Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365572	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastland Rehabilitation and Nursing Center	2425 Kimberly Parkway East Columbus, OH 43232

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review, staff interview, and policy review, the facility failed to complete a comprehensive assessment of continence for a resident. This affected one of three residents reviewed for incontinence (Resident #27). The facility census was 88. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] and diagnoses including diabetes, bipolar disorder, and septic arthritis of the left leg. Review of a nursing admission assessment dated [DATE] revealed a question: How long has the resident been incontinent or had a catheter? it was documented N/A Continent. It further stated the resident was wet during day and night time, small amounts. It stated the resident was continent of bowel. No further information was documented related to bowel or bladder incontinence. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed it stated Resident #27 had a brief interview for mental status score of 15, indicating intact cognition. It stated the resident required supervision with toileting, could walk 10 feet with supervision, and was frequently incontinent of bowel and bladder. Review of urinary incontinence tracking records revealed, between 03/29/24 and 04/22/24, the resident had two incidents of bladder continence and 44 incidents of bladder incontinence. Interview with Resident #27 on 04/22/24 at 10:35 A.M. revealed she indicated she only had a few bladder accidents and mostly went to the bathroom or used the bedside commode for toileting. However, interview with Nursing Assistant #137 on 04/23/24 at 11:50 A.M. revealed Resident #27 was incontinent of bowel and bladder all the time. She just goes in the bed. She stated she did not know why the resident did this when she is able to ask for assistance with toileting. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review did not reveal any further assessment of the incontinence identified on the MDS on 04/05/24. There was no evidence of a comprehensive assessment to include any observations, communication with the resident or staff to assess the incontinence. There was no evidence of a comprehensive assessment to attempt to identify the cause of the incontinence, prior history of bladder function, voiding patterns, tests or studies to identify the type of incontinence, or any environmental factors to provide direction for the development of appropriate interventions to maintain as much normal bladder function as possible. Review of the facility policy (revised October 2010) titled Behavioral Programs and Toileting Plans for Urinary Incontinence stated to conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary incontinence and assess the resident for appropriateness of behavioral programs which promote urinary incontinence. Interview with Regional Director of Clinical Services #300 on 04/23/24 at 11:20 A.M. confirmed there was not a comprehensive assessment of Resident #27's bowel and bladder incontinence. She stated the only assessment available was the admission nursing assessment. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00152613.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review and staff interview, the facility failed to ensure laboratory testing was completed as ordered, the physician was notified timely of the results after completed, and physician's orders were followed related to medication administration for one of five sampled residents (Resident #2). The facility census was 88. Findings include: Review of the medical record for Resident #2 revealed the resident was admitted [DATE] from the hospital where she had been treated for C-difficile colitis (inflammation of the colon caused by bacteria) with diarrhea, weakness, decreased appetite and malnutrition. The resident had additional diagnoses including adult failure to thrive, hypothyroidism, dysphagia, rheumatoid arthritis, cerebral vascular accident, and bipolar disorder. Review of a nursing progress note on 04/15/24 at 4:12 P.M. revealed the nurse was notified by physical therapy about a change in the resident's condition. The resident was assessed. Resident alert to self and denied pain. Resident stated she was ok and just tired. Vital signs were stable. The physician was notified and a new order was received for a Complete Blood Count (CBC) test and a urinalysis. Review of a physician's progress note on 04/16/24 revealed the resident had been in the hospital from 03/12/24 to 03/20/24 for diarrhea and weakness. Positive for C-difficile toxin which resulted in malnutrition. Hospital course included antibiotics and electrolyte replacement. Hospital course complicated by stroke alert for left sided weakness and ataxic gait. The note indicated the resident's thyroid supplement medication had been increased on admission to 75 micrograms due to hypothyroidism. A follow up TSH level was ordered. The note stated she was asked to see the resident by the nurse for altered mental status, suspected urinary tract infection and lab work was pending. A nursing progress note