08/25 revealed medications should be crushed and mixed with water and dilute the solid or liquid medications as appropriate.

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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 observation, record review, facility policy review and interview, the facility failed to provide effective and timely pain control for Resident #104 upon admission. This affected one resident (#104) of one resident who was reviewed for pain management. The facility census was 95.Findings include: Review of the medical record for Resident #104 revealed admission to the facility on [DATE] with diagnoses including heart disease with a triple vessel cardiac bypass, anemia (low blood count), depression, high blood pressure, spinal stenosis (narrowing of the vertebrae) of the neck and mid back, bilateral hip replacements, left knee replacement, and uterine cancer with radiation.Review of the hospital active medication list sent on 03/26/26 to the facility revealed Resident #104 was actively prescribed the following medication during hospitalization: Oxycodone (a potent opioid medication used to treat moderate to severe pain) five (5) milligrams (mg) every four hours as needed for post op(erative) pain, Tramadol (a prescription-only synthetic opioid analgesic used to treat moderate to severe pain) 50 mg every six hours as needed for pain, Tylenol (over the counter analgesic) 500 mg three times a day as well as Tylenol 650 mg every 4 hours as needed for pain. However, upon admission [DATE] at 7:45 P.M.) the resident only had an order for Tylenol 500 mg three times a day for post-op pain management.Review of the nursing admission assessment completed on 03/26/26 at 9:01 P.M. revealed Resident #104 rated her pain a three (3) on a scale of one to 10 with 10 being the most severe pain and described the pain as achy and infrequent. Review of a progress note dated 03/27/26 at 12:30 A.M. revealed a communication to the Telehealth on call physician requesting a new order for Tylenol 1000 mg three times a day instead of the hospital discharge order of 500 mg three times a day. An order was received at that time.A nursing progress note authored by Registered Nurse (RN) #473 and dated 03/27/26 at 1:08 P.M. revealed Resident #104 reported to the RN that she was on Oxycodone five mg every four hours for pain management in the hospital and requested to receive this medication for pain management. The note revealed RN #473 notified Primary Care Physician (PCP) #487 and he declined to prescribe the medication with no rationale noted.Further review of the progress notes for Resident #104 revealed another nursing note authored by RN #473 and dated 03/27/26 at 4:09 P.M. revealed Nurse Practitioner (NP) #486 was in to see Resident #104 and that NP #486 contact PCP #487 and discussed the resident's pain medications.Review of the history and physical assessment for Resident #104 completed on 03/27/26 revealed Nurse Practitioner (NP) #486 recommended Norco (a prescription medication combining hydrocodone (an opioid pain reliever) and acetaminophen, used to treat moderate to severe pain when non-opioid alternatives are insufficient) for severe pain and continue Tylenol for mild to moderate pain. A prescription for Norco 5-325 mg (one tablet) every eight hours as needed for pain was sent to the Remedi Pharmacy on 03/27/26 at 4:13 P.M. by PCP #487.Review of the medication administration record (MAR) for Resident #104 revealed a pain rating of 3/10 on admission on [DATE]. On 03/27/26 the resident's pain was documented to be rated an eight on a scale of one to 10 (which corresponded to the resident's request for pain medications. Additional documentation on the MAR included on 03/27/26 at 7:28 P.M. the resident's pain was documented to be a one on a scale of one to 10, on 03/27/26 at 9:43 P.M. pain was rated a one on a scale of one to 10 and on 03/27/26 at 10:40 P.M. the resident's pain was documented to be a three on a scale of one to 10. However, there were no nursing progress notes or comprehensive assessment completed to corroborate the numerical pain rating number documented on the MAR at these times. Review of the medical record revealed Resident #104 did not receive the requested pain medication until 03/28/26 at 12:11 A.M. when she requested something for severe pain rated a nine out of 10. Further review revealed Resident #104 continued to receive Norco pain medication again on 03/28/26 at 8:23 A.M., 03/28/26 at 4:28 P.M., 03/29/26 at 1:23 A.M., and 03/29/26 at 11:44 A.M. Resident #104 continued to receive Norco pain medication. Review of a nurse progress note dated 03/30/26 at 8:50 A.M. revealed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #104 reported her pain management was better, but her pain returned