

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER East Ohio Regional Hospital Long Term Care		STREET ADDRESS, CITY, STATE, ZIP CODE 90 North Fourth Street Martins Ferry, OH 43935	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on observation, record review, hospital document review, interview, and policy review, the facility failed to provide adequate and proper assistance to Resident #3 during staff assisted mobility/ transportation in a wheelchair to prevent a fall with major injury and failed to ensure fall interventions were in place for Resident #4.</p> <p>Actual Harm occurred on 04/26/24 when Resident #3, who was being being pushed in a wheelchair incorrectly over an exterior door threshold by Hospitality Aide (HA) #80 was thrust out of the wheelchair striking an outdoor wooden swing with her face and head. HA #80's hand slipped from the wheelchair handle and the resident's wheelchair rolled, unattended, down an approximate three percent grade slope. When Resident #3 attempted to stop the wheelchair by putting her feet on the ground, she was thrust out of the wheelchair. The resident complained of increased pain as a result of the incident and sustained displaced, comminuted (broken into several pieces) fractures of the nasal bones, a fracture of the anterior wall of the right maxillary sinus, and fractures to the medial wall of the right orbit (cavity in the skull where the eye is situated) as a result of the incident. The resident was transferred from a local hospital to a trauma center due to the extent of her injuries. This affected two residents (#3 and #4) of five residents reviewed for accidents. The facility census was 35.</p> <p>Findings include:</p> <p>1. Closed medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including vomiting, fall from chair, dehydration, generalized abdominal pain, acute kidney failure, unsteadiness on feet, weakness, and hypertensive heart disease.</p> <p>Review of the fall risk assessment, dated 04/10/24, revealed Resident #3 was identified as a fall risk.</p> <p>Review of the care plan, dated 04/11/24, revealed Resident #3 was at risk for falls related to requiring assistance for activities of daily living (ADLs), gait/balance problems, history of falls, weakness, and dizziness. Interventions included to keep the call light within reach and encourage use, ensure proper footwear was worn including non-skid socks or non-skid footwear when ambulating or mobilizing in wheelchair, ensure a clutter-free, safe environment, and to observe for medical side effects.</p> <p>(continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the 5-Day Minimum Data Set (MDS) 3.0 assessment, dated 04/16/24, revealed the resident was cognitively intact, with no behaviors or rejection of care. The assessment further revealed the resident had functional limitation of range of motion of the upper and lower extremities, with impairment on both sides. The resident's mobility devices were a wheelchair and a walker.</p> <p>Review of a facility Incident Report, (authored by the Director of Nursing), dated 04/26/24 at 2:50 P.M., revealed Resident #3 was being transported outside in her wheelchair by Hospitality Aide #80. The HA stated the wheelchair handle slipped out of her hand and then moved. The resident placed her feet on the ground and fell out of the wheelchair. The resident stated she was getting out of her wheelchair to sit on the swing and fell . The resident verbally complained of moderate pain in her right anterior shoulder.</p> <p>Review of the Post Fall Evaluation, dated 04/26/24 at 3:01 P.M., revealed the resident was alert and oriented at the time of the fall. The fall was witnessed. The resident was going outside to the swing in the courtyard and fell in the courtyard. Injury details listed were a laceration above the right eye and a laceration between the eyes.</p> <p>Review of a nursing progress note (authored by the Director of Nursing (DON), dated 04/26/24 at 5:15 P.M., revealed the resident asked to go outside in her wheelchair. While pushing the resident outside, Hospitality Aide (HA) #80 turned to shut the door and the wheelchair handle slipped out of her hand. The resident rolled down a small slant on the patio. Resident #3 stated that she put her foot down to stop and fell forward out of her wheelchair onto the concrete patio. The fall was witnessed by Hospitality Aide #80 and Activity Director (AD) #66. The resident was immediately taken to the emergency department (ED) for evaluation. The physician and family were notified.