STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365786	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA GEORGETOWN REHABILITATION AND HEALTHCARE CEN	8065 DR FAUL ROAD GEORGETOWN, OH 45121

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 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to manage his or her financial affairs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to have written authorization to handle a resident's personal funds. This affected one (Resident #8) of five residents reviewed for resident accounts. The facility identified 37 residents with personal funds account. The facility census was 70. Findings include: Review of Resident #8's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident was severely cognitively impaired. Review of the undated 'Resident Fund Management' services form on 03/12/20 at 3:16 P.M. revealed there was not a signature for the facility to handle Resident #8's funds. Review of Resident #8's Resident Statement Landscape on 03/12/20 revealed her account was opened on 01/20/20 and had a current balance of $969.04. Interview with Business Office Worker #88 on 03/12/20 at 3:16 P.M. verified Resident #8's account was opened since 01/20/20 and the facility did not have a signed authorization to handle the funds.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facilities policy review, the facility failed to update and revise a resident's care plans. This affected one (Resident #226) of 20 residents reviewed for care plan accuracy. The facility census was 70. Findings include: Review of the medical record for Resident #226 revealed a re-admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the nursing re-admission assessment, dated 03/05/20, revealed Resident #226 had two stage one pressure ulcers to the left and right buttock (intact skin with non-blanchable redness of a localized area), and three unstageable pressure areas (full thickness tissue loss in which the base of the ulcer is covered by slough or eschar in the wound bed) to the left great toe and to the left and right heels. Review of the wound assessment, dated 03/05/20, revealed Resident #226 had an unstageable area to the left great toe, an unstageable area to her right heel and had a stage two pressure ulcer to his left buttock. There was a reddened area surrounding to her buttocks measuring 9.0 cm. by 2.0 cm. Review of the admission Minimum Data Set (MDS) assessment, dated 03/09/20, revealed Resident #226 had moderate cognitive deficits, had presence of stage two pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, and may present as an intact or open/ruptured blister) and two deep tissue injuries (classified as purple or maroon area of discolored intact skin due to damage of underlying soft tissue) that were all present upon readmission. The MDS assessment showed the resident had deteriorated to two stage two pressure ulcers vs. the readmission nursing assessment and the initial wound assessment on 03/05/20 stated two stage one pressure ulcers. Review of the care plans revealed Resident #226 had a potential for impaired skin integrity related [MEDICAL CONDITION], alcohol dependence, hypertension, [MEDICAL CONDITION], malnutrition, and long term smoking. Resident #226 had a care plan in place for a skin tear to the left forearm and knee. There was no mention in the care plan of Resident #226 having actual skin breakdown with pressure ulcers noted. Interview on 03/12/20 at 3:22 P.M. with Registered Nurse (RN) #71 verified Resident #226's pressure ulcers were not care planned. Review of facilities Care Plan Policy, dated August 2014, revealed the resident's care plans are reviewed and revised by the interdisciplinary team quarterly, following completion of the MDS assessment, and following assessment for significant change. The care plan is individualized by identified resident problems, unique characteristics, strengths, and individual needs.
