STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365579	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Healthcare Center Inc	648 Longhorn Street Carrollton, OH 44615

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, record review, review of physician office visit notes and hospital records and interview, the facility failed to ensure Resident #24, who had an unstable burst fracture of the first lumbar vertebrae with spinal fusion on 10/18/24 and was admitted to the facility for post-operative care and therapy was provided timely, adequate and necessary wound care monitoring and treatment and antibiotic treatment as ordered by the resident's surgeon/physician for management of a surgical wound, to promote optimal healing and to prevent complications post-operatively. Actual harm occurred on 11/17/24 when Resident #24 was discharged home without evidence the surgical wound to his back was stable and without sign of infection and that wound care had been provided as ordered. On 11/18/24 the resident was seen by Surgeon #300 for an outpatient post operative wound care appointment. At the time of this visit, Surgeon #300 identified the wound had developed extensive dehiscence (splitting or bursting open of a wound) and superficial infection. The resident was immediately transferred and admitted to the hospital from the surgeon's office and had surgery (incision and drainage procedure) to the infected post-operative wound on 11/19/24. This affected one resident (#24) of three residents reviewed. Findings include: Review of the closed medical record for Resident #24 revealed the resident was admitted to the facility on [DATE] with diagnoses including unstable burst fracture of the first lumber vertebrae with spinal fusion, history of falls, diabetes, cerebral infarction, hypertension, and chronic kidney disease. The resident was discharged from the facility to his home on 11/17/24. Review of the admission assessment dated [DATE] revealed Resident #24 was admitted with an upper mid vertebrae surgical incision. An Admission Skin assessment dated [DATE] revealed Resident #24 had a spinal incision measuring 17.6 centimeters (cm) in length by 1.0 cm in width with no evidence of infection. The wound had sanguineous/bloody drainage, and the edges were attached. Review of the admission physician's orders revealed Resident #24 had an order (dated 10/24/24) to cleanse the surgical incision to the back with normal saline, apply a clean, dry dressing twice daily and as needed for soiling. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of surgical visit documentation for Resident #24, dated 10/29/24 (a scheduled follow-up appointment), revealed a handwritten note on the paper indicating an antibiotic (Keflex) had been prescribed by the doctor for wound care/management. Resident #24 had a follow up appointment scheduled 11/07/24. Review of the physician's order dated 10/30/24 revealed an order for Keflex 500 milligrams (mg) twice daily for surgical incision for 10 days. Review of the October and November 2024 Medication Administration Record (MAR) revealed Keflex 500 mg twice daily for 10 days was started at bedtime on 10/30/24 for Resident #24 and was completed on 11/09/24. Review of the Admission Minimum Data Set assessment dated [DATE] revealed Resident #24 had intact cognition and had a surgical wound. He had lower extremity impairment on one side, and he was dependent on staff for bed mobility, personal hygiene, dressing, bathing, and toileting. The resident was receiving antibiotic therapy. Review of the Skin assessment dated [DATE] revealed Resident #24 had a spinal incision measuring 15.1 cm in length by 0.9 cm in width with no evidence of infection. The wound had a moderate amount of sanguineous/bloody drainage, the edges were attached, and there was no swelling. The wound nurse would follow weekly until healed. Resident# #24 had a follow up appointment with Surgeon #300 (10/29/24) and was ordered Keflex 500 mg twice daily through 11/09/24 with a follow-up appointment scheduled for 11/07/24. Review of an Infection Screening form dated 10/30/24 revealed Resident #24 had new skin wound characteristics, increased swelling, pus, serous drainage and he met Loeb's and McGeer's Criteria (criteria used to determine if antibiotic treatment is appropriate for the infection indicated) for treatment of the surgical wound. This assessment was completed by Registered Nurse (RN) #360 Review of a progress note dated 10/31/24 at 10:33 A.M. revealed Resident #24 was on Keflex 500 mg twice daily for 10 days for surgical site infection. Review of a progress note dated 11/04/24 at 10:57 A. M. revealed the Nurse Practitioner was in to visit Resident #24 and had no new orders. Review of the Skin assessment dated [DATE] revealed Resident #24 had a spinal incision measuring 16.5 cm in length by 0.8 cm in width with no evidence of infection. The wound had a light amount of sanguineous/bloody drainage, and the edges were attached. Observation of a facility photograph of Resident #24's wound dated 11/06/24 revealed a wound with approximated edges except for one area, approximately 1/4 of the way down on the incision that was not closed, and the area was approximately one