</p> <p>Review of Activity Director #66's Witness Statement, dated 04/26/24, revealed she was coming around the side of the building while pushing a resident, who was looking at the landscaping, when she saw Resident #3 rolling down the sidewalk without anyone holding onto the wheelchair. AD #66 observed Hospitality Aide #80 standing at the door, when AD #66 started yelling 'grab her. AD #66 saw the resident put her foot down, momentarily stand, and then fall into the swing. AD #66 yelled at HA #80 to get a nurse.</p> <p>Review of Hospitality Aide #80's undated Witness Statement revealed she was taking the resident outside, when the wheelchair slipped out of her hand. AD #66 yelled, Catch her. I couldn't catch her quick enough. She fell out of her wheelchair.</p> <p>Review of Licensed Practical Nurse (LPN) #67's Witness Statement, dated 04/26/24, revealed an unnamed State tested Nursing Assistant (STNA) informed her that a resident fell outside. LPN #67 observed Resident #3 lying on her stomach with blood running from her face. LPN #67 applied a towel to control the bleeding. The resident was alert and oriented. The resident was placed on a board, ice was applied, and the resident was transferred to the Emergency Department (ED).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Emergency Department Note, dated 04/26/24 at 2:17 P.M., revealed a female was being pushed outside when she caught her toe on the ground and fell out of her wheelchair, striking the ground face first. The resident complained of nose, head, face, and neck pain. Computed tomography (CT) scan of the facial bones revealed comminuted displaced fractures of the nasal bones, likely extending into the nasal septum. There was a fracture of the anterior wall of the right maxillary sinus involving the orbital floor anteriorly with some mild, cortical offset. Fractures were also present to the medial wall of the right orbit. The resident was transported to a trauma center to be evaluated for an orbital fracture of the maxillary sinus and comminuted nasal fracture.</p> <p>Review of a Nurse Practitioner (NP) progress note, dated 04/26/24 at 10:49 P.M., revealed Resident #3 was in her wheelchair and wanted to be taken outside. Hospitality Aide #80 was pushing the resident through the door, something happened to the wheelchair, and it went forward. The resident was thrown from the chair and fell to the concrete and landed on her face. The resident was taken to the ED and had multiple facial fractures and contusions and transferred to a trauma center.</p> <p>Review of the hospital records (Trauma Center), dated 04/27/24, revealed Resident #3's arrived at 7:41 A.M. via ambulance due to a fall sustained at her skilled nursing facility. The resident was diagnosed with a closed fracture of the orbit, closed fracture of the maxillary sinus, closed fracture of the nasal bone, hypoxia, and pneumonia of the left, lower lobe due to infectious organism. Plastic surgery, orthopedics, pulmonary, and neurosurgery were consulted, sinus precautions were initiated, a Tetanus immunization and antibiotics were administered. The resident did not require surgical intervention related to injuries sustained in the fall. The resident was subsequently discharged to another skilled nursing facility.</p> <p>Interview on 05/22/24 at 2:47 P.M. with Activities Director #66 revealed she was in the courtyard pushing another resident in a wheelchair, when she came around the corner of the building and saw Resident #3 sitting in her wheelchair rolling away from the door, when she yelled to Hospitality Aide (HA) #80 to catch her! AD #66 stated she saw Resident #3 put her feet down to try to stop, but became completely upright and then immediately fell forward, hitting the wooden outdoor swing with her face and then hitting her head on the cement ground. AD #66 stated that she yelled for HA #80 to get help. AD #66 stated she then secured her resident and locked her wheelchair, and ran over to help, but by this time there were nurses and other staff assisting the resident. AD #66 stated she always transports the residents out of the door backwards due to the door threshold and slope, and she did not understand why HA #80 was pushing the resident out of the door in a forward position.</p> <p>Observation on 05/22/24 at 3:00 P.M. with AD #66 revealed the activities room had an exterior door, with a metal, raised threshold, leading out to a concrete sidewalk and patio. From the exterior door opening, the sidewalk led to a concrete patio, where a wooden, two-person garden swing was situated facing the doorway. There was an approximate 3-4% downward slope observed from the door to the swing/patio area. Per email received from the DON on 06/03/24 at 2:11 P.M., she confirmed the slope percentage was 3%.