F 0686 **Level of harm** - 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, staff interview, review of the facility's policy and review of the information from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to ensure timely treatments, interventions, and assessments were done for a resident's pressure ulcers. This resulted in actual harm when Resident #226's pressure ulcers to his bilateral heels and sacrum deteriorated in condition and increased in size from the delay in treatment. This affected one (Resident #226) of two residents reviewed for pressure ulcers. The facility identified three residents with pressure ulcers. The facility census was 70. Findings include: Review of the medical record for Resident #226 revealed a re-admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the nursing re-admission assessment, dated 03/05/20, revealed Resident #226 had two stage one pressure ulcers (intact skin with non-blanchable redness of a localized area) to the left and right buttocks and three unstageable pressure areas (full thickness tissue loss in which the base of the ulcer is covered by slough or eschar in the wound bed) to the left great toe and to the left and right heels. Review of the wound assessment, dated 03/05/20, revealed Resident #226 had an unstageable area to the left great toe upon re-admission described as reddened with no drainage and measured 1.2 centimeters (cm.) in length by 0.6 cm. in width. The resident had an unstageable area to her right heel described as dry with no drainage and measured 3.0 cm. in length by 1.4 cm. in width and had an unstageable area to her left heel described as dry with no drainage and measured 3.0 cm. in length by 2.0 cm. in width. The resident had a stage two pressure ulcer to his left buttock described as pink and dry with no drainage and measured 1.0 cm. in length by 0.6 cm. in width and 0.2 cm. in depth. There was a reddened area surrounding to her buttocks measuring 9.0 cm. by 2.0 cm. Review of the physician orders, dated March 2020, revealed on 03/05/20, there were orders to turn every two hours, house barrier ointment after each incontinent episode, and [MEDICATION NAME] skin barrier to buttocks every shift for the pressure ulcer. On 03/06/20, there were orders to float the heels when in bed and a low air loss mattress for wound management when authorization approved. On 0[DATE], there were new orders for a low air loss mattress to the bed and to monitor both heels and apply skin prep every shift and leave open to air. There were no treatments for the heels upon readmission until five days later, on 0[DATE] and there were no treatments for the area to the left great toe. Review of the admission Minimum Data Set (MDS) assessment, dated 03/09/20, revealed Resident #226 had moderate cognitive deficits, had presence of stage two pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, and may present as an intact or open/ruptured blister) and two deep tissue injuries (classified as purple or maroon area of discolored intact skin due to damage of underlying soft tissue) that were all present upon readmission. The MDS assessment showed the resident had deteriorated to two stage two pressure ulcers versus the readmission nursing assessment and the initial wound assessment on 03/05/20, which stated two stage one pressure ulcers. Review of the treatment administration record (TAR), dated March 2020, revealed the nurses were not documenting any treatments or monitoring of any wound areas until 0[DATE]. On 0[DATE], the nurse began to monitor both heels and apply skin prep every shift and began treatment of [REDACTED]. On 03/11/20, the nurse began to monitor the area to the left big toe and applied skin prep every shift for wound healing. Review of the certified nurse practitioner note, dated 0[DATE], revealed Resident #226 was admitted back to the facility with ulcerations to the bilateral heels and excoriation to the sacrum. He had unstageable areas to the left and right heels and a rash to the sacrum. There was no mention of an area to

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) the left great toe. Review of the wound assessment, dated 0[DATE], revealed Resident #226 had unstageable area to the right heel described as necrotic tissue and black in color with measurements of 2.5 cm. in length by 4.5 cm. in width. The width had increased in size since the last measurement on 03/05/20 and now it was necrotic. The unstageable area to the left heel was described as necrotic and black in color and measured 3.0 cm. in length by 5.0 cm. width. The width was larger from 3.0 cm. on 03/05/20 and now was necrotic. The stage two pressure ulcer to the sacrum now had 25 percent slough to the wound bed. There were no measurements for the area to the left great toe. Observations on 0[DATE] at 9:47 A.M., at 3:32 P.M., and 5:51 P.M. of Resident #226 revealed he was resting in bed with his eyes closed. He had his feet laying directly on the bed and not elevated and there were no pillows to the foot of the bed or on the floor beside the bed. Interview and observation on 0[DATE] at 5:51 P.M. with Registered Nurse (RN) #130 verified Resident #226 did not have his feet elevated off his bed. He stated he may have kicked his pillows off. Observation of his heels with RN #130 revealed they were dark purple in color and his left great toe was reddish purple in color. He was laying on his bottom and there was no observation of his sacrum wound was done at this time. RN #130 stated he had just been in earlier to assess him and he needed to get him a different treatment and better positioning. Interview on 03/12/20 at 2:08 P.M. with the Director of Nursing (DON) stated Resident #226 had been sent out to the hospital that morning due to complications from his trach. He verified the treatments