STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365569	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Ohio Regional Hospital Long Term Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on observation, record review, policy review and interview the facility failed to develop and implement a comprehensive and individualized plan of care to address an increase in urinary incontinence and provide timely and necessary incontinence care for Resident #14 resulting in unhealed skin impairment/irritation to the resident's perineal/coccyx area. This affected one resident (#14) of five residents reviewed for incontinence care. The facility census was 31. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including cerebral infarction, hemiplegia and hemiparesis affecting left dominant side, type two diabetes mellitus, and peripheral vascular disease. Review of the physician's orders revealed the resident had an order dated 07/03/23 for the diuretic medication, Lasix 20 milligrams daily. There was no evidence the resident's plan of care was updated at this time to address an increase in urination as a result of the diuretic medication and/or any additional personal care needs related to the medication administration. Review of the physician's order revealed the resident had an order dated 01/15/24 for Desitin external paste (zinc oxide) to buttocks and groin topically every four hours as needed for reddened coccyx and perineal area. Record review revealed no corresponding nursing progress note related to why the paste was ordered or the resident's skin condition at that time. Review of Resident #14's plan of care, dated 04/23/24 reflected the resident was on diuretic therapy. Interventions included administering (medication) as ordered and reporting any pertinent lab issues to the physician. The plan of care did not address monitoring or changes associated with increased urination because of the diuretic therapy. The resident had a plan of care, dated 04/23/24 which indicated the resident had bladder incontinence related to obstructive and reflux uropathy. Interventions included Resident #14 used disposable briefs and checking and changing every two hours for incontinence. A plan of care dated 04/23/24 revealed Resident #14 had potential for pressure ulcer development related to immobility. Goals included Resident #14 would have intact skin, free of redness and blisters. Interventions included monitoring, documenting, and reporting any changes in skin status such as appearance, color, wound healing, signs and symptoms of infection, wound size, and stage. (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: 365569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Ohio Regional Hospital Long Term Care	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident also had a care plan dated 04/23/24 with a focus Resident #14 had actual skin impairment to the buttock related to moisture and limited mobility. Interventions included monitoring and documenting location, size, and treatment of skin injury and providing weekly skin checks per facility protocol. Record review revealed the plan of care failed to identify and/or include interventions to address the identified issue of moisture at this time. In addition, there was no corresponding nursing progress note or assessment of the actual skin impairment identified to the resident's buttocks at this time. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had moderate cognitive impairment. The assessment revealed Resident #14 required extensive to total dependence (from staff) for all activities of daily living and was always incontinent of urine and bowel. The assessment revealed Resident #14 had no unhealed pressure ulcers but was identified as being at risk for pressure ulcers. Review of the weekly skin assessments revealed the most recent skin assessment dated [DATE] assessed Resident #14's skin to be warm, dry, and intact (with no skin impairment or areas of redness noted per the assessment). Review of the nurse's progress note dated 05/26/24 revealed Resident #14's left groin area had increased redness, irritation, and excoriation related to incontinent episodes and friction from brief. The note indicated staff encouraged Resident #14 to avoid wearing a brief in bed, but she requested she wear one for dignity. The area was cleansed with soap and water and Desitin cream applied to the bilateral groin areas as ordered. There was no documented evidence that the physician was notified. In addition, there was no evidence the facility implemented any new interventions to promote healing of the area or to prevent the area from deteriorating at this time. Review of the shower sheets dated 06/03/24, 06/07/24, 06/14/24, 06/17/24, 06/21/24, and 06/24/24 and completed by State tested Nursing Assistant (STNA) #507 revealed Resident #14's right groin, right upper thigh, and bilateral buttocks were reddened. All shower sheets were signed off as reviewed by Registered Nurse (RN) #502. Record review revealed no corresponding nursing progress note related to the resident's skin integrity at the time of these showers or evidence the facility implemented new interventions to address the areas of redness. Interview on 06/25/24 at 8:20 A.M. with RN #502 confirmed she signed off the shower sheets for Resident #14. She reported Resident #14 has had reddened areas to her buttocks for a long time. The areas would get better and then worse but would never go away. The RN revealed she was applying the Desitin paste as ordered when the STNA staff reported redness. However, there were no additional interventions implemented to resolve and/or prevent the impaired skin associated with moisture and incontinence. (continued on next page)

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 07/03/2024
