STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366309	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards of East Liverpool, The	709 Armstrong Lane East Liverpool, OH 43920

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 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. Based on observation, review of insulin inserts, interview and review of the facility policy, the facility failed to label and store medication in a manner that enabled staff to know when the medication should be discarded. This affected four (Residents #12, #36, #41, and #60) of five residents who had insulin stored on the [NAME] wing medication cart. The facility census was 45.Findings include:During observations of the medication cart for rooms 21-31 in the long-term care building with Licensed Practical Nurse (LPN) #270 on 12/15/25 at 11:45 A.M., the following medication storage concerns were identified:1. Resident #60 had an open Basaglar insulin (insulin glargine) pen. The pen was not dated with the date it was opened. Review of the Basaglar insulin insert revealed instructions not to use the pen more than 28 days after the pen was first used.2. Resident #41 had an open Lantus Solostar (insulin glargine) pen with no information regarding when it was opened.Review of the Lantus Solostar insert revealed instructions to throw the pen away after 28 days.3. Resident #12 had an open Lantus pen, open insulin Lispro pen and open Liraglutide pen. None of the pens were dated when they were opened.Review of the Lantus and insulin Lispro inserts revealed the pen should be discarded 28 days after opening.Review of the Liraglutide insert indicated it should be used or discarded within 30 days.4. Resident #36 had an open insulin Lispro pen. There was no date recorded when it was opened.On 12/15/25 at 11:45 A.M., LPN #270 verified insulin pens for Residents #12, #36, #41, and #60 were not marked with the date they were opened. LPN #270 stated she believed the pens could be used for 30 days.Review of the facility's Labeling of Medications and Biologicals policy (implemented 01/22/25) revealed labels for multi-use vials must include the date the vial was initially opened or accessed. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure chemical sanitation was completed on kitchen dishes in the rehabilitation unit. This had the potential to affect all ten (Residents #9, #19, #20, #23, #32, #40, #42, #44, #45, and #57) residing on the rehabilitation unit. The facility census was 45. Findings include:Initial tour of the kitchen on [DATE] from 9:13 A.M. to 9:20 A.M. with Dietary Manager #310 revealed the kitchen contained a low temperature dish washer that utilized chlorine for chemical sanitation. Observation on [DATE] at 9:13 A.M. of the chemical sanitation of a dishwasher cycle revealed the test strips did not register the chlorine dilution level 50 to 100 parts per million (PPM) as required. A total of three dishwasher cycles were ran all of which failed to register any chemical dilution level.A review of the Hydrion Chlorine test strips revealed they expired [DATE]. Dietary Manager #310 verified available test strips were all expired. Interview on [DATE] at 9:40 A.M. with Dietary Manager #310 revealed Info Service who was the provider of the test strips was contacted and advised the test strips that were delivered were all expired at which time Dietary Manager #310 was informed that new test strips would be delivered. Interview on [DATE] at 11:08 A.M. with Dietary Manager #310 revealed the facility followed the state guidelines for sanitation. Interview and observation on [DATE] at 11:22 A.M. revealed an Info Service technician reported he was performing preventative maintenance when asked if he was repairing the dishwasher. Interview and observation on [DATE] at 3:10 P.M. with Dietary Manager #310 revealed the Info Service technician provided new testing strips at which time the sanitation dilution level was tested again and found to be 10 PPM. Dietary Manager #310 reported the technician advised the dishwasher was not diluting properly. Dietary Manager #310 verified test strips were provided; however, they were also expired with an expiration date of 06/25.

