STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365447	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKVIEW HEALTHCARE CENTER	**214 HARDING STREET DEFIANCE, OH 43512**

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 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** Based on observation, staff interview, medical record review, and review of a facility policy, the facility failed to ensure residents identified at risk for developing pressure ulcers were provided interventions to prevent pressure ulcer development per physician orders. This affected two (#40 and #45) of four residents reviewed for pressure ulcer prevention. The facility identified 55 residents assessed at risk for pressure ulcer development. The census was 65. Findings include: 1. Review of Resident #40's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recently completed Minimum Data Set (MDS) assessment completed on 07/07/20 revealed Resident #40 had severely impaired cognitive skills for daily decision making and required extensive staff assistance with bed mobility, transfers, and dressing. Review of the most recently complete assessment use to determine pressure ulcer risk dated 07/08/20 revealed Resident #40 was at moderate risk for pressure ulcer development. Review of a physician order [REDACTED].#40 was ordered bilateral heel protector boots while in bed and removed when out of bed due to fall risks. Review of the August 2020 treatment administration record (TAR) revealed there was no documentation of Resident #40's heel protector boots applied on 08/10/20, 08/20/20, 08/22/20, and 08/23/20 on the 7:00 A.M. to 7:00 P.M. shift; and on 08/18/20 and 08/23/20 on the 7:00 P.M. to 7:00 A.M. shift. Observation on 08/24/20 at 6:45 A.M. with Stated tested Nurse Aide (STNA) #230 revealed Resident #40 was laying in bed on his back with covers up to his chin. When STNA #230 lifted the covers off Resident #40's feet they were noted to be flat on the bed with no protective boots in place. Further observation revealed the padded boots were laying on the bed next to Resident #40 among other personal items. Observations of Resident #40's heels at this time revealed no redness or skin breakdown present and Resident #40 was free from pain. Interview with STNA #230 on 08/24/20 at 6:45 A.M., while observing Resident #40's feet, confirmed the boots should have been on Resident #40's feet while he was in bed. An interview was attempted with Resident #40, however, he remained non-verbal after questioning. 2. Review of Resident #45's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recently completed MDS assessment dated [DATE] revealed Resident #45 had severe cognitive impairment and was totally dependent on staff for bed mobility, transfers, dressing, and bathing. Review of the most recently completed assessment use to predict pressure ulcer development dated 07/06/20 revealed Resident #45 was a moderate risk. Review of a physician order [REDACTED].#45 was ordered bilateral heel protectors while in bed and remove when out of bed. Review of the August 2020 TAR revealed there was no documentation of Resident #45's heel protector boots applied on 08/10/20, 08/20/20, 08/22/20, and 08/23/20 on the 7:00 A.M. to 7:00 P.M. shift. Observation on 08/24/20 at 7:08 A.M. with STNA #240 revealed Resident #45 was laying in bed on her back with covers up to her chest. When STNA #240 lifted the covers off Resident #45's feet they were observed to be laying in the mattress with no protective boots in place. Further observation revealed the padded boots were laying on a chair next to Resident #45's bed. Observation of Resident #45's heels revealed no redness or skin breakdown present and Resident #45 was pain free. Interview with STNA #240 on 08/24/20 at 7:08 A.M., while observing Resident #40's feet, confirmed the boots should be on Resident #45's feet while she is in bed. An interview was attempted with Resident #45 during the observations, however, Resident #45 was confused and did not answer appropriately to screening questions. Review of a policy titled, Pressure Injury Prevention Guidelines, dated 2020, revealed interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency in which to perform them. When physician orders [REDACTED]. This deficiency substantiates Complaint Number OH 126.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, review of staffing schedules, review of Resident Council minutes, and review of a facility policy, the facility failed to provide adequate staff to ensure residents identified at risk for developing pressure ulcers were provided interventions to prevent pressure ulcer development per physician orders. This affected two (#40 and #45) of four residents reviewed for pressure ulcer prevention. The facility identified 55 residents assessed at risk for pressure ulcer development. The census was 65. Findings include: 1. Review of Resident #40's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recently completed Minimum Data Set (MDS) assessment completed on 07/07/20 revealed Resident #40 had severely impaired cognitive skills for daily decision making and required extensive staff assistance with bed mobility, transfers, and dressing. Review of the most recently complete assessment use to determine pressure ulcer risk dated 07/08/20 revealed Resident #40 was at moderate risk for pressure ulcer development. Review of a physician order [REDACTED].