

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Eastland Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571</p> <p>Based on medical review, observation, staff interview and review of facility policy and procedure, the facility failed to follow infection control practices when changing a dressing. This affected one resident (#78) of three sampled residents. The census was 89.</p> <p>Findings include:</p> <p>Review of Resident #78's record revealed he was admitted to the facility on [DATE]. Diagnoses included anterior cord syndrome at T7-T10 level of the thoracic spinal cord, atrial fib, chronic kidney disease (CKD), and peripheral vascular disease. Review of the annual MDS dated [DATE] revealed his cognition was moderately impaired. He requires setup/clean up assistance for meals and oral hygiene and is dependent for toileting, shower/bathing, upper body dressing, footwear, personal hygiene and turning and repositioning. He is frequently incontinent of urine and always incontinent of bowel.</p> <p>Review of the physicians orders for 12/06/24 revealed to cleanse wounds to the superior sternum with normal saline and pat dry. Then apply hydroconductive dressing (wound dressings utilize a hydroconductive material to aid the clinician in wound bed preparation. It is a highly absorbent wound dressing that facilitates the movement of wound exudates into and through the dressing to the outer secondary material) to wound bed then cover with a super absorbent dressing, change on Monday, Wednesday, Friday, and when needed.</p> <p>On 01/29/25 at 11:00 A.M. observation of a dressing change to Resident #78's superior sternum wound revealed Licensed Practical Nurse (LPN) #257 cleaned her hands and put on gloves. LPN #257 then removed the old dressing on his chest, and a moderate amount of bloody drainage was noted on the old dressing. LPN #257 then removed her gloves and put on new gloves without washing her hands, and cleansed the wounds to the chest with normal saline and gauze. LPN #257 then removed her gloves and put on new gloves without washing her hands and placed the hydroconductive dressing on the wound and covered it with a dressing. LPN #257 then removed her gloves and cleaned her hands with sanitizer.</p> <p>On 01/29/25 at 11:05 A.M. interview with LPN #257 verified she had not washed her hands in between glove changes.</p> <p>Review of the Hand Washing/Hand Hygiene policy and procedure (dated 08/2015) revealed use of an alcohol-based hand rub or alternatively soap and water after removing gloves.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00161811.		