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	01/15/2026

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 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** Based on record review, interview and policy review the facility failed to ensure residents did not receive unnecessary medications. This affected one resident (Resident #61) of 20 residents reviewed for medical record accuracy and one resident (Resident #69) of six residents reviewed for antibiotic use. The facility census was 69.Findings include: 1. Review of Resident #61's medical record revealed an admission date of 08/22/25. Diagnoses included anoxic brain damage, hypertension, epilepsy, insomnia, anxiety disorder, major depressive disorder, history of accidental methadone poisoning, and migraine. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and received anti-convulsant (seizure) and antidepressant medication.Review of a nursing note dated 12/15/25 at 2:15 P.M. indicated Resident #61 returned from a neurology appointment with orders to increase Baclofen to 20 mg twice daily, continue Keppra 1500 mg twice daily, continue Prozac 40 mg daily, start Vistaril 25 mg every 8 P.M., and continue Topamax 100 mg twice daily. The orders were transcribed onto the medication administration record (MAR).Review of the hand-written orders from the neurology appointment, signed by the neurologist and dated 12/15/25 revealed to increase Baclofen (muscle relaxant) to 20 milligrams (mg) twice daily, continue Keppra (seizure medication) 1500 mg twice daily, continue Prozac (antidepressant) 40 mg daily, start Elavil (antidepressant) 25 mg every day at 8 P.M. and continue Topamax (seizure medication) 100 mg twice daily. Review of the December 2025 MAR revealed the resident received Vistaril 25 mg at bedtime from 12/15/25 through and including 12/22/25.Review of a nursing note dated 12/22/25 at 10:02 A.M. indicated the neurologist's office was called to clarify orders. A voice message was left requesting a return phone call at their earliest convenience to request clarification of orders.A nursing note dated 12/23/25 at 1:40 P.M. indicated the neurologist office provided clarification on all orders except Elavil and staff were to wait to start the medication until the office called back with clarification.Review of Resident #61's MAR revealed the Vistaril was discontinued 12/23/25. Review of telephone communication through the Health System to the neurologist dated 12/23/25 revealed the neurologist was informed of the request for clarification of the Elavil. The physician response was dated 01/06/26 and an order was provided to start Elavil 25 mg every night at bedtime. The order was transcribed onto the MAR and started 01/07/26.Interview with the Director of Nursing (DON) on 01/13/26 at 3:03 P.M. revealed she was told two nurses reviewed the orders from 12/15/25 and believed the order was for Vistaril, not Elavil and was transcribed as Vistaril on the MAR (resulting in the resident receiving a medication not ordered by the neurologist). When staff received clarification, the Vistaril was discontinued by the neurologist but it took until 01/06/26 to receive clarification for the Elavil order.2. Review of Resident #69's medical record revealed an admission date of 03/17/25 with admission diagnoses that include vascular dementia, severe protein-calorie malnutrition and congestive heart failure. Further review of the medical record revealed a Minimum Data Set (MDS) 3.0 quarterly assessment which indicated the resident had severe cognitive (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment. Review of the progress notes revealed on 11/22/25 Resident #69 had a fall in the facility and was transferred to the emergency room for further evaluation due to shoulder pain. Nursing notes after return indicated Resident #69 was diagnosed with a urinary tract infection (UTI) and had a new prescription for cephalexin (antibiotic). Review of Resident #69's physician orders revealed on 11/22/25 the resident was prescribed the use of cephalexin 500 milligrams (mg) every eight hours for five days due to a urinary tract infection UTI. Review of the antibiotic assessment completed on 11/23/25 indicated Resident #69 did not meet requirements for use of an antibiotic. Documentation on the assessment further indicated the orders were from the emergency department, the resident's primary physician was notified and advised to await results of the urinary culture. Further review of the medical record found no evidence of any culture results obtained or records from the ER visit on 11/22/25.On 01/14/26 at 1:10 P.M. interview with Registered Nurse (RN) #22 verified Resident #69 did not meet criteria for antibiotic use and the resident's physician said to wait for the urine culture results however, the resident was seen by the nurse practitioner on 11/24/25 and continued on the antibiotic. The RN confirmed the facility was unable to obtain the urine culture results from the ER. Review of the facility policy Antibiotic Stewardship with a revision/update date of 05/2025 revealed no evidence indicating antibiotics are required to meet criteria for use. This deficiency represents noncompliance investigated under Complaint Number 2710158.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, policy review, and interview, the facility failed to implement infection control protocols for residents with orders for Enhanced Barrier Precautions (EBP) and Transmission-Based Precautions (TBP). This had the potential to affect ten (Residents #8, #20, #44, #45, #54, #59, #61, #67, #73 and #78) of 15 residents observed during meal service and one (Resident #9) of one residents observed during administration of medication through a feeding tube.Findings Include: Based on observations, record review, policy review, and interview, the facility failed to implement infection control protocols for residents with orders for Enhanced Barrier Precautions (EBP) and Transmission-Based Precautions (TBP). This had the potential to affect ten (Residents #8, #20, #44, #45, #54, #59, #61, #67, #73 and #78) of 15 residents observed during meal service and one (Resident #9) of one residents observed during administration of medication through a feeding tube.Findings Include:1. During observations of lunch delivery service on 01/12/26, Activity Assistant #75 was observed donning a gown and entering Resident #11's room at 12:38 P.M. No N95 mask, no eye protection and no gloves were donned prior to entrance. Signage posted outside the room indicated Resident #11 was on airborne/contact/droplet precautions. Review of the signage for airborne/contact/droplet precautions indicated prior to entering the room, hands should be cleansed and a gown, an N95 mask, eye protection and gloves should be donned. Upon exiting Resident #11's room, the surgical mask remained on and no hand hygiene was performed. Activity Assistant #75 proceeded to obtain a tray from the meal cart and fluids from a cart with fluids. At 12:41 P.M., Activity Assistant #75 proceeded to Resident #33's room (had signage for airborne/contact/droplet precautions) and entered without donning any eye protection, gown or N95 mask. Upon exiting Resident #33's room, no hand hygiene was performed and the surgical mask was not changed. Activity Assistant #75 resumed obtaining trays from the meal cart and fluids from the fluid cart. At 12:44 P.M., after being instructed by another staff member to don a gown, Activity Assistant #75 donned a gown and entered the room of Residents #47 and #49 (had signage for airborne/contact/droplet precautions). No N95 mask or eye protection was donned. Upon exiting the room, Activity Assistant #75 performed hand hygiene. On 01/12/26 at 12:47 P.M., Activity Assistant #75 verified she had not worn eye protection into any of the COVID identified rooms while delivering trays and stated N95 masks were not required as long as she had a surgical mask applied. Activity Assistant #75 verified she had not worn a gown into Resident #33's room and no hand hygiene was performed when exiting rooms for Residents #11 and #33.