STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365696	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Forest Hill	100 Reservoir Road St Clairsville, OH 43950

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 - 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** 32801 Based on medical record review, observation, interview and policy review the facility failed to provide comprehensive, resident centered care related to edema and congestive heart failure. This affected one (Resident #24) of three records reviewed. Findings included: Record review revealed Resident #24 was admitted to the facility on [DATE] with a diagnosis of cerebrovascular disease, vascular dementia, Parkinson's Disease, congestive heart failure (CHF), cardiomegaly, and presence of cardiac pacemaker. Review of Resident #24's Minimum Data Set, dated dated dated [DATE] revealed no evidence the resident had behaviors including refusal of care. Review of Resident #24's current plan of care for congestive heart failure revealed no evidence to encourage the resident to elevate their lower extremities while sitting or in bed. Interventions included to monitor/document/report as needed any signs or symptoms of congestive heart failure (dependent edema of legs and feet and weight gain unrelated to intakes). Review of Resident #24's progress notes dated 06/01/24 to 08/12/24 revealed no evidence the resident refused to elevate his legs and feet. Review of Resident #24's Physician/Nurse Practitioner (NP) progress notes dated 06/22/24 and 07/19/24 revealed to continue to monitor the resident's weights and edema. Encourage to elevate lower extremities while sitting and in bed. Review of an Interdisciplinary Team (IDT) note dated 07/18/24 revealed the resident was non-complaint with elevating his feet, causing edema. Review of Resident #24's weights revealed the resident weighed 180.8 pounds on 07/21/24 (NP had ordered weights be obtained four days in a row while the resident was receiving Lasix (diuretic) and on 08/01/24 (monthly weight) the resident weighed 186.4 pounds, which was a 5.6-pound weight gain in 11 days. There was no evidence the resident was re-weighed on 08/01/24 or afterwards to ensure accuracy of the weight. (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: 365696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #24's progress notes dated 08/01/24 to 08/13/24 revealed only one entry regarding edema on 08/06/24 which indicated the resident had bilateral lower extremity edema present form his knees to feet. There was no further assessment available related to the edema. Observation on 08/12/24 at 8:03 A.M., 12:38 P.M., 2:52 P.M. and 08/14/24 at 2:00 P.M., revealed no evidence the resident's legs and feet were elevated. Interview on 08/13/24 at 8:14 A.M. with the DON revealed the facility had no parameters for weights related to care of residents with a diagnosis of CHF. Monthly weights are obtained on every resident from the first through the tenth of each month and if there was a specific order, she would provide the information to the floor staff. The DON confirmed the NP notes dated 06/17/24 and 07/19/24 indicated to have the resident elevate his legs while up and in bed, however it was not part of the resident's comprehensive careplan (including the STNA task information) related to CHF. The DON confirmed there was an IDT note in June that indicated Resident #24 was non-complaint with elevating his feet and legs however there was no additional supporting documentation regarding resident non-compliance related to elevating the resident's feet and legs when sitting or in bed. The DON also confirmed the staff were not comprehensively assessing the resident's edema to include if it was non-pitting or pitting and the severity of the pitting edema, if present. Interview on 08/13/24 at 10:12 A.M., with Physician #501 revealed a resident with CHF and not stable (with their weight changes) should be weighed every three days or more frequently so the resident can be closely monitored. Interview on 08/13/24 at 11:18 A.M., with NP #500 revealed Resident #24 would have been weighed at least weekly. Any resident with a diagnosis of CHF should be weighed weekly. The NP reported she was not notified of the resident's weight gain on 08/01/24. Interview via phone on 08/13/24 at 11:45 A.M., with Resident #24's daughter, #600, revealed the family was concerned with Resident #24's edema. She had voiced concerns to the facility about what they were doing to prevent the edema, but their concerns never get resolved. The daughter further shared the facility needed to implement interventions to help reduce the resident's edema. Lastly, the daughter shared the family had placed a recliner chair in the resident's room but once he got a roommate, the room was too small and the resident wouldn't sit in the chair for long periods of time. Interview on 08/13/24 at 12:11 P.M., interview with the DON confirmed there was no documented evidence Resident #24's provider was notified of the weight gain on 08/01/24. The DON also confirmed there was no order for obtaining more frequent weight checks due to the resident's diagnosis of CHF. Review of NP #504's general note dated 08/13/24 revealed Resident #24 was seen today for a problem visit. He was sitting in his room and had significant increased swelling in the lower extremities. He had a six-pound weight gain this month. He had a systolic murmur and plus four edema in the lower extremities. He had acute and chronic fluid retention. We will restart Lasix and check labs, set up appointment for cardiology for echocardiogram, a renal ultrasound for acute and chronic kidney disease. Monitor weights and intakes. (continued on next page)