before she was due for the next dose of pain medication. PCP #487 was notified and a new order was provided to stop the Norco 5/325 mg one tab every eight hours and change to Norco 5/325 mg one tab every six hours as needed for pain.On 03/31/26 a review of the (in process) Minimum Data Set (MDS) initial comprehensive assessment revealed the resident had a Brief Interview for Mental Status score of 15/15 indicating the resident had no cognitive impairment. Further review of the MDS assessment revealed Resident #104 required moderate to maximum assistance with dressing, bathing, bed mobility and transfer and ambulation (walking). Continued review of the MDS assessment revealed on admission Resident #104 had surgical pain to the breastbone rated 3/10 on a 0-10 pain scale. The pain was assessed to be frequent and interfered with her ability to perform everyday activities and sleep.On 03/31/26 at 9:23 A.M. Resident #104 was observed sitting up in chair. The resident was noted to be breathing heavily with facial grimacing, and guarded posture (non-verbal signs of pain). During the observation, an interview with Resident #104 revealed ported she was in pain rated an eight out of 10 to her chest from her recent triple cardiac bypass surgery and was waiting on the nurse to bring her pain medications. Resident #104 reported the aide was letting the nurse know about the need for pain medicine. Resident #104 reported Tylenol was not effective and she had a scheduled dose of Tylenol at 5:30 A.M. this morning and her last dose of pain medication (Norco) was around 11:30 P.M. last night. Resident #104 reported she could have it (Norco) every six (6) hours, but she waited too long this morning to ask for pain pill and now her pain had increased. Resident #104 appeared to be in significant pain at this time. During the conversation, Resident #104 reported she had some issues when she first arrived with pain management and the doctor would not prescribe anything other than Tylenol and it took a whole day to get her pain medications figured out. Resident #104 further reported they did increase her pain medication to every six hours yesterday and that had helped but this morning she was trying to go longer than six hours and the pain had caught up with her. Resident #104 was agreeable for further interview later in day after she got her pain meds and some rest.Review of the MAR revealed pain ratings on 03/28/26, 03/29/26, 03/30/26, and 03/31/26 ranging from six to nine out of 10 on the pain scale and relieved with the Norco pain medication.Interview on 04/01/26 at 8:25 A.M. with Licensed Practical Nurse (LPN) #382 revealed if a new medication or pain medication were prescribed late in day or after pharmacy drop off the nurse could get the medication from the emergency supply stock. After the prescription was called to the pharmacy then the nurse could verify with the on-call pharmacist and get an approval code to remove the designated medication from the emergency medication supply. LPN #382 verified this was also the process for obtaining pain medications if new orders were given and if a resident needed the medication sooner than the next pharmacy delivery. LPN #382 confirmed that the pharmacy generally delivers medications in late evening hours but was not sure of exact times.Interview on 04/01/26 at 11:21 A.M. with Registered Nurse (RN) #473 revealed that on 03/27/26 Resident #104 requested something more than Tylenol for pain and had been on Oxycodone five (5) mg every four hours while in the hospital. RN #473 reported she texted PCP #487 (on her personal phone) but he declined to change any medication or give orders for the Oxycodone. RN #473 denied receiving rationale as to why nothing was prescribed at that time. In addition, RN #473 reported she had since deleted all of the communication text from her personal cell phone with PCP #487. RN #473 did confirm NP #486 came in and saw Resident #104 later in the day and believed something was eventually prescribed for better pain control but was unable to recall when that occurred and what it was for.Interview on 04/01/26 at 4:19 P.M. with NP #486 revealed she had seen Resident #104 on 03/27/26 and spoke with her about the expectations of post-operative pain and agreed Resident #104 would need something more than Tylenol for pain. NP #486 said she spoke with PCP #487 and he agreed to call in a script for Norco to the pharmacy that day. NP #486 further revealed the PCP had not prescribed anything earlier because he had limited knowledge provided about the resident from staff and knew that the NP would be seeing Resident #104 later that day. Interview on 04/02/26 at 9:15 A.M. with Resident #104 revealed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was a retired nurse and that she