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/24 at 8:55 A.M. STNA #503 and STNA #504 were observed providing incontinence care for Resident #14. At the time of the observation, the resident's right upper thigh, right and left peri area, and left and right buttocks were bright red in color, and the skin was sloughing off it. There were trace areas of white ointment in spots. Resident #14 grimaced with pain when STNA #503 was gently cleaning the areas. Resident #14 kept urinating during the care and the STNA staff had to stop and clean her. During the observation, both STNA #503 and STNA #504 revealed Resident #14 frequently would urinate during perineal care. They reported with any slight movement Resident #14 urinated and stated she was a heavy wetter. The resident was noted to require a mechanical (Hoyer) lift for transfers and was dependent on staff for urinary/incontinence care needs. On 06/25/24 at 9:55 A.M. interview with the Director of Nursing (DON) confirmed Resident #14 had not had a formal skin assessment since 05/15/24. She reported that the former wound care nurse was no longer employed with the facility since 06/20/24 (as a reason why the skin assessments had not been completed). The DON reported all wounds (for all residents) were to be assessed weekly by a licensed nurse and if a wound was deteriorating, a nurse practitioner (NP) from the wound care center would come and assess the wounds. The DON confirmed Resident #14 was not assessed by any licensed nurse, physician, or nurse practitioner between 05/15/24 and 06/25/24. The DON revealed staff were aware of the resident's impaired skin integrity but failed to conduct any assessments or documentation during this time period. During the interview, the DON again confirmed the facility did not have a current wound care physician team as she stated the wound care center in the hospital was closing. Review of a wound care note dated 06/25/24 and authored by RN #502 revealed Resident #14's skin was warm and dry. The RN noted the resident's skin color was within normal limits and turgor was normal. The RN also noted Resident #14's groin and buttocks were reddened. However, no additional information was documented and there was no documented evidence of any new skin interventions to address the areas of skin impairment or to promote healing at this time. Review of a physician's note dated 07/01/24 at 9:10 A.M. revealed Resident #14's perineal area and buttocks had erythema (redness), blanched, was non-tender with no drainage or necrosis and no odor. The diagnosis was listed as contact dermatitis and noted to continue Desitin. Observation on 07/01/24 at 9:21 A.M. of Resident #14's coccyx and perineal area revealed the area still remained red. There were areas of dead skin flaking off which was confirmed by the DON at the time of the observation. Interview on 07/01/24 at 9:30 A.M. with STNA #507 revealed she was the facility shower aide. She reported Resident #14's coccyx and peri area had been reddened for at least three months. STNA #507 revealed the nurses sign off on the resident's shower sheets but do not come in and assess the resident while she was showering her. STNA #507 also revealed Resident #14 was an extremely heavy wetter and the slightest movement or touch caused her to begin urinating. (continued on next page)

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 07/03/2024
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 07/01/24 at 11:00 A.M. revealed she became the DON at the facility in 12/2023. The DON indicated to her knowledge Resident #14 had areas of skin impairment related to moisture from incontinence and immobility since admission (in 2021). The DON indicated the facility had been using Desitin paste since January 2024 with no additional changes to treatment or additional interventions being considered/implemented. The resident's plan of care related to incontinence was for the resident to be checked and changed every two hours which was the standard timeframe used in the facility for all residents with incontinence. There was no evidence any other interventions, including possibly a more frequent timeframe for incontinence care had been trailed or considered to assist in healing the area and/or to prevent the area from deteriorating. The DON also confirmed Resident #14 was a very heavy wetter due to the diuretic medication she received. The DON was unable to provide any additional information as to why the skin impairment was not healing/healed. Review of the facility policy related to Urinary Incontinence and Continence, last revised September 2022, revealed the purpose of the policy was to ensure each resident who was incontinent of urine was identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. Always incontinent residents had had no continent voids in the past seven days prior to the assessment. Diuretics may cause urgency, frequency, or overflow incontinence. The physician and staff would address treatable causes or contributing factors related to urinary incontinence to include implementing a fluid and/or bowel management program to meet assessed needs. As appropriate, based on assessing the category and causes of incontinence the staff would provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. A check and change strategy involved checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals were to maintain dignity, maintain comfort, and to protect the skin. Individuals who cooperate with prompted voiding and attempt to toilet regularly but have no reduction in incontinent episodes would be identified and referred to the physician for consideration of additional therapy such as bladder relaxant medications. This deficiency represents non-compliance investigated under Complaint Number OH00154699.

