STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366253	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMBERWOOD MANOR	245 SOUTH BROADWAY NEW PHILADELPHIA, OH 44663

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 medical record review and interview, the facility failed to identify resident skin impairment and seek treatment options in a timely manner. This affected one (Resident #45) of one resident identified with pressure ulcers during review of three residents with accidents. Findings include: Review of Resident #45's medical record revealed [DIAGNOSES REDACTED]. A nursing note dated 05/04/20 at 9:16 A.M. indicated a state tested nursing assistant (STNA)stated Resident #45 rolled out of bed while being washed. Resident #45 was found lying on her stomach with her head against the dresser. A nursing note dated 05/21/20 at 2:45 P.M. indicated a state tested nursing assistant reported Resident #45 was having significant pain in her right knee during care and repositioning. The physician ordered a right knee x-ray. A nursing note dated 05/21/20 at 6:44 P.M. indicated the x-ray results revealed a displaced and comminuted fracture (A comminuted fracture is a break or splinter of the bone into more than two fragments.) involving the transcondylar distal femur. There was extensive soft tissue swelling and osteopenic changes as well as [MEDICAL CONDITION] changes of the knee joint. The x-ray results indicated the age of the fracture was indeterminate but was likely recent. A nursing note dated 05/21/20 at 8:10 P.M. indicated at 7:45 P.M., Resident #45 was sent to the hospital to be evaluated. An Emergency Department report dated 05/21/20 revealed instructions to keep the splint clean and as dry as possible. Emergency Department Instructions revealed a recommendation to call an orthopaedic doctor or assigned managed care physician for follow up. A Departure skin check dated 07/28/20 at 10:50 A.M. indicated Resident #45 had a cast and wrap from the fracture and groin and breast skin folds were excoriated with redness fungal rash. Review of a visit note from the orthopedic doctor dated 07/28/20 indicated Resident #45 had an area measuring 3 x 3 centimeters (cm) of dry eschar (dead tissue) on the back of the right heel, possibly full thickness. The note indicated Resident #45 also had an area measuring 10 x 5 cm of partial thickness soft tissue breakdown with a bed of granulation tissue (Granulation tissue is new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process.) on the anterolateral (in front and to the side) right lower leg. The visit note indicated a recommendation for wound care for right lower leg and heel wounds. A Return skin check dated 07/28/20 at 2:00 P.M. revealed Resident #45 had a rash and redness (location not documented) and the presence of an ace wrap on the right lower extremity which was placed during the doctor visit. The assessment indicated the cast that had previously been worn was removed. A bi-weekly skin check dated 07/30/20 indicated there were no newly identified skin issues. A bi-weekly skin assessment dated [DATE] indicated there was a red area from the cast rubbing against the skin. There was no documentation regarding skin impairment on the heel. On 07/30/20 at 4:28 P.M. and on 08/03/20 at 10:07 A.M., a surveyor request was made to have the notes from the orthopaedic visit sent. On 08/03/20 at 12:07 P.M., Regional Clinical Nurse #150 stated the orthopaedic note was filed in the chart without being reviewed and staff were going to assess Resident #45's skin. On 08/03/20 at 12:34 P.M., during interview, Licensed Practical Nurse (LPN) #105 stated she was not aware of any skin impairment of the heel until 08/03/20 and she did an assessment. The heel had black eschar and an order was received for skin prep for treatment. When asked about the anterolateral leg skin breakdown referred to in the orthopaedic notes, LPN #105 stated there was no impairment noted. Review of two weekly wound assessment forms dated 08/03/20 indicated Resident #45 was assessed with [REDACTED]. The abrasion was described with a pink wound bed and was identified 08/03/20. This deficiency is cited as an incidental finding to Complaint Number OH 512
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to prevent a resident (who required extensive assistance of two staff for bed mobility and bathing) fall during the delivery of personal care. This resulted in actual harm on 05/04/20 when Resident #45 was being assisted by one staff and rolled out of bed from a height of three feet which resulted in a right femur fracture. This affected one (Resident #45) of three residents reviewed for accidents. Findings include: Review of Resident #45's medical record revealed [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #45 required extensive assist of two staff for bed mobility and was dependent for bathing with two staff assist. A nursing note dated 05/04/20 at 9:16 A.M. indicated a state tested nursing assistant (STNA) stated Resident #45 rolled out of bed while being washed. Resident #45 was found lying on her stomach with her head against the dresser. A nursing note dated 05/21/20 at 2:45 P.M. indicated an STNA reported Resident #45 was having significant pain in her right knee during care and repositioning. The physician ordered a right knee x-ray. A nursing note dated 