STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365046	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEFIORE HOME THE	ONE DAVID N MYERS PARKWAY BEACHWOOD, OH 44122

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure Resident #92's call light was within reach. This affected one of 36 sampled residents. The facility census was 222. Findings include: Review of the record revealed Resident #92 was admitted on [DATE] with [DIAGNOSES REDACTED]. The care plan for falls dated 03/09/17 indicated the resident had interventions including non-skid socks when up out of bed, restorative referral, lay resident down after meals, and be sure the resident's call light is within reach and encourage her to use it for assistance. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #92 had severe cognitive deficits with short and long-term memory impairments. The resident had no behaviors, no refusal of care, and required extensive assistance for bed mobility, transfers, toilet use, and locomotion on the unit. On 03/02/20 at 11:00 A.M., an observation revealed Resident #92 was lying in bed. She had the bed control to raise and lower her bed in her hand. The call light cord and call button were on the floor next to her bed. On 03/02/20 at 2:35 P.M., Resident #92 was lying in bed. The call light cord and call button were on the floor next to her bed. On 03/02/20 at 3:22 P.M., Resident #92 was in her room. She was calling out, Mama, mama. An observation revealed the resident was lying in bed with the call light cord and call button on the floor next to her bed. The surveyor informed the state tested nursing assistant the resident needed assistance. On 03/03/20 at 9:19 A.M., an observation revealed Resident #92 was seated in a recliner in her room. Her call light cord and call button were across the room attached to the grab bar about six feet away from the resident. On 03/03/20 at 10:03 A.M., Resident #92 remained seated in the recliner. Her call light cord and call button were across the room on the grab bar. On 03/03/20 at 11:31 A.M., an observation revealed Resident #92 remained seated in the recliner. Her call light cord and call button remained on the grab bar. On 03/03/20 at 4:29 P.M., Resident #92 was lying in bed. Her call light cord and call button were on the floor next to the resident's bed. On 03/04/20 at 7:01 A.M., an observation revealed Resident #92 was seated in a recliner in her room. Her call light cord was attached to her grab bar about six feet away from the resident. On 03/04/20 at 2:48 P.M., the surveyor and Nurse Manager #203 were standing in the hallway when State tested Nursing Assistant (STNA) #179 was observed coming out of Resident #92's room carrying a trash bag. At 2:49 P.M., an observation of Resident #92 revealed she was lying in bed with her call light cord and call button on the floor next to the bed. During an observation and interview at 2:50 P.M., Nurse Manager #203 confirmed Resident #92's call light cord and call button were on the floor next to the resident's bed. The nurse manager repositioned the call light so it was within reach of Resident #93.
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, interview, and record review, the facility failed to ensure interventions were in place for Resident #219's pressure ulcers as ordered. This affected one of seven residents reviewed for pressure ulcers (Residents #35, #41, #78, #170, #190, #200, and #219). The facility identified 16 residents as having pressure ulcers. Finding include: Review of the record revealed Resident #219 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set 3.0 assessment dated [DATE] indicated she had severe cognitive deficits and required extensive assistance with bed mobility, transfers, and walking. Review of the Braden Scale for Predicting Pressure Sore Risk dated 10/03/19 indicated she was at high risk for the development of pressure sores. Review of a progress note dated 11/15/19 indicated the nurse observed Resident #219 to have purplish-black colored area to both heels. The resident reported the areas were slightly painful. On 11/15/19, the nurse practitioner ordered a wound consult, a treatment order to pad and protect bilateral heels daily, and Prevalon boots every shift while in bed. (Prevalon boots help to minimize pressure to the heel area.) Review of the wound care consultant's assessment dated [DATE] indicated Resident #219's heels were suspected deep tissue injuries. The left heel was 100% fibrotic tissue with yellow slough, moist, and with scant clear drainage. The area measured 1.4 centimeters (cm) long by 1.7 cm wide by 0.2 cm deep. The right heel was black (necrotic tissue) hard, and without drainage. The area measured 3.0 cm long by 4.8 cm wide by 0.1 cm deep. During an observation on 03/04/20 at 7:20 A.M., Licensed Practical Nurse (LPN) #36 changed Resident #219's dressings to both heels. Upon entering the room, Resident #219 was in bed and not wearing the Prevalon boots to bilateral feet. LPN #36 described the left heel as having yellowish-white slough covering 50% of wound bed. She described the right heel as being covered by black, soft eschar (nonviable tissue). LPN #36 completed the dressing changes at 7:49 A.M. She did not apply the Prevalon boots to Resident #219's feet before leaving the room. During an interview on 03/04/20 at 7:50 A.M., LPN #36 indicated the state tested nursing assistant removed the Prevalon boots when she provided care to Resident #219 this morning. On 03/04/20 at 7:55 A.M., an observation accompanied by Nurse Manager #203 revealed the Prevalon boots were on the floor next to the recliner in Resident #219's room. The resident was lying in bed. The nurse manager confirmed the observation. On 03/04/20 at 10:22 A.M., an observation accompanied by Nurse Manager #203 indicated the Prevalon boots remained on the floor next to the recliner in Resident #219's room. The resident was still lying in bed. Nurse Manager #203 confirmed the observation. She then apologized saying she had been busy and had not had time to put the Prevalon boots on Resident #219.