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 07/03/2024
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)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on closed medical record review, hospital record review, facility policy review and interview the facility failed to timely identify an acute change in condition and seek medical intervention for Resident #34. This affected one resident (#34) of five residents for change in condition. The facility census was 31. Actual Harm occurred on 06/06/24 when staff failed to timely identify an acute change in condition, including stroke-like symptoms for Resident #34 resulting in her being transferred to the hospital outside the window of time for treatment of a stroke. The resident was subsequently placed on Hospice services and passed away after returning to the long-term care facility on 06/12/24. Findings include: Review of the closed medical record for Resident #34 revealed the resident was admitted to the facility on [DATE] and discharged [DATE]. Resident #32 had diagnoses including myocardial infarction, atrial fibrillation, and transient ischemic attack. Resident #34 had advance directives for a full code status which was changed on 06/11/24 to a Do Not Resuscitate Comfort Care (DNR-CC). Review of the original care plan dated 09/27/23 revealed Resident #34 was a full code. This was changed to a do not resuscitate comfort care on 06/11/24. The care plan also identified Resident #34 had congestive heart failure with an intervention to administer medications as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had mild cognitive impairment. The assessment revealed Resident #34 required extensive assistance (from staff) for all activities of daily living, was always incontinent of urine and frequently incontinent of bowel. The MDS revealed Resident #34 had no issues with communication and was able to make her needs known. No swallowing issues were identified. Review of the facility nursing progress note authored by Registered Nurse (RN) #502 dated 06/06/24 at 11:30 A.M. revealed Resident #34 had altered mental status. Vital signs documented at that time included blood pressure 129/72, pulse 88 beats per minute, 18 respirations per minute, and temperature 97.6 degrees Fahrenheit (F). The physician was notified, and an order for a urinalysis, (UA) culture and sensitivity (C and S) was obtained. The note indicated Resident #34 would make eye contact when spoken to but mumbled when she answered, which was not abnormal for Resident #34 to do when she was tired. The note indicated Resident #34 did eat some lunch, and the nurse would collect the urine sample. Review of the facility nursing progress note authored by RN #502 dated 06/06/24 at 12:25 P.M. revealed Resident #34 would not answer questions but would make eye contact. She was very lethargic. No additional information was available at this time to determine if the resident was further assessed or if the physician was contacted and updated at this time. Review of the facility nursing progress note authored by RN #502 dated 06/06/24 at 12:45 P.M. revealed Resident #34 was sleeping. She woke up when spoken to and when RN #502 asked her if she was ok, and Resident #34 responded yes. (continued on next page)

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 07/03/2024
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)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review revealed no additional nursing notes or evidence of monitoring of the resident were documented between 12:45 P.M. and the note written at 11:22 P.M. The next nursing progress note, authored by RN #501 dated 06/06/24 at 11:22 P.M. revealed Resident #34 very lethargic. She would make eye contact and respond to voices. Resident #34 would not answer questions and mumbled when she attempted to speak. A urine sample was obtained per physician order. The note included the resident's pupils were equal and reactive to light. Resident #34 was experiencing pitting edema in her right hand, her right eye was reddened with green discharge, and she was unable to follow simple commands. Resident #34 was unable to follow commands, had no grip strength bilaterally, was unable to swallow, or suck through a straw. Resident #34 was unable to take her medications. Vital signs were 97.8 degrees F, pulse 70 beats per minute, respirations