</p> <p>During the onsite investigation, maintenance measured the distance from the door to the swing to be approximately 23 feet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 05/23/24 at 12:07 P.M. with Therapy Director #74 revealed the main consideration while transporting a resident in a wheelchair through a door/threshold and an area with a slope would be to make sure the resident's back was against the chair. Therapy Director #74 further stated the direction of the wheelchair would be resident specific depending on if the resident will tolerate going backwards, but in the situation with the door threshold and the slope of the ground, it would probably be safer, to roll the wheelchair backwards.</p> <p>Interview on 05/28/24 at 3:12 P.M. with the DON confirmed the fall investigation determined HA #80 was transporting Resident #3 in her wheelchair from the activity room to the patio. While pushing the resident forward through the door opening, her hands slipped, and the wheelchair rolled down the slanted area. The resident was thrown from the wheelchair and hit her head and face on the wooden, outdoor swing, sustaining facial fractures and lacerations. The DON stated the root cause of the accident was the improper transport of the resident, HA #80 should have pushed the resident out of the door backwards and should have had both hands on the wheelchair. The DON stated she was unsure why HA #80 did not react immediately to attempt to catch the wheelchair, until told to do so by AD #66.</p> <p>Review of the facility's policy titled, General Safety for Patients and Employees, dated January 2021, revealed it is the responsibility for all nursing personnel to be aware of all hospital safety measures and requirements and adhere to these measures. Wheelchairs should be backed off and onto elevators and down inclines, with the operator at the back of the chair.</p> <p>2. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including history of falling, acute cystitis, hypertension, acute kidney failure, depression, and weakness.</p> <p>Review of the fall risk assessment, dated 05/07/24, revealed Resident #4 was determined to be a fall risk.</p> <p>Review of the 5-Day Minimum Data Set (MDS) 3.0 assessment, dated 05/13/24, revealed the resident was cognitively intact, with no behaviors or rejection of care. The assessment further revealed the resident required partial/moderated physical assistance with toileting and toilet transfer. The resident's mobility device was a walker.</p> <p>Review of the care plan, dated 05/07/24, revealed Resident #4 was at risk for falls related to required assistance for activities of daily living (ADLs), gait/balance problems, cardiovascular medications, history of falls, weakness, and dizziness. Interventions included to keep the call light within reach and encourage use, ensure proper footwear was worn including non-skid socks or non-skid footwear when ambulating or mobilizing in wheelchair, ensure a clutter-free, safe environment, and to observe for medication side effects.</p> <p>Review of a nursing progress note, dated 05/12/24 at 2:30 P.M., revealed the nurse was at the nursing station discussing Resident #4 with the Nurse Practitioner when an STNA came to the nursing station and stated the resident was on the floor in the bathroom. STNA #81 reported she had walked the resident to the bathroom with the assistance of the walker. STNA #81 stated the resident needed to have a bowel movement, so gave her some privacy and then heard knocking at the door. When she opened the door, she found the resident on the floor. The resident was alert, but confused and was being treated for a urinary tract infection (UTI). A hematoma was noted on the right side of her head. The resident was placed on a back board and transported to the emergency room .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of State-tested Nursing Assistant (STNA) #81 Witness Statement, dated 05/12/24, revealed she assisted Resident #4 onto the toilet and then walked into another resident's room to provide privacy per Resident #4's request. STNA #81 heard knocking on the door, opened the door, and found the resident lying on the floor, on her back.