could not understand why the hospital discharged her with only Tylenol for pain control and when she had been getting the Oxycodone every four hours for pain while in the hospital. Resident #104 further reported the nurse notified the doctor on the first night the resident was at the facility to get something stronger for pain control and the doctor would only increase the dose of Tylenol. Further interview with Resident #104 revealed she requested stronger pain medications again around 1:00 P.M. the second day and the doctor would not prescribe anything else. Then the nurse practitioner came in and saw her around 4:00 PM and agreed to order Norco for better pain control. Resident #104 then stated she had to wait almost eight hours to get her pain pill, and it was around midnight when she finally got it. Resident #104 reported she did not know why it took so long to get the medication. Resident #104 went on to report that she had a history of having both hips replaced and a knee replacement and hysterectomy and she had never had this kind of poor pain control. Resident #104 reported that her post operative pain to her breastbone was a steady 8/10 for the first twenty-four hours she was at the facility until she received the Norco. Resident #104 also reported the first night she was at the facility her pain in her chest was so bad she could not even sleep in the bed due to pain trying to lay down and get up and the staff did get her a reclining chair to sleep in and extra pillows to help assist with comfort that night but she did not sleep well.Continued interview with Resident #104 revealed her pain had since improved and was better controlled now that she was getting the Norco every six hours. The pain control allowed her to participate more in daily activities and physical therapy treatments.Review of facility Pain Management policy dated 12/08/25 revealed the health care team in collaboration with the attending physician and the resident would develop, implement, monitor, and revise necessary interventions to prevent or manage each individual resident's pain starting at admission to the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review the facility failed to ensure safe storage of medication when medications were left on the breakfast tray for Resident #95. This affected one resident (#95) of twenty residents receiving medication on the transitional care unit. The facility census was 95. Findings include:Review of the medical record for Resident #95 revealed admission to the facility on [DATE] with diagnoses including sepsis (a whole-body infection), venous ulcers to bilateral lower legs, severe peripheral vascular disease (narrowing of the vessels in the arms and legs decreasing blood circulation), diabetes, heart failure, heart disease, and acute kidney failure. Further review of the medical record for Resident #95 revealed a minimum data set (MDS) comprehensive assessment was completed on 03/25/26 and revealed Resident #95 required supervision and hands on assistance with dressing lower body, supervision with transfers from bed to wheelchair, and was dependent on staff for mobility of his wheelchair. The MDS assessment also revealed that Resident #95 had no cognitive impairment with a brief interview for mental status score of 15/15.Observation and interview on 04/02/26 at 9:07 A.M. with Resident #95 revealed he was sitting on the side of his bed with his breakfast tray in front of him on the bedside table. Further observation reveled a medicine cup with 30 milliliters of a brownish liquid and another medicine cup containing four pills (1 blue, 1 pink and 2 white) sitting on Resident #95's breakfast tray. Resident #95 reported he had been working on taking the medications and that there were 15 pills, but he can only take 3-4 at a time. Interview on 04/02/26 at 9:09 A.M. with registered nurse (RN) #473 revealed that she did not visualize Resident #95 take all of his medications when she administered them. RN #473 further confirmed that Resident #95 had four pills remaining in the medicine cup and that the brownish liquid in the other medicine cup was his ProSource supplement. RN #473 confirmed she should have observed Residents #95 taking all of his medications and should not have left the medications with Residents #95. RN #473 proceeded to stay with Resident #95 until he completed taking the remainder of his medications.Interview on 04/20/26 at 12:05 P.M. with the Director of Nursing (DON) confirmed the nursing staff are to make sure medications are taken by residents when they are administered and medications are not to be left in the resident's rooms.Review of the facility medication administration storage policy dated 10/01/25 revealed, During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.