for his bilateral heels were not started until 0[DATE] because they were just to keep them elevated prior to the initiation of treatment because they were 'reabsorbing'. He verified there was no further documentation, treatment or assessment for the pressure ulcer to the left great toe stating he was under the understanding it was 'reabsorbing'. He verified the wound measurements for the pressure ulcers to his bilateral heels and sacrum had grown bigger and deteriorated in condition. He stated the nurse may have documented wrong upon admission because he was not a certified wound nurse. He verified the wound assessments for the bilateral heels were done on 0[DATE] and revealed they were necrotic, and the sacrum wound had the presence of slough. He stated he was seen by nurse practitioner on 0[DATE]. Review of the facility's undated policy titled Best Practice Guidelines Skin Management Process Policy revealed residents identified having active skin issues will have a routine assessment and interdisciplinary team review and care plan implemented to maintain and or improve skin integrity. Review of the information from the NPUAP revealed a deep tissue pressure injury is intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage Three or Stage Four). Do not use deep tissue pressure injury to describe vascular, traumatic, neuropathic, or dermatologic conditions. Further review of the NPUAP revealed staff should assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices, implement interventions to ensure that the heels are free from the bed and use heel offloading devices or [MEDICATION NAME] foam dressings on individuals at high-risk for heel ulcers.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview and policy review, the facility failed to timely dispose controlled substances after resident's were discharged . This affected two (#230 and #229) of three controlled substance medication administration records reviewed. Facility census was 70. Findings include: Review of Resident #230 medical record, revealed an admission date of [DATE]. [DIAGNOSES REDACTED].#230 on respite care and discharged to home on [DATE]. Review of discharged Resident #230 medication administration record (dated February 2020) on [DATE], revealed last documented dose of controlled substance on [DATE] at 9:10 A.M., leaving four tablets of [MEDICATION NAME] in the blister pack. Review of Resident #229 medical record, revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. Resident #229 passed away at facility on [DATE]. Review of discharge Resident #229 medication administration record (dated for February 2020) on [DATE], revealed last documented dose of controlled substance on [DATE] at 10:19 A.M., leaving approximately 26 milliliters (ml) of liquid [MEDICATION NAME] in the bottle. Observation of locked controlled substance drawer in East unit medication cart with Licensed Practical Nurse (LPN) #52 on [DATE] at 9:55 A.M., revealed Resident #230 blister pack of [MEDICATION NAME] and Resident #229 liquid [MEDICATION NAME] was in drawer. Interview with LPN #52 on [DATE] at 9:55 A.M., verified both Resident #230 and Resident #229 no longer resided at facility. LPN #52 stated the nursing staff notify the Director of Nursing (DON) when residents are discharged with controlled medications requiring disposal. LPN #52 did not know if the DON had been notified of the discharged residents. Interview with DON on [DATE] at 10:21 A.M., verified that the nursing staff notifies her of resident discharge and controlled medication disposal. DON stated she wasn't aware of two (#229 and #230) residents with controlled substances requiring disposal. Interview with DON on [DATE] at 10:21 A.M., verified that the nursing staff notifies her of controlled medication requiring disposal. DON stated she wasn't aware of any residents with controlled substances requiring disposal. Review of facility policy titled Disposal/Destruction of Expired or Discontinued Medications dated [DATE], revealed controlled medications are not to be returned to the pharmacy, but disposed by a Registered Nurse and witness who holds a professional license, the controlled medication is to be signed-off and amount destroyed is to be documented on the MAR.
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 and staff interview, the facility failed to timely respond to monthly pharmacy recommendations. This affected two (#74 and #75) of five residents reviewed for pharmacy recommendations. Facility census was 70. Findings include: 1. Record review of Resident #74 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the 02/25/20 quarterly Minimum Data Set (MDS) revealed Resident #74 was cognitively intact and required total dependence for bed mobility, transfer, and toilet use, She required extensive assistance for personal hygiene, dressing and locomotion off unit. Review of the 12/13/19 Monthly Pharmacy Review revealed Resident #74 was prescribed [MEDICATION NAME] (an antiemetic drug) for treatment of [REDACTED]. The form was not seen by the physician until 02/26/20. and agreed to discontinue the medication. 2. Record review of Resident #75 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the the 01/27/20 quarterly MDS revealed the Resident #75 was severely cognitively impaired and required extensive assistance for bed mobility, transfer, dressing, personal hygiene and toilet use. Review of 12/13/19 Monthly Pharmacy Review revealed the Resident was due for a semi annual [MEDICATION NAME] (antidepressant) gradual dose reduction. The physician did not answer the recommendation until 02/26/20. Interview with the Director of Nursing (DON) on 03/12/20 at 10:27 A.M. verified the pharmacy recommendation for Resident #74 and #75 dated 12/13/19 was not addressed until with the physician until 02/26/20.