STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365643	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTSMOUTH HEALTH AND REHAB	727 EIGHTH STREET PORTSMOUTH, OH 45662

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** Based on medical record review, resident and staff interview, and policy review the facility failed to provide ordered treatment to a resident's surgical wound. This affected one of three residents reviewed for skin issues (Resident #146). Findings Include: Review of the medical record for Resident #146 revealed an admission date of [DATE] and a re-entry date of 08/08/20. [DIAGNOSES REDACTED]. Review of the Medicare 5 day Minimum Data Set (MDS) 3.0 assessment, dated 08/15/20, revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating an intact cognition. Resident #146 required extensive assistance from two staff members for bed mobility and extensive assistance from one staff member for transfers, walking in room and corridor, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Resident #146 currently required the use of oxygen and intravenous medication. Resident #146 was noted to have a surgical wound that required the application of a [DEVICE]-assisted closure (vac). Review of the plan of care dated 08/20/20 revealed Resident #146 was at risk for altered skin integrity non pressure, related to actual surgical wound to the abdomen. Interventions include weekly skin inspections, and treatments as ordered. Review of physician orders [REDACTED].#146 with orders for a wound vac to the upper left abdomen to be changed, apply Santyl (a topical ointment used to remove damaged tissue or debridement) to wound bed with each change and as needed every three days. A wet to dry dressing to abdominal wound until wound vac and supplies are available, and [MEDICAL TREATMENT] on Monday, Wednesday, and Friday every week. Review of treatment administration record (TAR) for 08/2020 revealed Resident #146 did not have her wound vac changed as per order on 08/10/20, 08/17/20, 08/19/20, 08/26/20, 08/28/20 and 08/31/20. Continued review revealed the wound vac was changed and documented under an as needed order for 08/11/20. Review of the as needed order for a wet to dry dressing change when the wound vac was not attached revealed this was completed on 08/14/20, 08/17/20, and 08/19/20. Review of the TAR for 09/2020 revealed Resident #146 did not have the ordered wound vac change completed on 09/02/20 due to the resident was admitted to the local hospital and out of the facility. Review of Non-Decubitus Skin Injury weekly measurements for Resident #146 revealed this document was completed on 08/12/20, 08/24/20, 08/31/20, and 09/07/20. Interview on 09/16/20 at 11:59 A.M. with LPN #80 confirmed there was a handful of times when Resident #146 did not have her wound vac changed due to going to her [MEDICAL TREATMENT] appointment. LPN #80 revealed the floor nurse is responsible for completing any scheduled treatment other than on Tuesday when the wound doctor and treatment nurse is in the facility. Interview on 09/16/20 at 2:30 P.M. with Resident #146 revealed she was admitted to the facility due to having a fall at home which caused a fracture to her wrist. Resident #146 revealed when she was in the hospital for her fall, she was noted to have a small pimple like area to her abdomen which was kind of warm and a little painful. The area was noted to be an abscess which was positive [MEDICAL CONDITION]. While at the hospital for her fall, the abscess was cleaned out and a wound vac was put in place. After her hospital stay she was admitted to a skilled nursing facility for therapy. While at this facility she would also have [MEDICAL TREATMENT] completed three times a week which happened to fall on the same days that her wound vac was to be changed. There were many times her wound vac did not get changed because she was out of the facility. Resident #146 continued to reveal that when she was admitted to the local hospital on [DATE], she was informed that it appeared her wound vac had not been changed for awhile. Interview on 09/16/20 at 3:30 P.M. with the Director of Nursing (DON) revealed the facility was informed of the problem concerning Resident #146's wound vac and a Self Reported Incident (SRI) was completed for this occurrence. The DON provided the surveyor with a written description of the investigation and outcome. The DON also included a phone interview completed with a staff nurse identifying Resident #146's wound vac was completed as per order on 08/31/20. Review of the investigation regarding Resident #146's wound vac revealed the facility was informed on 09/03/20 that Resident #146 claimed her wound vac had not been