sixteen breaths per minute, and blood pressure 130/58. The physician was notified, and she ordered Resident #34 to be sent to the hospital for evaluation. Resident #34's family was notified. Review of the emergency department note for Resident #34 dated 06/06/24 at 11:32 P.M. revealed the resident came from long term care because she apparently laid all day with stroke-like symptoms. She was a full code and had altered mental status and had not been able to swallow her pills. The note indicated the resident was out of any kind of window for any therapy or resuscitation from stroke. She was on four liters (L) of oxygen and her oxygen saturation was 95%. A computed tomography (CT) scan of her head showed no active bleed. The resident was also assessed to have a severe urinary tract infection that would be treated with the antibiotic, Ciprofloxacin. Laboratory testing revealed a brain natriuretic peptide (BNP) was also elevated at 12000 picograms per milliliter (pg/ml) (normal is less than 100 pg/ml) she received 250 ml of normal saline (intravenous) fluids and 40 milligrams (mg) of Lasix (diuretic). The resident was admitted to the hospital for further treatment. Review of a CT scan of the brain without contrast result, dated 06/07/24 at 12:12 A.M. revealed no acute intracranial hemorrhage, mass effect, evidence of large acute infarct. Review of a hospital cardiology consultation note dated 06/07/24 revealed female resident admitted from long-term care. She had been at the long-term care status post fractured femur that was conservatively managed. The resident was bedridden. She was found to have garbled speech and weakness of her right side. She was having difficulty expressing herself. Review of her examination revealed she did have garbled speech; difficult to understand and did not engage much. She did smile one time for her family and noted to have weakness on her right side. Resident #34 did have a history of trans-ischemic attack (TIA) and was hospitalized for this over a year ago. Review of the hospital progress note dated 06/08/24 revealed Resident #34 had extremely garbled speech and it was difficult to understand. She only would shake her head no when asking about chest pain or shortness of breath. Upon talking to the family at bedside, they reported they wanted the resident to be comfort care and do not resuscitate. Review of hospital progress note dated 06/10/24 revealed Resident #34 was confirmed to have suffered a stroke. Resident #34 was unable to move her lips or make any sounds. She does open her eyes and then close them. Resident #34 was not moving any extremities today, and she was evaluated by speech therapy and was unable to swallow. The family was offered a feeding tube and they refused. Hospice services were contacted and the family elected to have Hospice provided. Transfer was set up for Resident #34 to return to the nursing home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365569	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Ohio Regional Hospital Long Term Care	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the hospital discharge note dated 06/11/24 revealed Resident #34 was being discharged to the long-term care facility with Hospice services and a do not resuscitate comfort care order. Final diagnoses included cerebral vascular accident, congestive heart failure, and urinary tract infection. Telephone interview on 06/24/24 at 2:44 P.M. with RN #501 revealed she had come to work on 06/06/24 at 7:00 P.M. as she was scheduled to work the night shift (7:00 P.M. to 7:00 A.M.). Resident #34 was included on her assignment for this shift. RN #501 revealed when getting report from off-going RN, RN #502, the RN reported to her Resident #34 was not acting herself, and she reported that she was just lethargic. The day shift nurse also informed her that she called the physician to get an order for a UA for Resident #34, but she was unable to obtain it, and RN #501 would have to obtain it. RN #501 reported she then began passing her nighttime medications and around 9:30 P.M. she entered Resident #34's room to administer her pills. At that time Resident #34 was not even attempting to suck from a straw, she was not responding verbally and was lethargic. RN #501 reported she then got her supplies to obtain her UA and when she removed the covers from Resident #34 her whole right side