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Continuing Healthcare at Forest Hill	100 Reservoir Road St Clairsville, OH 43950

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/24 at 2:00 P.M., with Resident #24's daughter #601, who was visiting that day, revealed herself or Daughter #600 visit daily. The daughter reported concerns with the resident's edema and the resident's legs are never elevated and the family had voiced concern with no resolution. The facility had put foot pedals on the wheelchair, however the foot pedals disappeared until last week when they voiced concerns. The facility found the pedals under his bed, The daughter reported they have been asking for something to help elevate the resident's legs/feet for two years now. Review of the facility's weight policy undated revealed it was the policy of this facility to attempt to attain/maintain a resident's weight the recommended range as appropriate in relation to their medical and physical status. Weights would be obtained in a timely and accurate manner, documented, and responded to in an appropriate manner. The dietitian/diet tech or physician would be notified of routine weights, significant changes in weights, insidious weight loss and other concerns related to diet and intake. The physician and resident/resident representative would be made aware of significant changes in weight or intake of the resident. The facility's policy did not address resident with congestive heart failure.

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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 0686 Level of Harm - Minimal harm or potential for 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** 32801 Based on closed record review, policy review and interview the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of a pressure ulcer for Resident #78 within 30 days of admission. The facility failed to ensure adequate interventions and treatment were in place to promote healing and prevent deterioration of the ulcer. This affected one resident (#78) of two residents reviewed for pressure ulcers. The facility census was 74. Findings included: Review of Resident #78's hospice plan certification documentation dated 04/29/24 revealed skilled nursing to provide teaching related to altered skin integrity to include offloading, frequent position changes, keep skin clean and dry to prevent skin breakdown, and minimize friction and shearing. Medical equipment supplied gel mattress overlay. The resident was bedbound and able to bear weight. The resident received assistance with all activities of daily living (ADLS) except for eating. Review of a hospice note dated 04/30/24 revealed the resident was oriented to person, place, and time but was forgetful and confused. The resident had scattered bruising and ecchymosis to bilateral arms, dry skin, and poor skin turgor. The resident has stress incontinence and used briefs and pads. The resident was chairfast and required assistance with ambulation, continence, transfers, dressing, and bathing. The resident was able to stand and pivot. Able to ambulate a short distance with walker and stand by assist of two. Left arm flaccid. Ordered gel overlay due to thin, fragile skin. No redness noted to surgical site on right side of head. Skin without pressure injuries. Closed record review revealed Resident #78 was admitted to the facility on [DATE] for respite care from 05/03/24 to 05/07/24 with diagnoses including malignant neoplasm of the brain. Additional diagnoses including anxiety, difficulty walking, cognitive communication deficit, delirium, insomnia, hemiplegia, hypertension, chronic ischemic heart disease, weakness, chronic ischemic heart disease, history of malignant neoplasm of the breast, and chronic obstructive pulmonary disease. The resident was discharged home on 06/07/24. Review of an admission nursing assessment dated [DATE] revealed the resident's skin was intact. Review of an admission head to toe assessment dated [DATE] revealed the resident current Braden score (tool determine risk for pressure ulcers) was 11 (high risk). Review of an admission summary dated 05/03/24 revealed the resident had 43 staples intact on the right side of the skull, generalized bruising on all extremities, left side mastectomy, right groin pressure dressing intact, and a scab to the top of the right hand. Review of a baseline plan of care dated 05/03/24 revealed the plan of care was blank except for the resident demographics and advanced directives. The baseline plan of care had a skin integrity section for at risk however it was blank as well. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven (moderate cognitive impairment). The assessment revealed Resident #78 had functional limitation in range of motion on one side of the upper extremity, had not used a mobility device in the last seven days, dependent with toileting, substantial/maximal assistance with shower/bathe, upper and lower body dressing, putting on/taking off footwear, personal hygiene, sitting to lying, lying to sitting, sit to stand, chair/bed-to-chair transfer, tub/shower transfer, and walking 10 feet. The resident required partial/moderate assistance with roll left and right. Toilet transfer was not attempted. The resident does use a manual wheelchair and/or scooter and required substantial/maximum assistance to wheel 50 feet with two turns once seated. The resident exhibited no behaviors including requestion of care. The resident did not have any pressure ulcer but was noted to be at risk for developing pressure ulcers. The resident was noted to have skin tears and a surgical incision. The MDS revealed the resident did not have a pressure reducing device for her chair, however had a device for her bed. She was not on a turning/repositioning program or a nutritional or hydration intervention to manage skin problems. Review of Resident #78's incontinence plan of care related to impaired mobility, delirium, and malignant neoplasm to the brain initiated on 05/14/24 revealed to assist with being cleaned, dry, and comfortable, assist with toileting, monitor of signs and symptoms urinary tract infection and ensure the resident had an unobstructive path to the bathroom. Review of a skilled documentation note dated 05/15/24 revealed the resident's skin was intact, no wounds except a surgical wound to the right side of the head. No skin conditions noted. No new skin/wound medications or medication changes. Review of a general note dated 05/16/24 revealed a State tested Nurse's Aide (STNA) called the nurse to the resident room. The resident had an area to the crease of the left buttocks (sacrum) measuring three centimeters (cm) by 5.5 cm that was brown and yellow in the center with reddish/pink outer. New orders to cleanse with wound cleanser, apply medihoney (wound gel to treat open wounds by decreasing bacterial growth and anti-inflammatory effects to speed up healing and reducing pain) and dry dressing on Tuesday, Thursday, and Saturday. Review of a non-pressure skin assessment dated [DATE] and completed 05/24/24 revealed the skin alteration was new first observed on 05/16/24 on sacrum. The area was noted to be moisture associated skin damage measuring 3 cm by 5.5 cm. The surrounding area was pink. Treatment orders to cleanse the wound with wound cleanser, pat dry, medihoney, and dry dressing. The care plan was reviewed and revised. There was no documented evidence of the brown and yellow per the progress note written on 05/16/24. Review of physician orders dated 05/16/24 revealed a low air loss mattress to bed and may be up in reclining geri chair for comfort and positioning. Review of Resident #78's plan of care for pressure area on left buttock initiated on 05/16/24 revealed the plan of care had no intervention initially and then on 05/24/24 interventions were added to encourage the resident with turning and repositioning, encourage good nutrition, on and hydration, keep skin clean and dry, use lotion on dry skin, monitor/document location, size, and treatment of the skin, reposition frequently, protect the skin while in bed, up for meals only , and use caution when transferring. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a pressure ulcer note dated 05/21/24 (and signed on 05/29/24) revealed the resident had an existing area (05/16/24 that was originally documented as non-pressure) that had deteriorated and was in-house acquired. The resident's risk factors included impaired mobility, incontinence, altered nutrition, diagnoses of cancer, and cognitive impairment. The area was on the left buttocks and measured 3.0 cm by 4. 8 cm by 0.1cm and was assessed to be a Stage II (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer. The wound bed was granulation tissue, the wound bed was reddened, peri-wound was dark red or purple and/or non blanchable, and there was scant amount of serosanguineous (thin, watery, pale, red/pink drainage). The care plan summary and treatment note indicated the resident was seen by wound care. The area was originally a reddened area (05/16/24 note indicated it had a brown/yellow center). Repositioned with barrier cream. Applied medihoney foam. Record review revealed a second plan of care for pressure ulcer initiated on 05/21/24 revealed the resident was identified to have a pressure area on the left buttocks (sacrum) related to the following comorbidities or clinical situation, cancer and chronic bowel obstruction on 05/21/24; however, no interventions were implemented until 05/24/24 which included education on the importance to keep skin clean and moisturized, encourage and assist with turning and repositioning, encourage frequent shift of weight, evaluate ulcer, monitor bony prominences, monitor nutritional status, monitor of signs of progression or declination, provide skin care as needed, provide wound care as needed, reposition frequently, and refer to specialized practitioner for wound management. Review of the Oncology note dated 05/23/24 revealed the resident was seen for an evaluation and follow up from a right frontal craniotomy for glioblastoma multiforme. The patient was currently residing in a nursing facility. The family reports that the resident mental status was impaired today. The resident was brought into the office today via