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	05/28/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical records review, observations and staff interviews, the facility failed to provide dignity with dining for two residents who needed assistance with their meals (Resident # 4 and #31) out of fourteen residents reviewed for dining observation. This had the potential to affect five residents (#4, #12, #21, #31, and #33) that needed assistance with dining. The facility census was 76 residents. Findings include: 1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included muscle wasting, and glaucoma. Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he had a Brief Interview for Mental Status (BIMS) score of 12, indicative of moderate cognitive impairment. Review of Resident #4's full nutrition assessment dated [DATE] revealed he requires assistance with his meals. Review of Resident #4's physician order dated 09/26/23 revealed he was to have assistance with all meals on every shift. Observation on 05/19/25 at 8:17 A.M. revealed Resident #4 was being fed by Certified Nursing Assistant (CNA) #434. CNA #434 was standing over Resident #4 while she fed the resident. Interview with Registered Nurse (RN) #429 on 05/19/25 at 8:19 A.M. confirmed CNA #434 was standing over Resident #4 while feeding him. She stated that it was not a dignified dining procedure. RN #429 stated there was not a reason for CNA #434 to stand while feeding Resident #4 his meal. 2. Resident #31 was admitted to the facility on [DATE] with diagnoses that included unspecified protein-calorie malnutrition, cerebral infarction, aphasia, muscle wasting, dysphagia, vascular dementia, glaucoma and need for assistance with personal care. Review of Resident #31's quarterly MDS assessment dated [DATE] revealed his BIMS score was 6, indicative of severe cognitive impairment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's physician orders dated 02/06/25 revealed he was to be assisted with all of his meals. Review of Resident #31's full nutrition assessment dated [DATE] revealed he required assistance with all of his meals. Review of Resident #31's care plan dated 12/26/22 revealed that he need assistance with all of his meals due to poor vision and weakness. Observation on 05/19/25 at 8:28 A.M. revealed CNA #421 was standing over Resident #31 while feeding him in bed. Interview with CNA #421 on 05/19/25 at 8:28 A.M. confirmed she was standing over Resident #31 while feeding him in bed. CNA #421 stated that she knew that she was supposed to sit while assisting residents with feeding; however, she preferred to stand. Observation on 05/20/25 at 8:23 A.M. revealed that CNA #487 was standing over Resident #31 while he was being fed in his room while seated in his bed. Interview with CNA #487 confirmed that she was standing over Resident #31 while assisting him with feeding him his meal. She stated that she could have sat while feeding Resident #31; however, she preferred to stand.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on observation, record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer program to prevent the development and/or worsening of pressure ulcers and to ensure adequate and appropriate interventions/treatments were in place as ordered and to promote healing. This affected two residents (#40 and #49) of two residents reviewed for pressure ulcers. The facility census was 76. Actual harm occurred beginning on 04/10/25 when Resident #49, who was cognitively impaired, rarely/never understood and dependent on staff for activities of daily living was assessed by Wound Certified Nurse Practitioner (CNP) #1200 to have a Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) to the sacrum. The resident had been admitted to the facility on [DATE] with a Stage III pressure ulcer (An ulcer with full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) to the area with a lack of assessment, monitoring and/or intervention to prevent the decline. Following admission, the resident's sacral pressure ulcer continued to deteriorate and became infected with contributing factors including duplicate, inaccurate, and missed treatment applications as well as missed antibiotic medication doses and a lack of effective pressure ulcer reducing interventions. On 05/15/25 the resident was transferred to the hospital and admitted for treatment of a Stage IV pressure ulcer and osteomyelitis. Findings include: 1. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including adult failure to thrive, Alzheimer's disease, anxiety disorder, metabolic encephalopathy, and difficulty walking. Resident #49 was transferred to the hospital on 05/15/25. The resident remained hospitalized at the time of the onsite survey. Review of Resident #49's orders from admission to the facility from a transferring skilled nursing facility dated 04/02/25 revealed an order for a left knee wound. The order indicated to apply calcium alginate, Santyl (ointment used to remove damaged tissue from chronic skin ulcers and severely burned areas) with additional gauze island daily for 30 days. (The treatment had been initiated on 03/18/25). Review of Resident #49's orders from admission to the facility from a transferring skilled nursing facility dated 04/02/25 revealed the resident had a Stage III pressure ulcer to the coccyx. Orders included apply alginate calcium, secondary gauze island with border gauze every shift, and/or when soiled until resolved at bedtime. Review of the admission skin assessment dated [DATE] revealed Resident #49 had a coccyx Stage III pressure ulcer with no descriptions or measurements of the wound included in the assessment. The assessment also included the resident had a Stage IV pressure ulcer to the left knee with no descriptions and no measurements. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a physician order dated 04/03/25 at 6:16 P.M. revealed an order to cleanse wound on left knee with normal saline, pat dry, use calcium alginate and cover with dry dressing every night shift for 16 days. Review of the April 2025 TAR revealed the treatment was discontinued on 04/17/25; a treatment was not documented as completed on 04/07/25 or 04/10/25. A new treatment order was obtained on 04/17/25 as the wound was not healed as of this time. Review of a physician's order dated 04/03/25 at 6:30 P.M. revealed an order to cleanse wound on sacrum (identified to be the same area previously noted as coccyx) with normal saline, pat dry, apply Santyl and cover with dry dressing every night shift for 30 days. Review of the Braden Scale for Predicting Pressure Sore Risk dated 04/03/25 revealed a score of 7.0 on a scale of, 6 (high risk) to 23 (no risk), which indicated Resident #49 was at high risk for skin breakdown. Review of the plan of care dated 04/03/25 revealed Resident #49 had impairment to skin integrity related to incontinence, moderate protein-calorie malnutrition and pressure ulcer to the coccyx with interventions including but not limited to monitor/document location, size and treatment of the skin injury and to follow facility protocols for treatment of injury. Review of an admission evaluation completed by Facility Certified Nurse Practitioner #1000 (CNP) dated 04/07/25 reflected Resident #49 had a wound to the sacrum and to follow with in house wound (care). Review of an admission evaluation by Facility Medical Director #2000 (MD) dated 04/08/25 revealed Resident #49 had a sacral pressure injury, wound team to follow. Further review of the medical record from 04/04/25 through 04/09/25 revealed no attempts to reassess and measure the sacral Stage III pressure ulcer or left medial knee Stage IV pressure ulcer during this time period. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was rarely/never understood. The resident was assessed to require total dependence on toilet hygiene, shower/bathe self, bed mobility, and transfers. The assessment also noted the resident was always incontinent of bowel and bladder and had a Stage III pressure ulcer injury present on admission. Review of Wound Certified Nurse Practitioner (CNP) #1200's initial assessment dated [DATE] revealed Resident #49 had a Stage IV sacral pressure ulcer that measured 5.9 centimeters (cm) in length by 6.2 cm width with an undetermined depth. The ulcer was assessed to be a cluster wound with moderate serosanguinous drainage with 60% granulation, 30% slough, and10% tendon. The assessment note revealed to initiate Dakin's moistened gauze to minimize odor and decrease slough. A new order was written for Dakin's solution 0.125% cleanser, apply 0.125% Dakin's moistened gauze, and apply a clean dry dressing daily and as needed. Review of the physician order dated 04/10/25 at 4:44 P.M. revealed to cleanse wound on sacrum with 0. 125% Dakin's solution, apply 0.125% Dakin's moistened gauze and apply a clean dry dressing daily and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Wound CNP #1200's assessment dated [DATE] revealed Resident #49's sacrum Stage IV pressure ulcer measured at 6.3 cm by 6.1 cm with an undetermined depth; a cluster wound with moderate serosanguineous drainage and 70% granulation, 20% slough and 10% tendon. The wound had less odor. Continue to cleanse wound on sacrum with 0.125% Dakin's solution, apply 0.125% Dakin's moistened gauze and apply a clean dry dressing daily and as needed. Review of Wound CNP #1200's assessment dated [DATE] revealed Resident #49's sacrum Stage IV pressure ulcer measured at 6.1 cm by 5.7 cm with 3.4 cm depth; a cluster wound with moderate serosanguinous and 80% granulation and 20% tendon and to continue to cleanse wound on sacrum with 0.125% Dakin's solution, apply 0.125% Dakin's moistened gauze and apply a clean dry dressing daily and as needed. Review of the April 2025 Treatment Administration Record (TAR) revealed the order to cleanse the wound on sacrum with normal saline pat dry and apply Santyl and cover with dry dressing was an active order through the entire month and the resident did not have the wound care treatment documented as completed on 04/07/25 and 04/10/25. The resident also had an order for 0.125% Dakins solution, apply 0.125% Dakins moistened gauze and apply a dry dressing daily and as needed initiated on 04/10/25. However, the TAR revealed the treatment was not documented as completed