</p> <p>Review of the Post Fall Evaluation, dated 05/12/24 at 4:02 P.M., revealed a fall occurred in the bathroom after the resident was assisted to the bathroom by staff. The resident was left alone in the bathroom for privacy to have a bowel movement. The reason for the fall was the resident stood to pull her pants up resulting in a fall and sustained a hematoma to the right side of her head. The resident did not complain of pain, however, she was transferred to the ED.</p> <p>Review of a nursing progress note, dated 05/12/24 at 4:55 P.M., revealed the resident returned from the ED, all scans were negative. The resident did report some tenderness at the hematoma site. The resident remained confused and was previously diagnosed with a urinary tract infection. The resident was subsequently diagnosed with Coronavirus (COVID-19) on 05/13/24.</p> <p>Interview on 05/28/24 at 8:31 A.M. with the DON confirmed Resident #4 had been confused and should not have been left alone in the bathroom as she required toileting assistance from staff. The DON further confirmed STNA #81 was subsequently terminated following the incident.</p> <p>Review of the facility's policy titled, Fall Reduction Program, dated October 2023, revealed all residents would receive adequate supervision, assistance, and assistive devices to aid in the prevention of falls. Each resident would be evaluated for safety risks including falls and accidents. Care plans would be created and implemented based on the individual's risk factors to aid in prevention of falls. All falls were to be investigated and monitored. The facility would maintain a record that contains a list of all falls. All residents admitted to the skilled/rehab and long-term care unit would be considered at risk for falls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153899.</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>33019</p> <p>Based on interview, review of facility completed documents, and review of emails, the facility failed to have a governing body/designated person(s) functioning as such to appoint a qualified administrator, who was licensed by the State of Ohio. This had the potential to affect all 35 residents residing in the facility.</p> <p>Findings included:</p> <p>During the survey's entrance conference on 05/22/24 at 9:10 A.M., both the Director of Nursing (DON) and Social Services Director (SSD) #57 stated the licensed nursing home administrator was Administrator #70. A key personnel list received from the DON further indicated this information.</p> <p>An email with survey documents was sent to Administrator #70, however, a return email was received on 05/22/24 at 10:23 A.M. that indicated Administrator #70 was no longer the Administrator at the facility, and his last day was 05/15/24.</p> <p>Review of an email from a staffing agency, dated 05/14/24 at 1:13 P.M., sent to Social Services Director (SSD) #57, revealed, Administrator #70 let us know he is unable to extend out past this Friday, 05/17/24. Further review revealed on 05/14/23 at 1:35 P.M., the email was forwarded by SSD #57 to COO #40 and HR Director #72.</p> <p>Interview on 05/22/24 at 10:38 A.M., the Director of Nursing (DON) confirmed she had not been notified that Administrator #70 was no longer the facility's licensed nursing home administrator. The DON stated going forward she will contact Chief Operating Officer (COO) #40 with any issues or concerns until another administrator is in place.</p> <p>Interview on 05/22/24 at 12:10 P.M., the Human Resources Director (HR Director) #72 confirmed there was currently no licensed nursing home administrator employed at the facility and that he would facilitate the survey. HR Director #72 stated he was notified on 05/14/24, via email from a staffing agency, that Administrator #70's last day of employment at the facility would be 05/15/24. HR Director #72 verified that he had not received any notification directly from Administrator #70 that his last day of employment as the facility's Administrator would be 05/15/24. HR Director #72 stated that he notified the hospital's Chief Operating Officer (COO) #40 of the email on 05/14/24. HR Director #72 stated he had reached out to two area administrators and was hopeful that a new, interim administrator would be in place soon. HR Director #72 confirmed COO #40 would be the the person in charge of operational and management decisions until a licensed nursing home administrator was hired.</p> <p>Interview on 05/22/24 at 4:05 P.M. with SSD #57 revealed although she forwarded the email from the staffing agency on 05/14/24 to COO #40 and HR Director #72 regarding Administrator #70's last day of employment, she did not realize that he had not extended the contract and was under the assumption that he was still the facility's Administrator when she provided this information during the entrance conference.