changed for two weeks. An investigation was started immediately. The facility's findings were unsubstantiated due to per interview by a staff nurse and review of wound measurements, Resident #146's wound vac was completed on 08/31/20 prior to going to the hospital. Although there was a breech in standard of practice of providing the treatment as per physician orders, according to the statement of the nurses this was not intentional as there were circumstances that occurred during the shift such as [MEDICAL TREATMENT] treatment with unknown return times. Review of Resident visit summary to the local hospital on [DATE] revealed the resident was seen by the wound doctor during her visit. Interview on 09/16/20 at 4:00 P.M. with the wound treatment facility revealed the physician who treated Resident #146 while she was admitted at the local hospital had entered a progress note related to the visit. The progress note revealed the appearance of Resident #146's surgical wound appeared as though it was not being properly cared for by the facility where she resided. Review of facility policy titled Wound Management Program, revision date of 08/2019, revealed treatment orders will be completed as per physician orders. This deficiency substantiates Complaint Number OH 703.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and facility policy review, the facility failed to ensure residents (with known weight loss) were provided encouragement and assistance during meal time. This affected one (Resident #22) of four residents reviewed for needing assistance during meal time. Findings include: Review of the medical record for Resident #22 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the significant change Minimum Data Set (MDS) 3.0 completed on 06/17/20 revealed a Brief Interview for Mental Status (BIMS) of 09 indicating a moderately impaired cognition. Resident #22 required extensive assistance from one staff member for bed mobility, transfer and toilet use. Resident required supervision with set up help only for eating. Resident #22's noted weight was 74 pounds with a weight loss noted. Review of the plan of care dated 11/18/19 revealed resident may need assistance with daily care and mobility, including feeding and eating, related to [DIAGNOSES REDACTED]. Review of the plan of care dated 01/08/20 revealed the resident was at risk for potential alteration in hydration related to [MEDICAL CONDITIONS], and a decrease in oral intake at times. Intervention included to monitor weight per physician orders, notify the physician of a weight loss or gain, monitor skin turgor, observe for mental status changes, mood, and behavior changes. Review of the plan of care dated 11/14/19 with the revision date of 06/19/20 revealed a risk for weight loss due to [MEDICAL CONDITIONS], protein-calorie malnutrition, and anxiety. Interventions include to provide resident with diet as ordered by physician, provide healthy shakes, smoothies and fortified foods with meals, chocolate or banana pudding for night time snack, and encourage by mouth intake. Review of physician orders [REDACTED]. of the lunch meal revealed residents, including the Resident #22, were provided their meal trays. Resident #22's lunch tray was placed on her bedside table. Staff were not noted to open or assist with setting up the resident's meal tray. Staff did not inform Resident #22 that her meal tray had arrived. Observation on 09/16/20 12:40 P.M. revealed Resident #22 laying on her right side in bed with the head of bed flat. The

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365643	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTSMOUTH HEALTH AND REHAB	727 EIGHTH STREET PORTSMOUTH, OH 45662

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident's bedside table still had her lunch tray. The tray was still covered, the cups and bowls still had their lids on them and the drink was not opened. Observation on 09/16/20 between 12:01 P.M. and 12:48 P.M. of Resident #22 revealed no staff assistance or encouragement provided during this meal time. Resident #22 was noted to remain laying on her right side in bed resting with her eyes closed. Observation on 09/16/20 at 12:48 P.M. revealed staff entering residents rooms to remove their meal trays. Resident #22's meal tray was left on her bedside table. Staff did not encourage the resident to wake up and eat. Interview on 09/16/20 at 12:48 P.M. with State tested Nursing Assistant (STNA) #64 confirmed Resident #22's lunch tray was placed on her bedside table and was not set up for the resident to eat. STNA #64 confirmed Resident #22 was resting with her eyes closed, laying on her right side facing towards the wall. STNA #64 verified Resident #22 needed assistance with meals. STNA #64 stated the meal tray was left there until she felt like eating, if she decided eat. Review of facility policy titled Weight Loss Prevention Program, revision date of 11/2019, revealed staff will implement interventions to prevent weight loss including assistance with meal time and encouraging oral intake. This deficiency substantiates Complaint Number OH 703.