#40 was ordered bilateral heel protector boots while in bed and removed when out of bed due to fall risks. Review of the August 2020 treatment administration record (TAR) revealed there was no documentation of Resident #40's heel protector boots applied on 08/10/20, 08/20/20, 08/22/20, and 08/23/20 on the 7:00 A.M. to 7:00 P.M. shift; and on 08/18/20 and 08/23/20 on the 7:00 P.M. to 7:00 A.M. shift. Interview on 08/24/20 at 6:41 A.M. with State tested Nurse Aide (STNA) #230 the staffing on the secured unit on the night shift was short staffed with typically one nurse aide working the unit on the 10:00 P.M. to 6:00 A.M. shift. STNA #230 identified Resident #40, as well as another resident (#45), was supposed to have padded boots on his feet while he was in bed but they are hardly ever on because the staff members over look it because they are too busy with other aspects of all the residents' care on the secured unit. Observation on 08/24/20 at 6:45 A.M. with Stated tested Nurse Aide (STNA) #230 revealed Resident #40 was laying in bed on his back with covers up to his chin. When STNA #230 lifted the covers off Resident #40's feet they were noted to be flat on the bed with no protective boots in place. Further observation revealed the padded boots were laying on the bed next to Resident #40 among other personal items. Observations of Resident #40's heels at this time revealed no redness or skin breakdown present and Resident #40 was free from pain. Further observation revealed STNA #230 did not place the padded boots on Resident #40's feet as she exited the room and indicated she needed to begin providing care for other residents. Interview with STNA #230 on 08/24/20 at 6:45 A.M., while observing Resident #40's feet, confirmed the boots should have been on Resident #40's feet while he was in bed. An interview was attempted with Resident #40, however, he remained non-verbal after questioning. 2. Review of Resident #45's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recently completed MDS assessment dated [DATE] revealed Resident #45 had severe cognitive impairment and was totally dependent on staff for bed mobility, transfers, dressing, and bathing. Review of the most recently completed assessment use to predict pressure ulcer development dated 07/06/20 revealed Resident #45 was a moderate risk. Review of a physician order [REDACTED].#45 was ordered bilateral heel protectors while in bed and remove when out of bed. Review of the August 2020 TAR revealed there was no documentation of Resident #45's heel protector boots applied on 08/10/20, 08/20/20, 08/22/20, and 08/23/20 on the 7:00 A.M. to 7:00 P.M. shift. Interview on 08/24/20 at 6:57 A.M. with STNA #240 also stated the staffing on the secured unit on the night shift was short staffed with

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.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) typically one nurse aide working the unit on the 10:00 P.M. to 6:00 A.M. shift, and confirmed aspects of resident care are not completed as a result. Observation on 08/24/20 at 7:08 A.M. with STNA #240 revealed Resident #45 was laying in bed on her back with covers up to her chest. When STNA #240 lifted the covers off Resident #45's feet they were observed to be laying in the mattress with no protective boots in place. Further observation revealed the padded boots were laying on a chair next to Resident #45's bed. Observation of Resident #45's heels revealed no redness or skin breakdown present and Resident #45 was pain free. Further observation revealed STNA #240 did not place the padded boots on Resident #45's feet as she exited the room and began providing care on other residents. Interview with STNA #240 on 08/24/20 at 7:08 A.M., while observing Resident #45's feet, confirmed the boots should be on Resident #45's feet while she was in bed. An interview was attempted with Resident #45 during the observations, however, Resident #45 was confused and did not answer appropriately to screening questions. Observation on 08/24/20 at between 7:15 A.M. and 7:49 A.M. revealed Resident #40 and Resident #45 remained in bed with no padded boots on while STNA #230 and STNA #240 continued to provide care to other residents and assist residents with breakfast. Review of facility staffing schedules between 08/17/20 and 08/23/20 revealed on the 7:00 A.M. to 7:00 P.M. shift the facility had at minimum three nurses working, and on the 7:00 P.M. to 7:00 A.M. shift never had less than two nurses working in the facility. On the 6:00 A.M. to 2:00 P.M. shift and the 2:00 P.M. to 10:00 P.M. shift there were between four and five nurse aides working in the facility, and on the 10:00 P.M. to 6:00 A.M. shift no less than three nurses aides with at least one nurse aide always assigned to work the secured unit. Review of Resident Council minutes from 08/06/20 revealed facility residents noted a concern there was a lack of nurse aides and the facility was short staffed. Review of a facility policy from 2020 titled Nursing Services and Sufficient Staff, revealed the facility will provide sufficient staff with appropriate competencies and skills sets to assure resident safety and attain or maintain the highest practicable physician, mental, and psychosocial well-being of each resident. Providing care includes, but is not limited to, assessing, evaluating, planning, and implementing resident care plans and responding to resident needs. Review of a policy titled, Pressure Injury Prevention Guidelines, dated 2020, revealed interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency in which to perform them. When physician orders [REDACTED]. This deficiency substantiates Complaint Number OH 126.