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of facility completed documents including the Summary of Complaint form and Centers for Medicare and Medicaid Services (CMS) 671 form, dated 05/22/24, revealed the forms were completed and signed by COO #40 and HR Director #72.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154049.</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: The nursing home is disputing this citation.</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on medical record review, review of the infection control log, review of McGeer Criteria, interview, and policy review the facility failed to ensure antibiotics were initiated only when appropriate based on monitoring through the facility antibiotic stewardship program. This affected one resident (#2) of two residents reviewed for antibiotics. The facility census was 35.</p> <p>Finding included:</p> <p>Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, dysphagia, weakness, anxiety disorder, and uterovaginal prolapse.</p> <p>Review of the progress note dated 03/20/24 at 9:24 A.M. revealed the residents was confused last night and complained of feeling hot. The resident had a temperature of 97.8 degrees Fahrenheit. The medical doctor was notified and a new order was received for a urinalysis with culture and sensitivity.</p> <p>Further review of the progress notes dated 03/20/24 at 9:56 A.M. revealed the urine (specimen) was obtained via clean catch (a sample of urine that does not contain a lot of bacteria from the skin).</p> <p>Review of Resident #2's urinalysis with preliminary culture results, dated 03/20/24, revealed</p> <p>Escherichia coli 50,000 to less than 100,000 colony forming unit (CFU) (a measure of viable cell numbers in a milliliter of urine that are able to grow and form colonies) per one milliliter (ml) of urine, Pseudomonas aeruginosa 50,000 to less than 100,000 CFU/ml, and Proteus vulgaris group 50,000 to less than 100,000 CFU/ml.</p> <p>Review of a nursing progress note, dated 03/22/24 at 10:38 A.M., revealed the urine culture results were discussed with the nurse practitioner and a new order for Augmentin 500-125 mg, twice daily, for 14 doses was ordered. Awaiting sensitivity from microbiology at this time. The laboratory stated sensitivity will be available tomorrow.</p> <p>Review of Resident #2's physician order, dated 03/22/24, revealed the order to administer Augmentin 500-125 milligrams (mg) one tablet by mouth, two times a day, for urinary tract infection/E. coli for 14 administrations. Review of the March 2024 Medication Administration Record (MAR) revealed the resident received all 14 doses.</p> <p>Review of the Infection Control Log, dated March 2024, revealed the resident was ordered Augmentin for a UTI, with a start date of 03/22/24 and a stop date of 03/29/24.</p> <p>Review of McGeer Criteria for Non-Catheter-associated Urinary Tract Infection (non-CAUTI) for any age patient revealed the patient must meet elements one, two and three:</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: The nursing home is disputing this citation.</p>	<p>Element One: Patient had an indwelling urinary catheter in place for less than two consecutive days or the patient did not have an indwelling urinary catheter in place on the date of event not the day before the the date of events.</p> <p>Element Two: The patient has at least one of the following signs or symptoms: A fever greater than 100.4 degrees F; suprapubic tenderness; costovertebral angle pain or tenderness (pain over the area where the ribs meet the spine); urinary urgency; urinary frequency; painful urination</p> <p>Element Three: Patient has a urine culture with no more than two species of organism identified, at least one of which is a bacterium of greater than or equal to 100,000 CFU/ml.</p> <p>Interview on 05/28/24 at 2:25 P.M., Infection Preventionist/Licensed Practical Nurse (LPN) #69 confirmed the resident's symptoms did not meet McGeer Criteria for the initiation of antibiotics.</p> <p>Review of the facility policy titled, Antibiotic Stewardship Program, dated February 2021, revealed the antimicrobial stewardship program will monitor compliance with evidence-based guidelines or best practice regarding antimicrobial prescribing. Pharmacodynamic dosing principles will be used to optimize dosing regimens of antibiotics when appropriate and for the management of infections due to resistant pathogens.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153576.</p>