was flaccid, and her right eye was reddened with a small amount of crust forming around it. She stated at that time she immediately notified the physician who ordered Resident #34 to be sent to the emergency room and she transferred her. Interview on 06/25/24 at 8:20 A.M. with RN #502 revealed on 06/06/24 Resident #34 took her morning medications and then slept through breakfast. She reported however, she did not feel this was unusual for Resident #34 to sleep through breakfast or refuse to care for herself. She reported then at lunchtime, she was observed having staff feed her which she thought was also not unusual due to the resident often refusing to care for herself. RN #502 revealed Resident #34 was slurring her words but alert to self. The RN stated she was aware Resident #34 had a history of urinary tract infections, so she assessed her vital signs and called the physician. An order for a UA C and S was obtained. The RN stated Resident #34 ate dinner with no issues. She confirmed the night shift nurse obtained the UA C and S. Review of the physician's order revealed she did receive an order for a UA C and S on 06/06/24 at 12:54 P.M. Interview on 07/01/24 at 9:38 A.M. with State tested Nursing Assistant (STNA) #508 revealed on 06/06/24 between 9:15 A.M. and 10:10 A.M. she was in Resident #34's room providing restorative care to the resident's roommate. STNA #508 revealed Resident #34 was normally awake during this time, but on this date the was sleeping and making snoring sounds. The STNA stated she felt this was unusual for the resident because sometimes the resident could get loud, but on this date Resident #34 never woke up. STNA #508 revealed she did not report this to the nurse. Interview on 07/01/24 at 10:00 A.M. with STNA #503 revealed on 06/06/24 she was not caring for Resident #34, but she did go in to assist the resident to eat dinner around 4:45 P.M. The STNA revealed Resident #34 took three to four bites of her tomato soup but when she offered her the grilled cheese, Resident #34 shook her head no. Resident #34 did not verbalize any words to her, she just shook her head. STNA #503 then reported she offered iced tea to Resident #34 and when she took a sip, she began coughing. STNA #503 stated at that time she immediately left the room and notified RN #502. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365569	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Ohio Regional Hospital Long Term Care	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 07/01/24 at 10:40 A.M. with Hospital Nurse Practitioner (NP) #509 revealed she first saw Resident #34 on 06/10/24 and at that point, she was diagnosed with a confirmed stroke, but the family did not want any further interventions and wanted to change the resident's advance directives at which time Hospice services were ordered. The family did not want the resident to live being flaccid on the right side and unable to speak or respond. She confirmed she discharged Resident #34 back to long term care facility with hospice services. Hospital NP #509 reported that Resident #34 must have had a terrific stroke. Subsequent interview on 07/01/24 at 10:55 A.M. with RN #502 revealed Resident #34 did have issues with dinner due to her coughing, but stated she thought the resident was just clearing her throat. Interview on 07/01/24 at 11:00 A.M. with the Director of Nursing (DON) confirmed the hospital medical record indicated Resident #34 laid in long term care with stroke-like symptoms all day. During the interview, the DON denied knowledge of Resident #34 having a stroke and indicated the resident had been diagnosed with a urinary tract infection. The DON was shown the hospital documentation that stated a confirmed stroke, and she confirmed the diagnosis. Review of the facility policy titled Change in Condition, last approved November 2023, revealed a significant change in condition or status was not self-limiting, impacted on more than one area of a resident's health status and required interdisciplinary review or revision of the care plan. This included semi or unconsciousness. A policy indicated licensed nurse would notify the resident, physician, and guardian/interested family member of all changes as stated above. The person doing the notification would document all notification in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00154699.