wheelchair and had a sacral decubitus. The patient had hypokalemia, and she was referred to the emergency department so that this may be addressed. Review of the emergency room report dated 05/23/24 revealed the resident was seen for hypokalemia and decubitus skin ulcer. The female was a resident of a local skilled nursing facility who presents to the emergency room from the cancer center due to abnormal las. The resident was noted to have a potassium of 2.9 (reference range 3.6-5.2). The resident was administered potassium replacement in the emergency room and rechecked and it came up to 3.0. During the nurse's exam the resident was noted to have a decubitus ulcer to her coccyx. Cultures were obtained and sent. Area was cleaned and dressed. The resident is being discharged back to skilled nursing facility on the antibiotics, Keflex and Clindamycin as well as on Potassium Chloride 20 milliequivalents twice daily for five days then follow up with primary care doctor for repeat labs. Review of a general note dated 05/23/24 revealed the resident's daughter called and stated the resident's Oncologist ran labs and they were abnormal so they sent her to the emergency room (ER) and were currently running cultures on the buttocks wound and may keep her or may give her antibiotics and send her back. Review of a general note dated 05/23/24 revealed the resident returned from the ER and the daughter brought in paperwork and diagnosis for hypokalemia and decubitus ulcer. New orders given for Clindamycin 300 milligrams (mg) three time daily for 10 days, Cephalexin (Keflex) 250 mg four times daily for 10 days, and Potassium chloride 20 milliequivalents for five days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a pressure ulcer note dated 05/24/24 and signed 06/11/24 revealed the resident had an existing area on the left buttocks that has deteriorated. The area was assessed to be an unstageable area measured 3.0 cm by 4.8 cm with granulation and slough present. The wound bed was reddened and yellow. The peri-wound was dark red or purple and/or non blanchable. There was scant amount of serosanguinous drainage. There were no signs of infection. The care plan summary note indicated the resident was seen by wound care. The wound had deteriorated. The note included the area was unavoidable due to decline in condition, poor appetite, cancer, and skin failure. New orders to apply Santyl daily with saline and gauze and foam dressing. Liquid protein supplement added to diet. Up for meals only. Reposition in bed. Resident on low air loss mattress. Review of the Wound Nurse Practitioner (NP) #503 wound notes dated 05/24/24 revealed a telehealth visit was completed for Resident #78. The nurse reported the resident initially had moisture associated skin damage (MASD) of the left buttocks/crease on 05/16/24. The resident was ordered a low air loss mattress for prevention on 05/16/24. The unstageable pressure ulcer wound site was located on the pelvis/sacrum and was in-house acquired measuring 3.0 cm by 4.8cm by 0.2 with 75% slough and 25% granulation tissue. There was a small amount of exudate. There was a comment note that indicated the depth was undermined to determinate. There was a rapid decline, which the Wound NP determined was unavoidable due to the resident's end stage prognosis/diagnosis. New treatment orders for Santyl for enzymatic debriding daily and as needed. Hydrogel or saline moist gauze and cover dressing daily and as needed. Intervention include barrier cream every shift, turn and reposition per facility protocol, and low air loss mattress. Recommendation on 05/24/24 house liquid protein daily and house supplement eight once daily. Review of pressure ulcer note date 05/28/24 and signed 05/29/24 revealed the pressure ulcer on the left buttocks measured 2.0 cm by 2.5 cm by 0.2 cm had improved to a Stage III (full thickness tissue loss). The wound bed was 70% granulation and 20% slough. There was no indication/documentation what the other 10% of the wound bed was. There was moderate amount of serosanguineous drainage noted. The care plan summary note indicated the NP would follow up with next visit and to discontinue saline gauze due to drainage amount. Review of Wound NP #503 note dated 05/31/24 signed 06/10/24 revealed the resident was seen for buttocks wound present admission on 05/03/24. (Record review revealed there was no evidence the resident had a pressure ulcer on admission). The wound had declined after resident had been out to an unstageable. (There was no documented evidence the resident had been out except for an ER visit on 05/17/24 and Oncology/ER visit on 05/23/24). Nurses documented the wound had become more granular now since the resident had been back on a low air loss mattress. The wound bed was 30% slough and 70% granulation tissue. Treatment orders included Santyl, and hydrogel or saline moist gauze and cover dressing daily and as needed. All other prior intervention continued. Review of Resident #78's treatment administration record dated 06/2024 revealed no evidence the Santyl and hydrogel or saline moist gauze and cover dressing daily was administered on 06/01/24. Review of pressure ulcer note dated 06/04/24 and signed 06/05/24 revealed the pressure ulcer on the left buttocks had deteriorated to a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle). The