05/21/20 at 6:44 P.M. indicated the x-ray results revealed a displaced and comminuted fracture (A comminuted fracture is a break or splinter of the bone into more than two fragments.) involving the transcondylar distal femur. There was extensive soft tissue swelling and osteopenic changes as well as [MEDICAL CONDITION] changes of the knee joint. The x-ray results indicated the age of the fracture was indeterminate but was likely recent. Review of the facility's investigation included a form titled, Falls: In the event of a fall, you must do the following:, indicated interventions in place prior to the fall included bilateral grab bars on the bed and staff had to assist with all mobility. A Post Fall Huddle Fall Scene Investigation dated 05/04/20 revealed the root cause of the fall was to be investigated by asking three times why a resident fell . Entries to this question revealed: rolled too far over during the bath (did not indicate if staff rolled the resident or if the resident rolled herself). The second entry indicated the fall occurred because one STNA was providing care/bed bath. The third entry indicated Resident #45 was a total care with bathing. The Post Fall Huddle Fall Scene Investigation indicated Resident #45 fell from the bed to the floor, approximately 36 inches height. The investigation asked if all interventions were in place, why the fall occurred. The nurse documented: rolled too far over in bed while STNA (state tested nursing assistant) was bathing her. STNA #135 wrote a witness statement which indicated she was changing Resident #45 and she rolled to the side but rolled too far and fell off the bed. A statement by the Director of Nursing (DON) indicated on 05/04/20, at approximately 8:40 A.M., she was notified of Resident #45's fall. The DON documented when she asked STNA #135 what happened, STNA #135 stated as Resident #45 was rolling to her right side during her bath Resident #45 did not stop herself by holding onto the assist bar as she usually did. STNA #135 stated Resident #45 continued to roll all the way out of bed onto the floor. Review of the emergency room report revealed a note by a registered nurse (RN) from the hospital dated 05/21/20 at 8:06 P.M. which indicated according to the nursing home Resident #45 had a fall on 05/04/20 when she was rolled over in the bed and fell out due to not having enough staff assistance at the facility. On 08/03/20 at 10:48 A.M., during interview, STNA #135 stated Resident #45 was totally dependent on staff for activities of daily living. STNA #135 stated prior to the fall on 05/04/20, Resident #45 was able to roll herself in bed, stating she would use her leg to push herself over. On 05/04/20 when the fall occurred, Resident #45's leg slipped and she fell . STNA #135 stated the fall occurred so quickly she wasn't sure but she may have given Resident #45 a little push.

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) STNA #135 stated the bed was raised as she was providing care to Resident #45 and stated she had provided the same type of assistance to Resident #45 multiple times with no safety concerns. On 08/03/20 at 11:03 A.M., during interview, STNA #140 stated prior to Resident #45's fall she was able to use the grab bar and help turn herself but was unable to turn herself independently. On 08/03/20 at 11:15 A.M., during interview, STNA #100 stated prior to Resident #45's fall she could turn with one assist with the use of bed rails but required staff assistance. On 08/03/20 at 1:57 P.M., during interview, Licensed Practical Nurse (LPN) #145 stated prior to Resident #45's fall on 05/04/20 she would grab the rail and hold herself in position but could not turn independently. LPN #145 stated Resident #45's care could be provided by one assist prior to the fall but there were times, especially if she had an urinary tract infection, when she required two staff assist. This deficiency is cited as an incidental finding to Complaint Number OH 512.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, review of product labels, interview, and policy review, the facility failed to adhere to infection control policies in areas of isolation, hand hygiene, screening visitors, and environmental and equipment disinfection. This affected Residents #10, #15, #70 and had the potential to affect all 40 residents. Findings include: 1. On 07/29/20 at 7:05 P.M., a sign noted on the entry door revealed instructions not to enter until screened. State tested Nursing Assistant (STNA) #100 opened the inner entry door which was locked. When informed of the purpose of the surveyor's visit STNA #100 had the surveyor wait while he informed Licensed Practical Nurse (LPN) #105 of the visit. At 7:08 P.M., LPN #105 walked into the vestibule and was given an explanation for the visit. LPN #105 motioned for STNA #100 to use the key code on the wall and open the inner door. LPN #105 was asked if she needed to screen the surveyor prior to entry before doing so. After surveyor intervention, LPN #105 screened the surveyor prior to entrance. Review of the Facility Entry Screening for COVID 19 policy, revised 03/20/20, revealed all visitors, employees, providers and anyone else requesting entry to the facility would be actively screened before each entry into the building. 