on 04/10/25, 04/19/25, 04/20/25, or 04/21/25. Review of the TAR from 04/18/25 to 04/24/25 revealed the ordered treatment to the wound on Resident #49's left lateral knee was not completed as ordered on 04/19/25. In addition, Resident #49 had orders to apply barrier cream to peri area and or buttock after each episode of incontinence every shift prevent/personal hygiene, and to turn and reposition every two hours as tolerated every shift not documented as completed on the day shift on 04/10/25, 04/11/25, 04/18/25, 04/19/25, 04/20/25,04/21/25 or on the evening shift on 04/07/25 and 04/10/25. Review of Wound CNP 1200's assessment dated [DATE] revealed Resident #49's sacrum Stage IV pressure ulcer measured 5.9 cm by 5.7 cm with 3.2 cm depth; a cluster wound with moderate serosanguinous drainage with 90% granulation and 10% tendon. Continue the treatment to cleanse wound on sacrum with 0.125% Dakin's solution, apply 0.125% Dakin's moistened gauze and apply a clean dry dressing daily and as needed. Review of Wound CNP #1200's assessment dated [DATE] revealed Resident #49's sacrum Stage IV pressure ulcer measured 6.4 cm by 8.2 cm with an undetermined depth; a cluster wound with moderate tan, serosanguinous drainage with 30% slough, 10% tendon and 60% necrotic wound base with odor. The wound was noted to have declined. The assessment note also included Resident #49 had contributing factors of being poorly complaint with offloading, dementia/confusion, poor nutritional intake, declining medical condition, poor medical condition and incontinence which makes the presence of the wound unavoidable. Treatment order to increase the concentration of the Dakin's solution to 0.5% and change the dressing twice a day for treatment. The note revealed will start oral antibiotics as well. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's order revealed on 05/08/25 the treatment order dated 04/21/25 at 2:11 P.M. to cleanse multiple clustered wounds on sacrum with 0.125% Dakin's solution, 0.125% Dakin's moistened gauze, apply clean dry dressing daily and as needed was discontinued. A new physician order was initiated on 05/08/25 at 5:01 P.M. to cleanse multiple clustered wounds on sacrum with 0.125% Dakin's solution, 0.125% Dakin's moistened gauze, apply clean dry dressing every morning and night shift and as needed. This order increased the frequency of the dressing change to twice a day but did not reflect the CNP's change of concentration of the Dakins solution for Resident #49. Additionally, an order was received on 05/08/25 at 4:51 P.M. for Doxycycline Hyclate (antibiotic) oral tablet 100 milligrams (mg); give one tablet every morning and at bedtime until 05/21/25. Review of the May 2025 Treatment Administration Record (TAR) revealed the order to cleanse wound on sacrum with normal saline pat dry and apply Santyl and cover with dry dressing was an active order through 05/02/25, and all treatments were documented as completed. The order for 0.125% Dakins solution, apply 0.125% Dakins moistened gauze and apply a dry dressing daily completed daily through 05/07/25 and the order was changed on 05/08/25 to cleanse multiple clustered wounds on sacrum with 0.125% Dakin's solution, 0.125% Dakin's moistened gauze, apply clean dry dressing every morning and night shift and as needed. The TAR revealed the treatment was not completed on the day shift on 05/08/25, 05/12/25, or on the day and evening shift on 05/13/25. Review of the May 2025 TAR revealed the ordered treatment to the left medial knee was not completed as ordered on 05/12/25 and 05/13/25. In addition, review of the May 2025 TAR revealed Resident #49 had orders to apply barrier cream to peri-area and/or buttock after each episode of incontinence every shift prevent/personal hygiene, and to turn and reposition every two hours as tolerated every shift not documented as completed on the day shift on 05/12/25 and not completed on the day and evening shift on 05/13/25. Review of the May Medication Administration Record revealed the resident did not receive the Doxycycline Hyclate (antibiotic) 100 mg at bedtime on 05/12/25 or 05/13/25 for the morning dose. Review of the medical record for Resident #49 revealed no monitoring of antibiotic effectiveness once antibiotic was initiated on 05/09/25. Further review of the medical record for Resident #49 revealed no daily skilled charting, which include vital signs, from 05/10/25 until 05/14/25. Review of the skilled nursing charting dated 05/14/25 at 2:29 A.M. revealed Resident #49 was hypotensive with a blood pressure of 84/46. No follow up blood pressure or assessment was documented in the resident's medical record. Review of Wound CNP 1200's assessment on 05/15/25 at 10:45 A.M. revealed the sacrum Stage IV pressure ulcer measured 11.6 cm by 8.4 cm with an undetermined depth; a cluster wound with moderate tan, serosanguinous drainage and 30% slough, 10% tendon, 10% bone, 20% and purple or maroon discoloration with odor. The wound presented worsening of infection with a recommendation to transfer the resident to the emergency department for rapid evaluation of wound. Review of the progress note dated 05/15/25 at 4:15 P.M. revealed Resident #49 was transferred to the hospital and all parties responsible were aware. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/20/25 at 9:12 A.M. via telephone with Wound CNP #1200 revealed a facility nurse would perform wound rounds with her while she was seeing residents (including Resident #49) and the facility nurse placed the orders she recommended into the electronic medical record system based on the notes she dictated and verbally communicated to them. Wound CNP #1200 stated she did not know Resident #49 received the Santyl treatment that was ordered on admission from the hospital daily throughout her stay until 05/02/25. The CNP stated she ordered Dakin's solution when she assessed the sacrum wound on 04/10/25 because the wound had odor and Dakins was a good skin first line of treatment for what she observed. The CNP revealed she would recommend the Santyl treatment at a later stage of healing and not at that time based on her initial assessment or her subsequent assessments of the wound during Resident #49's stay. CNP #1200 stated she ordered the antibiotic on 05/08/25 due to odor, the presence of dead skin in the wound, and as it appeared the wound had increased drainage as the wound had worsened. She also stated she ordered 0.5% Dakins solution twice a day on 05/08/25 as well. The next week on assessment on 05/15/25, the wound declined again with the presence of purple tissue and the size was extending of the wound, so she felt a general surgeon needed to assess and recommended the resident be sent to the emergency room . CNP #1200 revealed Resident #49 had contractures to her extremities and the facility had issues positioning the resident, but to her knowledge the resident never refused any care because she was not able to communicate. CNP #1200 verified she was not aware the Dakin's solution treatment ordered on 05/08/25 was not ordered correctly, as she wanted it to be 0.5% solution, an increase due to the worsening of the wound and could not confirm if that contributed to the wound decline, but verified the order was not followed as she wanted it to be. Interview on 05/20/25 at 10:07 A.M. with Licensed Practical Nurse (LPN) #401 revealed he completed rounds with Wound CNP #1200 when she was in the facility and then he entered orders the CNP verbally tells him and dictates on her reports. LPN #401 revealed the CNP sends in the dictations the same day to him, so he is able to put the orders in for the residents for their wound treatments that day. LPN #401 stated when a resident was admitted the floor nurses were responsible for the initial skin assessment on admission and then he tried to come behind to recheck them stated he was not always able to do so. During the interview, LPN #401 revealed he had no training in wound care including staging of wounds and added he stepped in to help when the previous wound nurse left sometime last year. LPN #401 also shared the admitting floor nurse goes through the discharge paperwork for newly admitted residents and places orders for wounds if they had them included in the admission orders. Chart checks were sometimes done by him or the Director of Nursing (DON) to make sure orders were correctly transcribed from admitting orders. The LPN revealed the checks were not always completed but they complete them if they get time. The LPN also revealed Resident #49 was hard to turn and staff had to use a lot of pillows because the resident was very contracted; however, the resident never refused care. LPN #401 verified the Dakin's solution of 0.5% was not ordered correctly on 05/08/25 from Wound CNP #1200 and he entered that order and reviewed her notes. During the interview, LPN #401 also verified Resident #49 did not have an accurate order for the left medial pressure ulcer entered in the system on admission and verified the resident had duplicate treatment orders from 04/10/25 through 04/17/25. The LPN revealed the only treatment that should have been ordered was from Wound CNP #1200. Interview on 05/20/25 at 10:15 A.M. with the DON verified wound measurements were not completed on the admission wound assessment for Resident #49 for the Stage III pressure ulcer to the resident's sacrum or for the left medial knee Stage IV pressure ulcer. The DON also verified there were no further attempts to reassess or measure the pressure ulcers from 04/03/25 through 04/09/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/20/25 at 10:35 A.M. with the Regional Operations and the DON revealed if an order was in the system for a wound treatment and the wound CNP (CNP #1200) ordered a different treatment, the staff should discontinue the current order and then place the new order for the treatment the CNP ordered. There shouldn't be multiple (different) orders in the resident's chart. The Regional Operations and DON subsequently reviewed and verified for Resident #49 all of the missing treatments on the TAR and MAR for wound treatments, lack of evidence of prevention of pressure ulcers including turning/repositioning and barrier cream to peri area, and the missing antibiotic doses. It was also verified the calcium alginate order