inch in length. Review of a surgical visit note from Surgeon #300's office dated 11/07/24 revealed the resident was to receive Keflex 500 mg twice a day for 10 days and the medication would be sent via mail. The resident had a follow-up appointment scheduled for 11/18/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of the medical record revealed no evidence the surgeon was contacted for clarification regarding the Keflex order documented on the surgical visit note provided to the facility following the appointment on 11/07/24. There was no follow-up regarding if this Keflex was in addition to the current round he was receiving, why the antibiotic was ordered or why the prescription would be arriving via mail. Review of the plan of care dated 11/07/24 revealed Resident #24 had an unstable burst fracture of the first lumbar. Interventions included treatment to back incision as per order, observe dressing as indicated, observe and document observation of surgical site with dressing changes, monitor for signs and symptoms of infection; redness, drainage, warm to touch, increased pain at site and fever. Review of the physician's order dated 11/13/24 revealed Resident #24 had an order for Keflex 500 mg twice daily for prophylaxis and possible incision infection. Further review of the medical record revealed no documentation as to why the Keflex was implemented on 11/13/24. Review of the November 2024 Medication Administration Record revealed Resident #24 was administered Keflex 500 mg from 11/13/24 to 11/17/24 (discharge) twice daily for prophylaxis and possible infection. Review of the skin assessment dated [DATE] revealed the back incision for Resident #24 measured 14.4 cm in length by 0.7 cm in width by undetermined depth. The assessment included there was no evidence of infection and light sanguineous/bloody drainage with no odor was noted. Observation of a facility wound photograph taken 11/13/24 revealed the surgical area had scattered opens area in the wound with yellow, crust-like areas noted. Review of Physician #355's Discharge Note dated 11/14/24 revealed the resident was admitted to the facility on [DATE] from the hospital. Skilled diagnosis was lumbar fracture status post spinal fusion. Surgical incision to back, dressing in place and treatment orders. The note revealed the resident continued on antibiotics per orthopedics. Reports good pain control. Insurance has issued last covered day of 11/16/24 and the resident will be discharged home on 11/17/24. Oriented times three (person, place and time) and insight appropriate. The resident would be discharging home this weekend and would be following up with his spine surgeon as well. Review of the Treatment Administration Record (TAR) revealed on the morning of 11/15/24, Licensed Practical Nurse (LPN) #367 documented Resident #24 refused his dressing change. Staff had signed off the TAR indicating wound care completed as ordered on the evening of 11/15/24 and morning and evening of 11/16/24. Resident #24 discharged home on the morning of 11/17/24 prior to wound care being completed. Review of the medical record on 11/17/24 at 11:00 A.M. revealed Resident #24 was given discharge instructions and orders. The resident was made aware of follow-up appointments. The resident's wife signed the discharge papers and gathered the resident's personal belonging and medications. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of information provided by Surgeon #300's office as part of the State agency investigation revealed Resident #24 had presented to the surgeon's office on 11/18/24 for a post operative appointment following a thoracic fusion on 10/18/24. On 11/07/24 the resident had been seen in the office and Surgeon #300 had ordered Keflex due to the incisional area appearing to be starting an infection. However, the office was never updated with the appropriate pharmacy and the medication prescription was sent to the wrong pharmacy and the resident was unable to start the medication. The facility never prescribed the medication and never contacted the office. On 11/18/24 when the resident's dressing was removed from Resident #24's (incision) the dressing was soiled with green purulent fluid with an odor. The dressing that was removed was dated 11/15/24 with the initials for LPN #367. The wound was dehisced and infected. Resident #24 was a direct admit to the hospital with an additional procedure scheduled for the next day. Review of the hospital progress note from Surgeon #300 dated 11/18/24 at 12:58 P.M. revealed Resident #24 was in his office for a follow up appointment. The resident was having moderate pain at the incision site. Management options and their respective risks and benefits were discussed with Resident #24. The hospital note revealed the resident never received his second round of antibiotics (as ordered) and the information was never communicated with his office. Resident #24 now had extensive dehiscence and a superficial infection. Resident #24 would be admitted and scheduled for surgical incision and drainage (I&D) the next day. Review of the hospital surgery note dated 11/19/24 revealed the resident's old incision was opened and immediately purulent discharge was observed in the