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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	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure comprehensive assessments of skin impairment were documented for one (Resident #32) of two residents reviewed for non-pressure-related skin impairment. 16 residents were screened for non-pressure skin impairment. The facility census was 45. Findings include:Review of Resident #32's medical record revealed diagnoses including necrotizing fasciitis (also known as flesh-eating disease; is a bacterial infection that affects the tissue under your skin called fascia), Methicillin-Resistant Staphylococcus Aureus (MRSA) infection (type of infection that many antibiotics don't work on), osteomyelitis (serious bone infection), displaced trimalleolar fracture (fracture of the lower leg sections that form the ankle joint and help move the foot and ankle) of the right lower extremity, fracture of the shaft of the right tibia (shin bone), peripheral vascular disease, and local infection of the skin and subcutaneous tissue. Review of Resident #32's admission assessment dated [DATE] revealed there was a [NAME] dressing (compression dressing for temporary stabilization of fractures) to the right ankle which was clean and dry. Documentation revealed staff were unable to view the surgical site related to the dressing. An order for a weekly skin assessment was discontinued on 08/13/25. On 08/22/25, Resident #32 had an appointment with the surgeon, and the [NAME] dressing was removed. A progress note from the appointment revealed dressing changes were ordered for every other day. There was no assessment of the surgical site documented. An order was written to start treatment on 08/24/25 to clean the ankle with normal saline solution and gauze, apply an ABD (abdominal) pad (dressing) and wrap with Kerlix (bandage roll) every night shift every other day for incision and wound management. A skilled nursing note dated 08/24/25 at 9:10 P.M. indicated the surgical incision was well approximated with no drainage. Staples/sutures were intact. A nursing note dated 08/25/25 at 6:55 P.M. revealed the incision was well approximated with no drainage. Subsequent nursing notes on 08/30/25, 08/31/25 and 09/01/25 revealed the incision was well approximated with no drainage noted. On 09/03/25 a skilled nursing note indicated the surgical incision was noted with warmth, redness to the site, purulent drainage and black with an odorous smell. A nursing note dated 09/03/25 at 11:13 A.M. revealed the physician was informed of the findings regarding the surgical wounds and an order was received to admit directly to the hospital. Review of a hospital history and physical dated 09/03/25 indicated there was right ankle swelling and postoperative complications including scabbing and delayed healing with drainage. The nursing facility staff called the surgeon that morning and sent photos that showed necrotic skin over the lateral ankle and dorsum (upper surface) of the foot as well as pressure ulcer on the heel. Resident #32 was admitted to the hospital for a debridement of necrotic skin and incision and drainage and exploration. The history and physical indicated there was thickened eschar over the lateral (outer) aspect of the ankle and a significant sized decubitus (pressure) ulcer over the posterior heel and a pressure ulcer over the medial (inner) aspect of the ankle. There was moderate swelling of the right foot and ankle and some drainage from the lateral incision site. The dorsum of the foot also had some scabbing. The area of the eschar on the lateral side was about 11.0 centimeters (cm) in length and the distal portion having a scab/eschar measured 5.0 cm in width. The medial side blackened skin area measured about 8.0 x 6.0 cm and the dorsum of the foot had small areas of skin necrosis measuring about 4.0 x 3.0 cm. The note indicated Resident #32 had postoperative pressure necrosis of the lateral ankle and the heel with eschar and skin necrosis of the lateral anterior and medial ankle and dorsum of the foot, but the possibility of necrotizing fasciitis was not entirely ruled out. A hospital consultation report dated 09/04/25 indicated Resident #32 was sent to the emergency room (ER) for possible infection. Initially, Resident #32 had a surgical procedure for a trimalleolar ankle fracture on 08/08/25 where the incision became infected so he was sent to the ER for admission and surgical incision and drainage. The wound was debrided 09/03/25 and cultures were in progress. Another (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consultant report only indicated necrotizing fasciitis of the ankle and foot. On 09/29/25 at 10:00 A.M., Resident #32 was observed with a dressing on his ankle. During an interview on 09/30/25 at 2:24 P.M., Licensed Practical Nurse (LPN) #244 stated when she changed Resident #32's ankle dressing on 09/02/25 she observed the top of his foot and outer ankle were black. LPN #244 was unable to recall if there was any impairment on the right heel, stating the whole foot was a mess. LPN #244 stated she was unsure if the condition of the foot was new onset as she had not seen the wound previously. LPN #244 stated she was unable to locate any assessments for comparison. LPN #244 stated she contacted the wound care consultant and Resident #32 was supposed to be seen the next day, which was when the orthopedic doctor was contacted and he was a direct admit to the hospital. After requesting any comprehensive assessments of the surgical site or the foot prior to 09/02/25, Registered Nurse (RN) #275 provided a typed synopsis of information included in the medical record notes on 12/15/25 at 12:35 P.M., acknowledging that was the information the facility was able to locate and it did not include ongoing comprehensive assessments. On 12/15/25 at 4:50 P.M., RN #275 and RN #309 verified no comprehensive assessments were located from the time Resident #32's [NAME] boot was removed on 08/22/25 through 09/03/25. RN #309 stated the foot was being monitored during dressing changes.