STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365997	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKVUE HEALTH CARE CENTER	3800 BOARDWALK BLVD SANDUSKY, OH 44870

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to notify a resident's representative of a newly developed pressure ulcer. This affected one (#60) of three residents reviewed for pressure ulcers. The facility census was 79. Findings include Review of the closed medical record for Resident #60 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the significant change Minimum Data Set (MDS) assessment, dated 12/28/19, revealed the resident had impaired cognition. Review of the weekly ulcer tracking tool dated 01/11/20 at 9:58 P.M. revealed Resident #60 had a stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer to the sacrum. The area measured three centimeters (cm) in length, two cm in width, and 0.1 cm in depth. The wound was assessed as round, with no tunneling and no undermining. The wound had no odor and the resident had no pain at the time of the wound assessment. The wound had scant serous (thin watery) drainage. The skin surrounding the wound was noted as [DIAGNOSES REDACTED]tous (red) and without maceration (lighter in color and wrinkly). The wound bed color was noted as other with no description. The wound assessment noted granulation tissue was not present in the wound bed. Review of the nurse's notes dated 01/11/20 through 01/30/20 revealed no evidence the resident's representative was notified of the resident's skin break down. Interview on 03/12/20 at 3:04 P.M. with Licensed Practical Nurse (LPN) #275 revealed there was no documentation to support Resident #60's representative was notified of the resident's stage two pressure ulcer. Review of facility policy titled Pressure Ulcer Care, revised 02/01/12, revealed for staff to notify resident and/or family member/responsible party of skin breakdown and document notification in the medical record. This citation substantiated allegations in Complaint Number OH 515.
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 review of the medical record, staff interviews and policy review, the facility failed to accurately assess and monitor pressure ulcer wounds. This affected two (#60 and #63) of three residents reviewed for pressure ulcers. The facility identified eight residents with pressure ulcers. The facility census was 79. Finding include Review of the closed medical record for Resident #60 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the physician order [REDACTED]. Review of the significant change Minimum Data Set (MDS) assessment, dated 12/28/19, revealed the Resident #60 had impaired cognition. Review of the weekly ulcer tracking tool dated 01/11/20 at 9:58 P.M. revealed Resident #60 had a stage two stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer to the sacrum. The area measured three centimeters (cm) in length, two cm in width, and 0.1 cm in depth. The wound was assessed as round, with no tunneling and no undermining. The wound had no odor present. The resident had no pain at the time of the wound assessment. The wound had scant serous (thin watery) drainage. The skin surrounding the wound was notes as [DIAGNOSES REDACTED]tous (red) and without maceration (lighter in color and wrinkly). The wound bed color was noted as other with no description. The wound assessment noted granulation tissue was not present in the wound bed. Continued review of the weekly ulcer tracking tools revealed weekly wound assessments and measurements for the stage two sacral ulcer were not completed from 01/23/20 through the resident's discharge from the facility on 02/05/20. Interview on 03/12/20 at 3:04 P.M., Licensed Practical Nurse (LPN) #275 verified Resident #60 required weekly wound assessments. LPN #275 verified there was no documentation Resident #60's pressure ulcer was assessed after 01/22/20. LPN #275 revealed the resident's wound should have been assessed on 01/29/20 and 02/05/20. Review of facility policy titled Pressure Ulcer Care, revised 02/01/12, revealed to assess pressure ulcer at least weekly for effectiveness of treatment and other pressure ulcer reduction/prevention interventions until pressure ulcer is documented as healed. 2. Review of the medical record for Resident #63 revealed an admitted d of 12/20/19. [DIAGNOSES REDACTED]. Review of the ulcer tracking tool dated 12/20/19 revealed the resident had a stage two pressure ulcer to the coccyx measuring three cm in length by 1.3 cm in width by 0.1 cm in depth. The wound was assessed as irregular with no tunneling, no undermining, no odor present. The surrounding skin was noted as intact. Review of a physician order [REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had impaired cognition. Further review of the assessment revealed the resident required the extensive assistance of two staff for bed mobility, transfers, and toileting. The resident was clinically assessed with [REDACTED]. Further review of the ulcer tracking tools revealed the wound measurements were not completed for the resident on 02/29/20 and 03/07/20. Interview on 03/12/20 at 4:42 P.M., LPN #275 verified the weekly wound measurements were not completed for Resident #63 on 02/29/20 and 03/07/20. Review of facility policy titled Pressure Ulcer Care, revised 02/01/12, revealed to assess pressure ulcer at least weekly for effectiveness of treatment and other pressure ulcer reduction/prevention interventions until pressure ulcer is documented as healed. This deficiency substantiated allegations in Complaint Number OH 515.

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.