STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366410	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST CLARE COMMONS	**12469 FIVE POINT ROAD PERRYSBURG, OH 43551**

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, medical record review and staff interview, the facility failed to ensure pressure relief interventions were consistently implemented to promote skin integrity. This deficient practice affected one (#1) of three residents reviewed for pressure ulcer prevention. The facility census was 56. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE], with the [DIAGNOSES REDACTED]. Review of the minimum data set (MDS) assessment dated [DATE] Resident #1 is identified with severe cognitive impairment, dependent on staff for the completion of activities of daily living, requires two staff for transfer and repositioning, and incontinent of bowel and bladder. The assessment also indicated the resident was at risk for pressure ulcer development with no current skin breakdown. No documentation indicated the facility implemented a plan of care related to the residents risk of pressure ulcer development. Review of physician order [REDACTED]. According to the 12/21/19 assessment the resident was noted with no skin breakdown. No weekly assessment for 13 days and documented on 01/03/20. This assessment revealed Resident #1 was discovered with an unstageable pressure ulcer to the left heel. Review of the wound documentation documented on 01/03/20 at 5:11 P.M., a skin and wound weekly document was initiated. The document recorded a left heel unstageable pressure ulcer measuring 5.4 centimeters (cm) by (x) 8.5 cm with scant serous drainage. The document noted the wound was not present on admission. Review of the nursing plan of care dated 01/03/20 was developed to address the left heel pressure ulcer related to [MEDICAL CONDITION] and immobility. Interventions included assess/record/monitor wound healing per facility policy, report improvements and declines to the physician, alternating air mattress to bed, and gel cushion to wheelchair. Review of physician orders [REDACTED]. Review of the wound documentation dated 02/25/20 noted the heel area to measure 4 cm x 4.5 cm with no drainage and necrotic tissue. Review of the nurses notes on [DATE] at 1:49 P.M., documented the resident was sent out to the hospital for the evaluation of shortness of breath. On [DATE] at 6:42 P.M., the resident was returned from the hospital for treatment of [REDACTED]. Review of the wound specialist notes dated 03/11/20 documented wounds were described as follows: left great toe vascular in nature full thickness ulceration measures 2 cm x 2.5 cm x 0.1 cm no drainage. Left heel pressure injury unstageable full thickness ulceration measuring 4.8 cm x 5 cm x 0.1 cm no drainage. Left lateral foot proximal vascular measures 2 cm x 1.5 cm x 0.1 cm with no drainage. Left lateral foot distal vascular in nature measuring 1.3 cm x 1.8 cm x 0.1 cm no drainage. The wound specialist ordered a vascular consultation for non-healing wounds to the left lower extremity. Additionally, soft heel suspension boots, elevate bilateral lower extremities on pillow when in bed and discontinue skin prep treatment to left foot ulcers. Observation on 0[DATE] at 7:50 A.M. and 8:59 A.M., identified the resident in bed with the air mattress operational. The resident had slip resistant socks to both feet. No pressure relief boots were in place and the residents feet were resting on the mattress without elevation. At 9:50 A.M., observation and interview with Licensed Practical Nurse (LPN) #201 during an observation of the residents heels noted the socks removed and the left sock soiled with drainage. The residents left heel was resting on the mattress with blood tinged drainage on the cover sheet. Further interview with LPN #201 at the time verified the resident did not have a current treatment to the left heel wound and lacked the pillows or soft heel suspension boots. Interview on 0[DATE] at 2:55 P.M., with the Director of Nursing verified no skin assessment was conducted between 12/21/19 and 01/03/20, and the area was discovered as an unstagable pressure ulcer on 01/03/20. Additional interview verified pressure relief devices to the bilateral lower extremities were to be applied as ordered and were not. This deficiency substantiates Complaint Number OH 740.

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