area measured 2.2 cm by 3.8 cm by 0.9 cm. with undermining at 3:00 P.M. of 1.0 cm. The wound bed was 40% slough and 60% muscle. The wound had moderate serosanguineous drainage. The wound was packed with strips of calcium alginate dipped in Santyl and covered with a foam. X-ray ordered to rule out osteomyelitis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Wound NP #503 noted dated 06/04/24 signed 06/11/24 the resident was seen for a buttock wound. The pressure ulcer was a Stage IV measuring 2.3 by 3.8 by 0.9 with moderate serous drainage. There was 40% slough noted. The wound required excisional debridement. Treatment orders included Santyl and alginate daily, cover with dressing. Review of a general note dated 06/07/24 revealed the resident was discharged home with hospice care due to being discharged from skilled services. Interview on 08/14/24 from 9:34 A.M. to 12:44 P.M., with RN #505, RN/IP #169, the Director of Nursing (DON) and the Administrator revealed the facility had no documented evidence pressure relieving interventions were implemented on admission for Resident #78, however the staff reported all mattresses were pressure relieving, all residents should be receiving barrier cream after incontinence care was performed, and all residents in a wheelchair should have pressure relieving devices. The staff verified a skin alteration plan of care with interventions was not completed until 05/24/24. Further interview with RN #505 confirmed the progress note on 05/16/24 indicated the resident's wound had a yellow and brown center, however the skin grid did not indicate the area was pressure or the yellow and brown center. The facility doesn't have a wound nurse currently; however, they stated a new wound nurse would be starting the following Monday. The DON reported she called the nurse who worked on 06/01/24 and she could not recall if she completed Resident #78's treatment on 06/01/24. The DON confirmed there was no documented evidence the treatment was administered to the resident left buttocks on 06/01/24. Review of the facility undated policy titled Pressure Ulcer Prevention and Risk Identification revealed the facility would assess each resident for risk of pressure ulcer development in an effort to establish measures to prevent the development of pressure ulcers within the facility or to prevent further decline of already existing pressure ulcers. The licensed nurse would complete a Braden Scale risk assessment for each resident upon admission, then quarterly, and with significant change thereafter. Preventative measures would be implemented based upon the residents assessed need and risk score. A care plan would be developed and updated routinely with identification skin risk and/or actual wound development. Intervention would be implemented as indicated by the physician and as determined by the Interdisciplinary team, This deficiency represents non-compliance investigated under Complaint Number OH00156411.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed record review and interview the facility failed to ensure residents were placed in contact isolation precautions as indicated. This affected one (Resident #78) of two residents reviewed for pressure ulcers. Findings included: Closed record review revealed Resident #78 was admitted to the facility on [DATE] for respite care (discharged from hospice on 05/07/24 to skilled services) with a diagnosis including malignant neoplasm of brain, anxiety, difficulty walking, cognitive communication deficit, delirium, insomnia, hemiplegia, hypertension, chronic ischemic heart disease, weakness, chronic ischemic heart disease, history of malignant neoplasm of the breast, and chronic obstructive pulmonary disease. Review of the emergency room report dated 05/23/24 revealed the resident was seen for hypokalemia (low potassium level) and decubitus skin ulcer. The female was a resident of a local skilled nursing facility who presents to the emergency room from the cancer center due to abnormal las. During the nurse's exam the resident was noted to have a decubitus ulcer to her coccyx. Cultures were obtained and sent (to lab). Area was cleaned and dressed. The resident is being discharged back to skilled nursing facility on Keflex (antibiotic) and clindamycin (antibiotic). Review of the wound culture that was obtained during the ER visit on 05/23/24 and the results were dated 05/26/24 revealed the organisms were Escherichia Coli and Methicillin Resistant Staphylococcus Aureas (MRSA). There was notation to use contact precautions. The MRSA was resistant to Clindamycin treatment and Keflex was not listed under E. Coli or MRSA as a treatment option. Review of the facility's infection control log dated 05/2024 revealed Resident #78's infection was community acquired, meet McGeer criteria for infection and treatment with an antibiotic, and was reviewed by the Infection Preventionist (IP). The organism box and isolation box was blank. Review of Resident #78's McGeer Criteria for Infection Surveillance Checklist form dated 05/28/24 and reviewed on 05/30/24 revealed the resident met criteria for wound as evidence by having pus, heat, redness, swelling, and tenderness. There was a handwritten note in the comment section that indicated the left buttocks wound grid (slough, reddened yellow) and diagnosed in the