from Resident #49's discharge paperwork from another facility where Resident #49 came from did not get ordered on admission for the sacrum Stage III pressure wound. The Regional Operations and DON revealed the previous facility wound nurse (who had wound training) left the facility last year. The DON revealed she had no specific wound training but would take responsibility for not overseeing the wound management as she should for the facility residents since LPN #401 was an LPN and had no wound training as well. Interview on 05/20/25 at 12:20 P.M. with MD #2000 revealed she was not aware Resident #49 was not receiving the calcium alginate and only Santyl to her sacrum pressure ulcer on admission. MD #2000 revealed she was only at the facility on Tuesdays and was not made aware of any concerns from Wound CNP #1200 or the facility staff throughout Resident #49's stay. MD #2000 denied concerns from the facility about issues with Resident 349 being noncompliant with care and had no identified concerns with the resident's nutritional status. MD #2000 revealed she referred to Wound CNP #1200 for all recommendations for wounds and follows the treatments and recommendations she advised and expected facility staff to follow her recommendations and enter them into the system to be followed. Interview on 05/20/25 at 3:40 P.M. with the Regional Operations (RO) verified Resident #49 did not have a recheck of her blood pressure from the check on 05/14/25 at 2:40 P.M. when it was 84/46. The Regional Operations revealed the facility documents by exception, and when residents were on antibiotics, they do not check their vitals daily. However, Regional Operations verified Resident #49 was a skilled resident and although it was not part of the facility policy, it was the expectation of the facility that skilled residents receive daily charting which included a full body assessment and vital signs. During the interview, the RO also verified Resident #49 did not leave for the hospital until 3:44 P.M. on 05/15/25 even though Wound CNP #1200's assessment was completed in the morning with a note for rapid evaluation because the RO believed there was no urgency in transferring the resident. Resident #49 was transported by the facility transportation and not emergency medical services (EMS). Review of hospital admission paperwork dated 05/15/25 revealed Resident #49's vital signs in the emergency room included a pulse 115 (tachycardic), blood pressure of 128/76 and elevated temperature of 99.7 degrees Fahrenheit. Laboratory results revealed an elevated white blood cell count of 12.3 (associated with infection). The hospital record revealed Resident #49 presented with an infected sacral decubitus ulcer with verification of a computed tomography (CAT) scan of abdomen pelvis with contrast revealing a deep sacral decubitus ulcer measuring 15 millimeters (mm) deep and measuring 60 mm mediolaterally. There was underlying exposed bone, with adjacent myositis. This resident was admitted to the hospital for a Stage IV decubitus ulcer infection with osteomyelitis. During the resident's stay, the general surgeon did not want to do surgery but did encourage enzymic debridement. The infectious disease physician continued intravenous (IV) Vancomycin (antibiotic) and Zosyn (antibiotic) started in the emergency room . A wound culture showed the wound with heavy pseudomonas, sensitivities pending. Bacteremia, two sets of blood cultures with coagulase-negative staphylococcus. The wound care team continuing dressing changes daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility undated policy titled Wound and Skin Care revealed if a pressure ulcer was present on admission, a skin care assessment would be completed. A pressure area/ulcer would be measured and monitored weekly. Documentation of the pressure ulcer/area would include measurements in centimeters (width, length, depth), wound margins, undermining, clock hands for tunneling, drainage, amount of drainage, type, color and odor. 2. Review of the medical record for Resident #40, revealed an admitted [DATE] with diagnoses including major depressive disorder, muscle weakness, peripheral vascular disease, altered mental status, dementia, and anxiety. Review of the Braden Scale for Predicting Pressure Sore Risk dated 02/17/25 for Resident #40 revealed a score of 13.0 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at moderate risk for skin breakdown. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) of 06. The resident was assessed to require total (staff) dependence for toilet hygiene, shower/bathe self, bed mobility and transfers. This resident was also assessed to be at risk for pressure ulcers. Review of the plan of care revised on 04/13/25 revealed Resident #40 had actual skin integrity issues with interventions including but not limited to float heels in bed, turn and reposition every two hours as tolerated and to monitor weekly. Review of a nurse assessment dated [DATE] revealed Resident #40 had a right lateral ankle open area that measured 1.2 cm by 0.9 cm with no depth with minimal drainage and no classification of the wound being a pressure, arterial or vascular ulcer. Further review of the resident's assessments revealed weekly skin assessments were not completed for the dates of: 04/23/25 through 05/06/25 or 05/08/25 through 05/19/25. On 05/21/25 at 9:29 A.M., 11:39 A.M., and 1:36 P.M. Resident #40 was observed in bed, on his back and his heels were not floated. Interview on 05/21/25 at 11:33 A.M. with the RO verified Resident #40 had missing weekly skin assessments for the dates of 04/23/25 through 05/06/25 and 05/08/25 through 05/19/25 and that assessments should be completed weekly. An Interview on 05/21/25 at 1:37 P.M. with LPN #534 verified Resident #40 had not been turned at all today and that his heels were not floated. Observation on 05/21/25 at 2:27 P.M. with the Director of Nursing of Resident #40's right lateral ankle wound revealed the resident had a Stage III pressure ulcer to the area and verified the resident should have his heels floated when in bed. Review of the facility undated policy titled Wound and Skin Care revealed a pressure area/ulcer would be measured and monitored weekly. Documentation of the pressure ulcer/area would include measurements in centimeters (width, length, depth), wound margins, undermining, clock hands for tunneling, drainage, amount of drainage, type, color and odor.

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	365572	A. Building B. Wing	05/28/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on resident record review, observations and staff interviews, the facility failed to provide supervision in the dining room for a resident who was at risk for choking. This affected one resident (Resident #33) and had the potential to affect 23 residents that the facility identified as having dysphagia, difficulty swallowing (Resident #2, #9, #12, #16, #22, #25, #28, #29, #33, #34, #38, #44, #46, #49, #59, #67, #71, #73, #74, #75, #78, #133, and #233.) The facility census was 76 residents. Findings include: Review of Resident #33's medical chart revealed that she was admitted to the facility on [DATE] with diagnoses that included abnormal posture, cognitive communication deficit, muscle wasting and atrophy, dysphagia, and vascular dementia. Review of Resident #33's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that she had a Brief Interview for Mental Status score of 14, indicative of intact cognition. Review of the MDS assessment dated [DATE] revealed that she required supervision or touching assistance for eating. Further review revealed that she was on a mechanically altered diet. Review of Resident #33's Nutrition assessment dated [DATE] revealed that she was recommended to have one-on-one supervision and assistance with her meals. Observation on 05/18/25 from 11:51 A.M. to 11:53 A.M. revealed that there were two residents (Resident #33 and Resident #41) that were unsupervised in the dining room feeding themselves. Certified Nursing Aide (CNA) #469 entered the dining room at 11:53 A.M. Interview with CNA #469 on 05/18/25 at 11:53 A.M. confirmed that Resident #33, who was identified as a choking risk, was unsupervised in the dining room eating.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52017 Based on interview, medical record review, and facility policy review, the facility failed to communicate with dialysis center and failed to perform pre and post dialysis assessments for one, Resident #29. This had the potential to affect four residents (Residents #6, #29, #31 and #36) who received dialysis. The facility census was 76. Findings include: Review of Resident #29's medical record revealed that he was admitted on [DATE] with diagnoses that included congestive heart failure, diabetes mellitus with neuropathy, morbid obesity, chronic obstructive pulmonary disease, dependent on renal dialysis and end stage renal disease. Review of Resident #29's most recent Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 indicating the resident was cognitively intact. Review of Resident #29's Physician's orders dated 04/25/25 revealed an order for dialysis in center every Monday, Wednesday and Friday at 1:15 P.M. The orders did not indicate any before or after dialysis assessment. Review of Resident #29's progress notes dated 04/19/25 to 05/20/25 revealed no notes for pre- dialysis or post- dialysis assessment. Review of Resident #29's assessments, dated March 2025 to May 2025 revealed no assessments for pre-dialysis or post-dialysis. Review of Resident #29's Dialysis communication records revealed missing communication records for 04/23/25, 05/02/25, 05/14/25 and 05/19/25. Further review revealed the dialysis communication records contained no pre-dialysis assessments on 04/21/25, 04/23/25, 04/30/25, 05/02/25, 05/05/25, 05/12/25, 05/14/25 and 05/19/25 and no post-dialysis assessments on 04/21/25, 04/23/25, 04/25/25, 04/28/25, 04/30/25, 05/02/25, 05/05/25, 05/07/25, 05/09/25, 05/12/25, 05/14/25, 05/16/25 and 05/19/25. Interview on 05/20/25 with RN #429 revealed the process for dialysis patients on dialysis days is the day shift nurse takes the residents vitals, they send communication sheet with the resident to the dialysis center and the dialysis center returns the sheet with vitals, residents weight, and any new orders. There is an order prompt in electronic medication administration record (eMAR) to complete pre/post dialysis communication for the staff to document all the information into the electronic health record. They also do vitals and check for pain, bleeding or swelling at the shunt site and put in any new orders. She also stated that after reviewing the dialysis communication sheet the nurse files the sheets in the resident's chart or dialysis book. RN# 429 confirmed there was no order to complete pre/post communication forms for Resident #29 in the eMAR. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/21/25 at 11:50 A.M. with the Director of Nursing (DON) revealed residents who receive dialysis have a communication sheet the nurse sends to the dialysis center on dialysis days, the sheet is completed by the nurse with residents' weight and vitals. When the resident returns, the nurse checks communication sheet for any new orders and puts them in the computer if needed, the nurse should also check the resident for pain, bleeding and shunt function. She also stated that all dialysis residents should have an order to add information. Review of communication sheets with DON on 05/21/25 at 11:55 A.M. confirmed there were multiple days of missing communication sheets and that multiple sheets were void of pre and post dialysis assessments on multiple days. Review of undated facility Hemodialysis policy states that the facility will assure each resident receives care and services for the provision of hemodialysis consistent with the professional standards of practice. It also stated that the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The nurse will monitor the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. The nurse will ensure that the dialysis access site (AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for bruit and palpating for thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52020 Based on record review, staff interviews, and facility policy review, the facility failed to ensure proper parameters were identified for as needed (PRN) pain medications. The deficient practice affected one resident (#26) of five residents reviewed for unnecessary medications. The facility census was 76. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Medical diagnoses included obesity, Type II Diabetes, anxiety, adjustment disorder, adult failure to thrive, lymphedema, hypertension, personal history of pulmonary embolism, and panniculitis. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating intact cognition. Review of facility care plan for Resident #26 initiated 09/23/24 revealed Resident #26 had chronic pain due to his diagnoses and that medications should be administered as ordered. Review of the physician orders dated 04/17/25 revealed Resident #26 had an order for Oxycodone (opioid)/Acetaminophen (analgesic) 7.5-325 milligrams (mg) with instructions Give 1 tablet by mouth every 6 hours as needed (PRN) for severe pain. The order did not define the word severe. This order was discontinued 05/16/25. Review of the Medication Administration Record (MAR) dated May 2025 revealed Resident #26 received PRN administration of the Oxycodone/Acetaminophen 7.5-325 mg every day from 05/01/25 through 05/15/25. On the May MAR, the patient's pain levels recorded at the time PRN Oxycodone/Acetaminophen was administered ranged from zero (no pain) to nine (severe pain). Resident #26 also had an order dated 05/16/25 for Percocet Oral Tablet 7.5-325 MG (Oxycodone /Acetaminophen) which stated, give one tablet by mouth every six hours for moderate pain for three days and give one tablet by mouth every six hours as needed for moderate pain. This order did not define the word moderate. Interview on 05/20/25 at 2:14 P.M. with Registered Nurse (RN) #446 confirmed the Oxycodone/Acetaminophen orders did not define or provide a numeric rating for the words moderate or severe. She stated that resident wouldn't ask for pain medicine unless he was in pain. She said she thought of moderate pain as a rating of three through seven. She admitted she didn't have a reference point for that definition. Interview on 05/20/25 at 2:28 P.M. with Director of Nursing (DON) who confirmed the orders on the MAR did not have parameters and that severe and moderate should have been defined in the orders. She wondered whether it was left off when information was transferred to the MAR and noted they just recently changed their process. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Pain Assessment and Management revealed that pain management interventions shall reflect the sources, type and severity of pain.