2. On 07/29/20 at 7:15 P.M., an isolation cart was observed in the hall outside Resident #15's room. There was no sign indicated staff should see the nurse or a sign indicating what type of isolation was required. On 07/29/20 at 7:22 P.M., LPN #110 stated Resident #15 was on isolation precautions due to being a new admit to monitor for signs of COVID 19. Review of Resident #15's medical record revealed an admission date of [DATE]. On 07/29/20 at 7:41 P.M., during interview, the Director of Nursing (DON) confirmed there was no sign posting what type of isolation was needed when entering Resident #15's room. Review of the facility's Transmission-Based Precautions policy, revised 03/24/20, revealed a sign was to be placed on the door frame of the resident's room indicating visitors should stop at the nurse's station before entering. 3. Review of Resident #10's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. A daily skilled nursing note dated 07/22/20 at 9:00 A.M. indicated Resident #10 was on droplet precautions to monitor for COVID 19 due to being a new admission. On 07/29/20 at 7:15 P.M., a sign on Resident #10's door indicated Resident #10 was on droplet isolation precautions and an isolation cart was in the hall outside Resident #10's room. STNA #115 was observed in Resident #10's room standing directly next to the bed offering her a snack. STNA #115 was also observed handling the wheelchair next to the bed with both hands and touching the overbed table. STNA #115 was not observed performing hand hygiene prior to leaving Resident #10's room. STNA #115 then left the room and held onto the snack cart with both hands and started to push it in the hall. STNA #115 had a glove on one hand. STNA #115 was interviewed at that time and stated she had changed gloves prior to leaving the room. STNA #115 verified she should have performed hand hygiene after touching inanimate objects in Resident #10's environment. Review of the facility's Hand Hygiene/Handwashing policy, revised October 2019, revealed hand washing was the most important component for preventing the spread of infection. Use of gloves did not replace the need for hand cleaning. The policy indicated hand hygiene was to be performed after removing gloves and after contact with inanimate objects in the immediate vicinity of the resident. 4. On 07/30/20 at 6:55 A.M., STNA #120 was interviewed regarding how staff disinfected the environment and/or equipment. STNA #120 stated staff used the Triple Quick disinfecting cleaner. The disinfectant was sprayed on and wiped off. STNA #120 was not aware of any requirements for contact time of the disinfectant with the item being disinfected. The label was reviewed with STNA #120 who verified the label indicated when used on environmental inanimate hard surfaces the disinfectant exhibited viracidal activity against human coronavirus ([DIAGNOSES REDACTED] associated coronavirus) with a contact time of two minutes. 5. On 07/30/20 at 7:03 A.M., Housekeeper #125 was interviewed about the cleaning/disinfection protocols implemented to protect against COVID 19. Housekeeper #125 stated the facility used Triple Quick disinfectant and stated the contact time was one minute. During review of the product label of the Triple Quick with Housekeeper #125, she verified the label indicated a two minute contact time was required to be effective against coronavirus associated with [DIAGNOSES REDACTED]. 6. On 07/30/20 between 7:21 A.M. and 7:37 A.M., LPN #130 was observed administering medication. At 7:21 A.M., LPN #130 entered Resident #70's room with medications and equipment used to monitor vital signs. Resident #70 indicated his deodorant had fallen on the floor. LPN #130 picked the deodorant up and placed it in a basket that was placed on the bed. The basket and a radio were then placed on the overbed table in front of Resident #70. LPN #130 was observed using the equipment she had taken into the room to monitor Resident #70's temperature, blood pressure and pulse oximetry level. LPN #130 was also observed moving the items she had placed on the table back to the bed upon Resident #70's request. Prior to leaving the room, LPN #130 went into the bathroom to wash her hands. The technique used in washing her hands was less than ten seconds. At 7:30 A.M., LPN #130 obtained vital signs for Resident #75 without disinfecting the equipment. At 7:37 A.M., LPN #130 administered medication to Resident #75. Before leaving Resident #75's room, LPN #130 washed her hands for 8.18 seconds. On 07/30/20 at 7:40 A.M., LPN #130 was shown the timer used when she washed her hands and she did not refute the findings. LPN #130 verified she did not disinfect the equipment used to gather vital signs between residents even though she had picked items up off the floor and handled other inanimate objects before taking the vital signs for Resident #70 without washing her hands between the time the items were handled and the vital signs were obtained. Review of the facility's Hand Hygiene/Handwashing policy, revised October 2019, revealed hand washing was the most important component for preventing the spread of infection. The policy indicated hand hygiene was to be performed before and after direct contact with residents and after contact with inanimate objects (including medical equipment) in the immediate vicinity of the residents. The hand washing method including rubbing hands together using friction for 20 seconds.