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 observation, interview, medical record review and policy review the facility failed to ensure adequate supervision to prevent a fall with subsequent head injury for Resident #46 and failed to ensure a new intervention was added to prevent further injury related to Resident #84 banging her left hand on a transfer bar. Actual harm occurred on 0[DATE] when Resident #46, was left unsupervised in the dining room, and was found on the floor with her head in a pool of blood. Resident #46 sustained bruising and a 0.1 centimeter (cm) x 0.1 cm open area to the forehead for which she was sent to the hospital for treatment. This affected two of five residents reviewed for accidents. The facility census was 222. Findings include: 1. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive assessment (MDS 3.0) dated 12/19/19 indicated she was severely cognitively impaired and had no signs of [MEDICAL CONDITION] or displayed behavioral symptoms. Resident #46 required the extensive assistance of one person for transfers, toileting and personal hygiene. No falls were indicated. Review of fall risk assessment dated [DATE] indicated she was at risk for falls. Review of the fall care plan initiated on admission revealed interventions included to get the resident up between 7:00 A.M. and 7:30 A.M., put her in the common area and provide music, and to assist the resident to bed between 8:00 P.M. and 9:00 P.M. An intervention dated 05/30/19 indicated staff were to ensure no items on the floor for her to try and pick up, and one dated 06/16/19 indicated staff were to assist her into the recliner and place in a common area when restless in bed. Interventions dated 08/23/19 indicated to assist the resident to the dining room last for monitoring and observe for non-verbal signs of restlessness that may precipitate movement and attempts

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) to stand/walk unattended. An intervention dated 0[DATE] indicated a physical therapy consult for wheelchair seating. Review of the nursing progress notes indicated she was known to bend forward and try to pick things up off the floor. A progress note dated 05/30/19 at 5:45 P.M. revealed Resident #46 was in the dining room with one knee on the floor and the other bent bearing her body weight, both hands touching the floor. She appeared to be picking up a piece of paper off the floor. Nursing progress notes dated 0[DATE] at 8:20 A.M. revealed Resident #46 was found in the dining room laying on her left side with her head in a puddle of blood. Her left arm was tucked underneath her and both legs were flexed. Resident #46 was alert and sent to the hospital. Review of the investigation dated 0[DATE] at 8:20 A.M. indicated Resident #46 was observed in the dining room laying on her left side and her head was in a puddle of blood. Her left arm was tucked underneath her and both legs were flexed resting on the floor. The investigation determined Resident #46 fell trying to reach and pick something off the floor, striking her face, and suffering a laceration. She had bruising and a 0.1 centimeter (cm) x 0.1 cm open area to the forehead. Review of staffing for 0[DATE] indicated there were three State tested Nurse Aides (STNAs) assigned to provide care for 40 residents on Mandel II. One STNA was assigned to the secured dementia unit where Resident #46 resided. The one STNA was assigned to 14 residents. Interview with Licensed Practical Nurse (LPN) #35 on 03/02/20 at 10:00 A.M. revealed Resident #46 recently fell in the dining room during breakfast and sustained a bruise. Interview with LPN #65 on 03/02/10 at 10:00 A.M. reported two aides were necessary on the secured dementia unit. She indicated the residents on the secured unit were very busy and required constant supervision. LPN #65 reported last Monday (0[DATE]) there was only one aide on the secured dementia unit and that was when Resident #46 fell . Interview with STNA #115 on 03/02/20 at 10:30 A.M. revealed there were usually two aides on the secured unit but last Monday (0[DATE]) there were only three STNAs for the entire floor, and that was when Resident #46 fell . STNA #115 said she and the nurse (LPN #65) were providing care to another resident in their room, leaving no one to supervise Resident #46 and the other residents in the dining room. Resident #46 was observed on 03/02/20 at 12:40 P.M. in the common television lounge with other residents. She was in a custom wheelchair with padded leg rests and a head rest. She was wearing glasses. A yellowing bruise was visible above and below her left eye. There was a nickel sized scab on her forehead. On 03/02/20 at 3:01 P.M. she was observed in a tilt and space wheelchair, reaching forward trying to adjust her pants. 