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to ensure recommendations from pharmacy reviews were addressed in a timely manner. This affected one (Resident #40) of five residents reviewed for medication use and one (Resident #42) of two residents reviewed for antibiotic use. The facility census was 45. Findings include:1. Review of Resident #40's medical record revealed diagnoses including atrial fibrillation, stage 4 chronic kidney disease, severe protein-calorie malnutrition, and gastro-esophageal reflux disease. On 09/09/25 an order was written for protonix (pantoprazole sodium - a proton pump inhibitor that decreases the amount of acid produced in the stomach) 40 milligrams (mg) twice a day. A medication regimen review dated 10/01/25 addressed the use of pantoprazole since 09/09/25. A request was made for the physician to consider changing the frequency of administration to as necessary or changing to another class of acid reducing medication related to increased risk for osteoporosis fracture with long term use of proton pump inhibitors. A nursing note dated 10/18/25 at 2:00 P.M. indicated Resident #40 was discharged home. Further review of the medication regimen review dated 10/01/25 revealed a physician response dated 11/10/25 in which the physician provided an order to discontinue the use of the pantoprazole. On 12/15/25 at 1:20 P.M., Registered Nurse (RN) #275 stated when the pharmacy recommendations were received (and if not urgent) they were placed in a folder for the physician to review during their next visit. Resident #40's attending physician visits varied but he generally visited about every week. RN #275 was unable to state why it took until 11/10/25 for the response or why the physician wrote an order for a resident no longer in the facility. RN #275 stated the physician probably did not realize Resident #40 had been discharged when he responded to the recommendation. Review of the facility's Medication Regimen Review (implemented 01/22/25) revealed the pharmacist was responsible for communicating non-urgent irregularities to the facility via written communication to the attending physician, the facility's medical director, and the Director of Nursing (DON). The irregularities were required to be provided within ten working days of the review. Facility staff were responsible for acting upon all recommendations according to procedures for addressing medication regimen review irregularities. No time frame for non-urgent irregularities was specified. Review of the facility's Addressing Medication Regimen Review Irregularities (implemented 01/22/25) revealed the medication regimen of each resident must be reviewed by a licensed pharmacist at least once a month (or more frequently, as indicated by the resident's condition). The pharmacist must report any irregularities to the attending physician, the facility's medical director, and the DON and the reports must be acted upon. Time frames for physician response were only addressed for irregularities that required immediate action to protect a resident and in relation to residents whose anticipated length of stay was less than 30 days. 2. Review of Resident #42's medical record revealed diagnoses including diaphragmatic hernia, gastro-esophageal reflux disease, and anemia. On 09/05/25 an order was written for pantoprazole sodium 40 mg every day. A medication regimen review dated 10/01/25 addressed the use of pantoprazole since 09/06/25. A request was made for the physician to consider changing the frequency of administration to as necessary or changing to another class of acid reducing medication related to increased risk for osteoporosis fracture with long term use of proton pump inhibitors. There was no response documented. Resident #42 was discharged home on [DATE] but was re-admitted to the facility on [DATE] with the pantoprazole reordered. On 12/16/25 at 10:22 A.M., RN #275 verified there was no evidence that the pharmacist's recommendation regarding the use of pantoprazole had been addressed between 10/01/25 and the date of discharge on [DATE]. RN #275 stated Resident #42 continued to receive pantoprazole 40 mg every day since her readmission on [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, interview and facility policy review, staff failed to wear appropriate personal protective equipment (PPE) while administering medication intravenously (IV) and failed to maintain infection control practices while changing an IV access dressing. This affected one (Resident #42) of four residents observed for medication administration and one (Resident #42) of one resident observed for dressing change. The facility census was 45.Findings include:Review of Resident #42's medical record revealed diagnoses including sepsis (a life-threatening illness that develops when an existing infection triggers an extreme immune system response in the body) and osteomyelitis (infection in a bone). Physician orders included changing the Peripherally Inserted Central Catheter (PICC) line dressing every Monday (ordered 09/06/25) and Vancomycin Hydrochloride (antibiotic) 1.5 grams IV every day (ordered 09/10/25). During observation of medication administration by Licensed Practical Nurse (LPN) #244 to Resident #42 on 09/29/25 between 8:45 A.M. and 8:47 A.M., LPN #244 was observed preparing and initiating Vancomycin 1.5 grams in 500 milliliters (ml) of Normal Saline Solution (NSS) via IV route through a PICC in the left arm. No gown was worn.On 09/29/25 between 11:50 A.M. and 12:00 P.M., LPN #244 was observed changing Resident #42's PICC dressing. No gown was donned. After LPN #244 opened the sterile dressing pack, the sterile gloves were immediately applied and used to remove the old dressing dated 09/22/25, clean the site and apply a sterile dressing.On 09/29/25 at 12:02 P.M., LPN #244 verified there was no order for Enhanced Barrier Precautions (EBP) although Resident #42 had an indwelling medical device. LPN #244 verified she had not used a gown when administering medications through the IV. LPN #244 verified she had not used a mask or gown when changing the PICC line dressing, and she applied the sterile gloves prior to removing the old dressing and kept them on throughout the remainder of the dressing change. Review of the facility's EBP policy (implemented 01/22/25) revealed an order for EBP would be obtained for residents with indwelling medical devices such as central lines even if a resident was not known to be infected or colonized with a multi-drug-resistant organism. Gowns and gloves were to be made available in close proximity to the entrance of the resident's room. High-contact resident care activities included indwelling device care. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound healed or indwelling medical devices were removed.Review of the facility's PICC/Midline/CVAD Dressing Change policy (implemented 01/22/25) revealed after staff performed hand hygiene, he/she was required to don a mask, place a mask on the resident if they could not keep their head turned away, perform hand hygiene again, and set up a clean field on the overbed table with needed supplies for the dressing change. A disposable cloth or linen saver was to be placed on the overbed table then hand hygiene performed prior to opening the sterile dressing change kit and laying out supplies on the sterile field being careful not to contaminate them. The policy indicated hands should be washed again and clean gloves applied. The old dressing was to be removed beginning at the device hub and gently pulling the dressing perpendicular to the skin toward the insertion site. Prior to applying the new dressing, hand hygiene was to be performed and sterile gloves applied.