on 04/16/24 at 5:30 P.M. (late entry-not documented until after the surveyor requested the laboratory results on 04/22/24) revealed the resident refused a straight cath, was assisted to toilet and unsuccessful for urine collection. It was documented that the provider was made aware and an order was obtained to discontinue the urinalysis test. Review of laboratory results revealed on 04/17/24 blood was collected for a comprehensive metabolic panel (CMP), a Thyroid Stimulating Hormone (TSH), and Vitamin D level. The laboratory indicated that the quantity of blood collected was not sufficient to complete a CBC test as ordered. There was no evidence of additional attempts to obtain the CBC until 04/22/24 (5 days later). Review of the laboratory results for 04/17/24 revealed several abnormal levels including: Calcium 8.3 (normal 8.6-10.3), Albumin 2.9 (normal 3.5-5.5), TSH 15.4 (normal 0.3-5.5 and noted as very high), Vitamin D level less than 7 (normal 30-100 and noted as very low). The laboratory results had a notation stating the results were reviewed with provider which was noted by Director of Nursing (DON) #100 and a new order obtained to discontinue urinalysis (order received 04/16/24). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the director of nursing (DON) #100 on 04/23/24 at 10:25 A.M. revealed the results were not reviewed with the provider 04/16/24, even though documented as such. She confirmed the medical provider was not made aware of the results of the laboratory testing done on 04/17/24 until 04/22/24. She stated the order to discontinue the urinalysis had been received from the psych provider, not the medical provider. She further confirmed that, even though the CBC was ordered due to a change in condition on 04/15/24, it was not obtained until 04/22/24. Interview with Certified Nurse Practitioner (CNP) #220 on 04/23/24 at 10:25 A.M. revealed she was not notified of the results of the laboratory tests from 04/17/24 until 04/22/24. She confirmed staff should not have waited to obtain the CBC until 04/22/24. Review of a nursing progress note on 04/22/24 at 3:02 P.M. revealed Resident #2's family member was concerned about resident not being able to perform activities of daily living. The physician was notified and laboratory testing was ordered including CBC, CMP, and Urinalysis. (These tests had already been ordered on 04/15/24 and completed on 04/17/24 (except urinalysis). However, the physician was not notified of the results until 04/22/24). A CBC, BMP, and urinalysis were completed on 04/22/24. The urinalysis did not indicate a urinary tract infection. The resident's red blood cell count was 2.55 (normal 4-5.2), hemoglobin 7.2 (normal 12-16), and hematocrit 23.7 (normal 36-46). Interview with CNP #220 on 04/23/24 at 10:25 A.M. revealed, as a result of the TSH and Vitamin D laboratory tests on 04/17/24, she had given orders on 04/22/24 to increase the resident's thyroid supplement medication from 75 micrograms daily to 100 micrograms daily. She also ordered a Vitamin D supplement. Review of the physician's orders and medication administration record (MAR) for April 2024 on 04/23/24 revealed no order for a Vitamin D supplement. Further review revealed that a thyroid supplement medication 100 micrograms had been added daily on 04/22/24. However, the 75 microgram supplement was not discontinued. Review of the MAR for 04/23/24 revealed the nurse documented at 6:00 A.M. the Resident #2 received both the 75 microgram and the 100 microgram Thyroid supplement medication. Interview with CNP #220 on 04/23/24 at 10:25 A.M. confirmed the resident should not receive both dosages. She was only to receive 100 micrograms. Interview with Assistant Director of Nursing (ADON) #106 on 04/23/24 at 10:45 A.M. revealed he had received the order from CNP #220 on 04/22/24 to increase the thyroid supplement. He confirmed he did not discontinue the 75 microgram supplement when he added the 100 microgram supplement and should have. He stated he was distracted. He stated he did not remember the CNP giving an order for a Vitamin D supplement. The facility then provided documentation to the surveyor that the nurse who documented she gave the 75 microgram thyroid supplement on 04/23/24 at 6:00 A.M. had documented on 04/23/24 at 12:28 P.M. (after surveyor questioned that both doses were documented as given) that the 75 microgram dose was not given. The facility provided no explanation as to why, if the nurse knew that she was not supposed to give the 75 microgram dose of thyroid supplement, she left the medication on the MAR where it would be given by the next nurse when it was due again the next day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00152613.