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 52017 Based on observation, interview, and facility policy review. The facility failed to store Insulin in a safe manner on the 100 and 300 hall medication carts. This had the potential to affect six residents (Residents #2, #14, #16, #36, #41 and #47) who received insulin on those halls. The facility census was 76. Findings include: Observation on 05/20/25 at 8:10 A.M. of 300 hall medication cart revealed the following medications in the top drawer: two Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) with no resident identifier on the Insulin pen which was opened and undated (date the pen was opened); Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) vial, no resident identifier on the vial which was opened and undated; Tresiba FlexTouch Pen-injector 100 UNITS/ML, with no resident identifier on the pen which was also opened and undated. Interview on 05/20/25 at 8:15 A.M. with Licensed Practical Nurse (LPN) #506 verified insulin vial and pens on 300 hall medication cart that were undated and had no resident identifiers. Observation on 05/20/25 at 8:56 A.M. of 100 hall medication cart revealed the following medications in the top drawer: Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) with no resident identifier on insulin pen which was opened and undated; Admelog Injection Solution 100 UNIT/ML (Insulin Lispro) vial, no resident identifier on insulin vial which was opened and undated; Lantus 100 UNITS/ML (Insulin Glargine) vial, no resident identifier on insulin vial which was opened and undated; Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) vial, no resident identifier on the vial which was also opened and undated. Interview on 05/20/25 at 08:57 A.M. with Registered Nurse (RN) #429 verified Insulin vials and pens on 100 hall medication cart that were undated and had no resident identifiers. Review of the facility policy Storage of Medications dated, April 2007 revealed the facility shall store all drugs and biologics in a safe, secure and orderly manner. It also stated drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received, and drug containers that have a missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50008 Based on observation, staff interview, and review of facility policy, the facility failed to store food in a sanitary manner. This had the potential to affect 73 of 76 residents who ate food from the kitchen (Residents # 20, #42, and #55 were identified by the facility as not eating or drinking from the kitchen.) The facility census was 76 residents. Findings include: Observation on 05/18/25 from 8:25 A.M. to 8:45 A.M. revealed the kitchen dry storage room had three cans of three bean salad, a case of hot dog buns, a case of sliced pineapple rings, and two cases of snack pack puddings that were stored directly on the floor. Interview with Dietary Aide #402 on 05/18/25 at 8:30 A.M. confirmed the above food items were stored directly on the floor in the kitchen's dry storage room. Further interview with Dietary Aide #402 revealed the food items were received at the facility on 05/16/25 and the food items had been stored on the floor since that date. Observation on 05/18/25 from 8:25 A.M. to 8:45 A.M. revealed there was a dusty light fixture over the steam wells in the food serving area, as well as an approximately two-foot-long crack in the painted ceiling, with visible paint chips in it. Interview with Dietary Aide #425 on 05/18/25 at 8:34 A.M. confirmed there was a dusty light fixture and an approximately two-foot-long crack in the painted ceiling. Observation on 05/19/25 from 10:32 A.M. to 10:51 A.M. revealed an approximately four foot crack with peeling paint that was hanging down two inches from the ceiling in the food preparation area. The crack and peeling paint was directly over a rack of stored clean food trays and over open drinking cups. There was also a dusty light fixture over the food serving Interview with Dietary Manager #431 on 05/19/25 at 10:51 A.M. confirmed there was a four-foot crack with peeling paint and a dusty ceiling fan over the steam wells in the food serving area. Review of the facility policy titled, Food Receiving and Storage dated July 2014 revealed food in designated dry storage areas shall be kept off of the floor at least 18 inches. Food services will maintain clean food storage areas at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on record review, interview, and facility policy review, the facility failed to ensure enhanced barrier precautions were in place for Resident #49 who had pressure ulcer wounds while at the facility. This affected only Resident #49 who was reviewed for enhanced barrier precautions. This had the potential to affect 10 residents on the same hall. The total facility census was 76. Findings include: Review of the medical record for Resident #49, revealed an admitted [DATE] and a transfer to the hospital date of 05/15/25. Diagnoses included but were not limited to adult failure to thrive, Alzheimer's disease, anxiety disorder, metabolic encephalopathy, and difficulty walking. Review of the active care plans dated 04/03/25 revealed Resident #49 to be on enhanced barrier precautions related to chronic wounds. Review of the physician orders dated 04/03/25 through 05/15/25 for Resident #49 revealed no order for enhanced barrier precautions due to having chronic pressure ulcer wounds. Interview on 05/21/25 at 2:35 P.M. with Regional Administrator #417 verified no order was present for enhanced barrier precautions during facility stay for Resident #49. No policy on enhanced barrier precautions was provided by the facility.