hospital and (the resident) returned to the facility. There was an additional handwritten note on the bottom of the form that indicated the resident had E.Coli and Staphylococcus Aureus. Cephalexin for 10 days was discontinued on 05/28/24 and Bactrim DS was added for five days. There was no documented evidence the resident had MRSA or was placed in isolation precautions. Review of Resident #78's paper and electronic medical record revealed no evidence the resident was placed in or was ordered contract isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/15/24 at 9:41 A.M., with the Infection Preventionist (IP) #169 revealed she was not aware of the wound culture results that were obtained on 05/23/24 and resulted on 05/26/24 from the ER visit. The IP confirmed the resident was not placed in isolation for MRSA because she was not aware of the results but confirmed the wound culture from the ER visit on 05/23/24 indicated the resident had MRSA in the wound and she should have been placed in contact isolation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER: Continuing Healthcare at Forest Hill		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Reservoir Road St Clairsville, OH 43950	

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed record review, interview, and policy review the facility failed to ensure antibiotic use was appropriate and criteria was met for the treatment of infections. This affected one resident (Resident #78) of two residents reviewed for pressure ulcers. Findings included: Closed record review revealed Resident #78 was admitted to the facility on [DATE] for respite care (discharged from hospice on 05/07/24 to skilled services) with a diagnosis including malignant neoplasm of brain, anxiety, difficulty walking, cognitive communication deficit, delirium, insomnia, hemiplegia, hypertension, chronic ischemic heart disease, weakness, chronic ischemic heart disease, history of malignant neoplasm of the breast, and chronic obstructive pulmonary disease. Review of the emergency room report dated 05/23/24 revealed the resident was seen for hypokalemia and decubitus skin ulcer. The female was a resident of a local skilled nursing facility who presents to the emergency room from the cancer center due to abnormal labs. During the nurse's exam the resident was noted to have a decubitus ulcer to her coccyx. Cultures were obtained and sent (to lab). Area was cleaned and dressed. The resident is being discharged back to skilled nursing facility on Keflex (antibiotic) and clindamycin (antibiotic). Review of the wound culture results that were obtained from the ER visit on 05/23/24 and the results dated 05/26/24 revealed the organisms were Escherichia Coli and Methicillin Resistant Staphylococcus Aureus. The MRSA was resistant to Clindamycin and Keflex was not listed under the E. Coli or MRSA as potential treatment options. Review of the facility's infection control log dated 05/2024 revealed Resident #78's infection was community acquired, meet McGeer Criteria, and was reviewed by the Infection Preventionist (IP). The organism box and isolation box was blank. Review of Resident #78's McGeer Criteria for Infection Surveillance Checklist form dated 05/28/24 and reviewed on 05/30/24 revealed the resident met criteria for having a wound infection as evidence by having pus, heat, redness, swelling, and tenderness. There was handwritten note in the comment section that indicated the left buttocks wound grid (slough, reddened yellow) and diagnosed in the hospital and the resident returned to the facility. There was an additional handwritten note on the bottom of the form that indicated the resident had E. coli and Staphylococcus Aureus. Cephalexin for 10 days discontinued on 05/28/24 and Bactrim DS was added for five days. There was no documented evidence the resident had MRSA or was placed in isolation precautions. Review of Resident #78's paper and electronic medical record revealed no evidence the resident had heat, swelling, or tenderness of the left buttocks. Review of Resident #78's medication administration record dated 05/2024 and 06/2024 revealed the resident received Clindamycin three times daily from 05/24/24 to 05/28/24, Cephalexin (Keflex) four times day from 05/24/24 to 06/02/24, and Bactrim from 05/28/24 to 06/02/24 for a wound infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Forest Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Reservoir Road St Clairsville, OH 43950	

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 9:41 A.M., with the Infection Preventionist (IP) #169 revealed she was not aware of the wound culture results that were obtained on 05/23/24 and resulted on 05/26/24 from the ER visit. The IP confirmed Clindamycin was resistant to MRSA and Keflex was not listed under the MRSA or E.Coli as potential treatment. The IP nurse also confirmed there was no documented evidence the resident had heat, swelling, or tenderness of the left buttocks and would have not met McGeer Criteria for treatment at that time. Review of the facility's policy titled Antibiotic Stewardship undated revealed the facility would implement an antibiotic stewardship program which would promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic uses. This deficiency represents non-compliance investigated under Master Complaint Number OH00156411.