subcutaneous area. Specimens were obtained for culture. The entire incision was exposed and washed with saline to remove any debris and old sutures. One gram of powdered Vancomycin (antibiotic) was used, and a drain was placed in the wound. Review of the wound culture dated 11/22/24 revealed the wound of Resident #24 had a candida tropicalis (yeast infection) and polymorphonuclear leukocytes (white blood cells). On 12/26/24 at 12:45 P.M. an interview with the Director of Nursing (DON) revealed Resident #24 went to the surgeon on 10/29/24 and received an order for Keflex 500 mg twice daily which was administered from 10/30/24 through 11/09/24. She stated when he went to the surgeon on 11/07/24, the surgeon ordered Keflex 500 mg twice daily for 10 days again but stated the resident was already on the antibiotic. The DON revealed on 11/13/24 Resident #24's significant other brought in a bottle of Keflex stating the surgeon called it in to the pharmacy on 11/07/24 so the DON revealed the facility started the antibiotic again on 11/13/24. The DON stated she did not know if anyone from the facility had reached out to the surgeon on 11/07/24 to let him know the resident was already on the antibiotic or to clarify the order from the visit on 11/07/24. A subsequent interview on 12/26/24 at 1:57 P.M. confirmed there was no documentation or evidence in the medical record Surgeon #300 was contacted to clarify the Keflex order from 11/07/24. On 12/26/24 at 2:25 P.M. an interview with Licensed Practical Nurse (LPN) #302 revealed she was the nurse who went over the discharge instruction with Resident #24 and his significant other on 11/17/24. The LPN revealed she did not know Resident #24 was going home that day until his significant other came to the facility and stated she was taking him home. The LPN revealed she had to hurry up, get all his stuff together, and fill out the discharge paperwork. She stated she went over everything with them both and went over his wound treatments. She stated she did not look at his wound or show them how to clean the wound at the time of discharge. She also stated she did not send any supplies home with them for wound care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/26/24 at 4:26 P.M. an interview with Family Member #400 revealed the facility had sent paperwork with her for Resident #24 for both his follow-up appointments. She stated she brought paperwork back and gave it to the facility both times. Family Member #400 revealed when they went to surgeon's office on 11/18/24 the dressing to Resident #24's back was dated 11/15/24 with the initials for LPN #367. The resident had four steri-strips on his wound that were not there before, and she did not know when they were applied. She stated the nurse from the surgeon's office took a picture and the surgeon was upset the facility had not called him about how bad his wound looked. On 12/26/24 at 4:30 P.M. an interview with Resident #24 revealed concerns that facility staff did not change his dressing every day like they were supposed to, but he stated he could not remember what specific days the dressing had not been changed during his stay in the facility. On 12/30/24 11:14 A.M. RN #360 revealed she never observed Resident #24's surgical wound during the resident's stay in the facility and used hospital documentation to assess if the resident met criteria for antibiotic treatment. She stated she did not review the facility's skin assessment because it had not been completed for 11/13/24. On 01/02/25 at 9:50 A.M. telephone interview with the DON revealed that Surgeon #300's office did call the facility on 11/18/24 but the DON was not working, and Medical Records staff took the call. Medical Records staff then reported to the DON the surgeon's office was concerned because Resident #24's dressing had not been changed and the wound was dehisced. The DON stated she had not called the surgeon's office back, and they called her again on 11/19/24 or 11/20/24, she was unable to remember which date, and the surgeon's office reported the same concerns to her. The DON stated staff had updated the resident's primary care provider (PCP) on the resident's wound (however, this was not documented in the medical record). During the interview, the DON verified the facility was responsible to reach out to the prescriber if there was any confusion with an order. The DON stated the nursing staff were to monitor the condition of wounds and any increase in drainage, they would let the wound nurse know and the wound nurse would follow weekly. Lastly, the DON verified LPN #302 did not provide the resident and family education regarding wound care prior to discharge. Attempts to interview/contact RN #310 and LPN #311 during the complaint investigation were unsuccessful as neither nurse was available or returned phone calls to the surveyor. Review of the facility policy titled Dressings, Dry/Clean with a revision date of 03/26/21 indicated to verify that there was a physician's order for this procedure and to apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initial to the top of dressing. This deficiency represents non-compliance investigated under Complaint Number OH00160077 and Complaint Number OH00160049.