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review, the facility failed to provide proper feeding tube care and maintenance. This affected one (Resident #90) reviewed for feeding tube care and maintenance. Findings include: Review of the medical record for Resident #90 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician orders for the month of 09/2020 for Resident #90 revealed an order for [REDACTED]. Cleanse tubing insertion site with soap and water, apply split gauze and apply antibacterial ointment around tube if there are any signs or symptoms of infection. 200 cc of water flushes via feeding tube every shift and 30 cc of water flush before and after administration of medication. Head of bed is to remain elevated at least 35 degrees at all times. Review of Resident #90's significant change MDS 3.0 assessment dated for 06/24/20 revealed the resident with a BIMS of 99 indicating resident with severely impaired cognition. Resident #90 required extensive assistance from two staff members for bed mobility, dressing, toilet use, and extensive assistance from one staff member for transfers and eating. Resident #90 was noted to weigh 79 pounds, and had a feeding tube. Review of the plan of care dated for 06/25/20 revealed the resident was dependent on tube feeding due to inadequate food and beverage intake due to agitation, and Alzheimer's. Observation on 09/16/20 at 11:48 A.M. revealed Resident #90 laying supine in bed with the ordered [MEDICATION NAME] 1.5 cal infusing at 55 cc/hour. The date on the bottle of [MEDICATION NAME] 1.5 cal was 09/15/20 timed at 2:29 P.M. Observation of the tube running from the bottle of [MEDICATION NAME] 1.5 cal, through the feeding pump and to Resident #90's feeding tube revealed a date of 09/14/20 at 2:00 P.M. Interview on 09/16/20 at 11:59 A.M. with Licensed Practical Nurse (LPN) #80 revealed she was not sure how often the feeding tube bottle and tubing was to be changed but she believed it was every 24 hours. She also stated that when staff change the feeding bottle, the tubing is to be changed as well. LPN #80 confirmed the tubing for Resident #90's feeding was dated for 09/14/20 at 2:00 P.M. and the [MEDICATION NAME] bottle was dated for 09/15/20 at 2:29 P.M. LPN #80 revealed the dates and times on the tubing and bottle indicated when they were last changed and replaced with new items. LPN #80 confirmed the tubing was changed over 24 hours ago and also confirmed the bottle of [MEDICATION NAME] was changed but the tubing was not changed at the same time. Interview on 09/16/20 at 2:30 P.M. with the Director of Nursing (DON) revealed the facility's policy stated to change the tubing in a closed system every 48 hours. The DON confirmed when the bottle of [MEDICATION NAME] was changed on 09/15/20, the feeding system was no longer considered to be a closed system as for the tip of the tubing that connects to the bottle of [MEDICATION NAME] is exposed to environmental elements and is now considered to be an opened system. Review of the facility policy Tube Feeding, no date noted, revealed staff are to label the enteral administration set with the date and time that it was first hung. If an open system is used the administration set and tubing can be used continuously for a maximum of 24 hours. Change the open-system every 24 hours to prevent bacterial growth. This deficiency substantiates Complaint Number OH 703.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review the facility failed to ensure a complete and accurate medical record related to completed resident treatments. This affected one (Resident #146) of three residents reviewed for complete and accurate medical records. Findings include: Review of the medical record for Resident #146 revealed an admission date of [DATE] and a re-entry date of 08/08/20. [DIAGNOSES REDACTED]. Review of the Medicare 5 day Minimum Data Set (MDS) 3.0 assessment, dated 08/15/20, revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating an intact cognition. Resident #146 required extensive assistance from two staff members for bed mobility and extensive assistance from one staff member for transfers, walking in room and corridor, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Resident #146 currently required the use of oxygen and intravenous medication. Resident #146 was noted to have a surgical wound that required the application of a [DEVICE]-assisted closure (vac). Review of the plan of care dated 08/20/20 revealed Resident #146 was at risk for altered skin integrity non pressure, related to actual surgical wound to the abdomen. Interventions included weekly skin inspections, and treatments as ordered. Review of physician orders [REDACTED].