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, staff interview, resident interview, and policy review, the facility failed to ensure a resident maintained acceptable parameters of nutritional status including body weight. This affected one of three residents reviewed for meal assistance (Resident #2). The facility census was 88. Findings include: Review of the medical record for Resident #2 revealed the resident was admitted [DATE] from the hospital where she had been treated for C-difficile colitis (inflammation of the colon caused by bacteria) with diarrhea, weakness, decreased appetite and malnutrition. The resident had additional diagnoses including adult failure to thrive, dysphagia, rheumatoid arthritis, cerebral vascular accident, and bipolar disorder. The resident was noted with a pressure ulcer on the right buttock on admission. The resident weighed 153.7 pounds on admission and had a physician's order dated 03/20/24 to weigh weekly for four weeks then monthly. Review of a nutritional assessment on 03/25/24 revealed the resident was 66 inches tall and was on a regular diet. Current intake noted to be 50-75% of meals. Has a pressure ulcer on right buttock. The goal was to tolerate diet, consume greater than 50%, and for her weight to remain stable. Recommendations included assistance with meals and house shake from kitchen on lunch tray to support calorie intake due to risk of malnutrition. There was no evidence of follow up on the recommendation for a house shake from kitchen on lunch tray until 04/15/24 when a physician's order was obtained (21 days after recommended). Interview with Dietary Director #201 on 04/23/24 at 12:55 P.M. revealed he had received an order for a house shake from the kitchen on lunch tray for Resident #2 on 04/17/24 and it was added to her tray card (for dietary staff to follow when preparing tray). Review of the plan of care dated 03/25/24 revealed it stated Resident #2 was at risk for impaired nutritional status related to enterocolitis with C-difficile, dysphagia, adult failure to thrive, and wound. The goal was for the resident to be free from significant weight change. There was an intervention for diet as ordered. The interventions did not include any nutritional supplements. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status score of 14, indicating intact cognition. It stated the resident required set up help with eating. However, a MDS assessment on 03/31/24 stated the resident required partial to moderate assistance with eating. Review of a physician's progress note on 04/16/24 revealed the resident had been in the hospital from 03/12/24 to 03/20/24 for diarrhea and weakness. Positive for C-difficile toxin which resulted in malnutrition with a history of 15 pound weight loss in February. Hospital course included antibiotics and electrolyte replacement. Hospital course complicated by stroke alert for left sided weakness and ataxic gait. The note indicated lab work was pending. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of laboratory results on 04/17/24 revealed the resident's albumin level was 2.9 (normal listed as 3. 5-5.5). (Low albumin is a symptom of malnutrition). Interview with Certified Nurse Practitioner #220 on 04/23/24 at 10:25 A.M. revealed she was not made aware of the results of the lab tests until 04/22/24. Observation of the lunch meal on 04/22/24 at 12:18 P.M. revealed Resident #2 did not receive a house shake on the lunch tray. The resident received ham, sweet potato, green beans, roll, cake, and lemon aide. Nursing assistant #137 assisted the resident with eating. The resident ate only a few bites. Interview with Nursing Assistant #137 on 04/23/24 at 11:50 A.M. revealed the resident had never received a nutritional supplement with lunch. Interview with the Assistant Director of Nursing #106 on 04/23/24 at 10:45 A.M. revealed nutritional supplements were to be listed on the medication administration record so the nurse could sign off that they were given. He confirmed Resident #2 did not have a nutritional supplement listed on the medication administration record and there was no evidence a supplement had been provided daily as ordered on 04/15/24. Interview with Resident #2 on 04/23/24 at 1:35 P.M. revealed she did not remember if she had received any nutritional supplements prior to 04/23/24. She stated that she had received two already on 04/23/24. Review of the facility policy (revised September 2008) and titled weight assessment and intervention revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at that point, weights will be measured monthly thereafter. Weights will be recorded in the medical record. Review of a nutritional progress note on 04/22/24 revealed the resident's intakes had been 25-75% of meals. Resident does require assistance with meals. Recommendations included to update weight and start a house supplement 240 milliliters daily from nursing to support oral intakes due to risk of malnutrition. As of 04/23/24, there was no evidence Resident #2 had been weighed since admission on 03/20/24. There was no evidence of any additional nutritional supplement orders. Interview with Director of Nursing #100 on 04/23/24 at 10:25 A.M. confirmed there was no evidence Resident #2 had been weighed since 03/20/24. Interview with Certified Nurse Practitioner #220 on 04/23/24 at 1:00 P.M. confirmed weights should have been done weekly for Resident #2 and are helpful to monitor nutritional status. Resident #2 was weighed on 04/23/24 per surveyor request with a weight of 147.5. This indicated a 6.2 pound, 4% weight loss in one month. This deficiency represents non-compliance investigated under Complaint Number OH00152613.