#146 with orders for a wound vac to the upper left abdomen to be changed, apply Santyl (a topical ointment used to remove damaged tissue or debridement) to wound bed with each change and as needed every three days. A wet to dry dressing to abdominal wound until wound vac and supplies are available, and [MEDICAL TREATMENT] on Monday, Wednesday, and Friday every week. Review of the treatment administration record (TAR) for 08/2020 revealed Resident #146 did not have her wound vac changed as per order on 08/10/20, 08/17/20, 08/19/20, 08/26/20, 08/28/20 and 08/31/20. Continued review revealed the wound vac was changed and documented under an as needed order for 08/11/20. Review of the as needed order for a wet to dry dressing change when the wound vac is not attached did not reveal any documentation of this being completed. Review of the TAR for 09/2020 revealed Resident #146 did not have the ordered wound vac change completed on 09/02/20 due to being admitted to the local hospital and out of the facility. Review of Non-Decubitus Skin Injury weekly measurements for Resident #146 revealed this document was completed on 08/12/20, 08/24/20, 08/31/20, and 09/07/20. Interview on 09/16/20 at 2:30 P.M. with the Director of Nursing (DON) revealed the facility was informed of the problem concerning Resident #146's wound vac and a Self Reported Incident (SRI) was completed for this occurrence. The DON provided this surveyor with a written description of the investigation and outcome. The DON also included the wound vac treatment was completed on 08/31/20 but the nurse who completed it did not document it. A phone interview was completed with that nurse verifying the treatment for [REDACTED]. Review of facility policy titled Wound Management Program, revision date of 08/2019, revealed treatment orders will be completed as per physician orders [REDACTED].
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview and facility policy review, this facility failed to maintain infection control practices during a wound treatment change. This affected one (Resident #38) of the four residents reviewed for proper wound care. Findings include: Review of the medical record for Resident #38 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status score of 06 indicating resident with severely impaired cognition. Resident #38 required extensive assistance from two staff members for bed mobility, transfers and eating. Resident #38 was noted to always be incontinent of bowel and bladder. Resident #38 was noted with a pressure wound to her coccyx which required daily treatment care. Review of Resident #38's physician orders for the month of 09/2020 revealed an order for [REDACTED].M. of Registered Nurse (RN) #80 completing a dressing change for Resident #38's coccyx wound. RN #80 was observed performing proper hand hygiene. As RN #80 continued with the ordered dressing change, RN #80 pulled a pair of scissors out of her pocket and cut a dressing supply to the proper size which would be placed against Resident #38's wound. It was also noted that RN #80 had brought in an open bag of gauze and placed the bag on Resident #38's dresser where she then proceeded to remove a handful of gauze for use. After the dressing was completed, RN #80 was observed taking the same open bag of gauze out of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365643	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTSMOUTH HEALTH AND REHAB	**727 EIGHTH STREET PORTSMOUTH, OH 45662**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) #36's room and placing it back in the treatment cart for future use on other residents. Interview on 09/16/20 at 1:50 P.M. with RN #80 confirmed she did not clean her scissors prior to cutting the clean dressing and also failed to provide a barrier to lay the gauze on and placed it back in the cart for other resident use. Interview on 09/16/20 at 3:10 P.M. with the Director of Nursing (DON) confirmed RN #80 needed to ensure the scissors used were clean and the bag of gauze should have not been returned to the treatment cart. Review of the facility policy, Infection Control, no date, revealed staff are to ensure all infection control procedures are followed to ensure the safety of residents. This deficiency substantiates Complaint Number OH 703.