2. Review of the nurses note dated 06/05/19 at 3:59 P.M. indicated the STNA noted Resident #84 had a bruise on her left fourth finger. The area was bluish purple from the tip of her finger to the second joint and at the knuckle. The resident was banging on the left transfer bar with her left hand prior to the bruise. The transfer bar was recovered with foam and tape. The transfer bar had been padded with foam prior to discovery of the bruising but the resident took it off and threw it on the floor. Review of the investigation dated 06/05/19 revealed a pain evaluation indicating Resident #84's left back hand and left fourth finger was bruised from the tip of the finger to the second joint and also near the knuckle. Review of the X-ray of the left fingers revealed there was a fracture involving the fourth proximal phalanx without displacement. There was associated soft tissue swelling and significant [MEDICAL CONDITION] evident. There was no evidence of a new intervention to prevent further injury due to the resident banging her hand on the transfer bar. Resident #84 was observed on 03/02/20 at 10:00 A.M. lying in a low bed with a mat next to the bed. The resident was hitting her left hand against the transfer bar which was not padded. A wheel of blue foam padding was laying on the floor mat next to the bed. On [DATE] at 4:47 P.M. Resident #84 was observed lying in a low bed and the foam padding was on the floor mat next to her bed. On 03/04/20 at 8:24 A.M. the resident was in a low bed, and the foam padding was on the floor mat. The resident was pulling on the transfer bar. On 03/04/20 at 3:22 P.M. Resident #84 was observed in bed, and there was no padding on the transfer bar. Interview with STNA #115 on 03/04/20 at 3:30 P.M. verified the padding was not on Resident #84's transfer bar. STNA #115 said the resident was able to remove the padding and then she would bang her hand on the bar. The padding did not stay securely on the transfer bar and she showed evidence of where she tried to tape the padding to the bar but it failed. Interview with Registered Nurse (RN) #204 on 03/04/20 at 5:40 P.M. verified Resident #84 pulled the foam padding off the transfer bar frequently and they had not tried any alternative interventions to protect the resident from possibly injuring herself by banging her had on the transfer bar. Review of the fall intervention program revised November 2017 indicated upon admission, the admitting nurse would gather information that may identify risks for falls and complete the fall intervention review. A fall intervention review was to be completed when a resident was admitted , found on the floor, witnessed fall, change in status, change in medication regimen, unwitnessed fall. A nurse would complete an investigation reviewing risk factors, update the care plan with alternative interventions as necessary. The nurse manager would review the information. Therapy would be notified of all falls and make recommendations when applicable. The nurse manager forwards the report to the director of nursing for review. The resident would be monitored for three days and document in the nurses notes and 24- hour report.
F 0725 **Level of harm** - 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, interview and medical record review the facility failed to ensure consistent adequate staffing to meet the care needs of residents residing on the secured dementia unit. Actual harm occurred on 02/24/20 when Resident #46, was left unsupervised in the dining room, and was found on the floor with her head in a pool of blood. Resident #46 sustained bruising and a 0.1 centimeter (cm) x 0.1 cm open area to the forehead for which she was sent to the hospital for treatment. This affected one (Resident #46) of five residents reviewed for accidents and had the potential to affect 13 additional residents (Residents #18, #22, #31, #36, #47, #60, #71, #78, #84, #131, #149, #167 and #208) currently residing on the secured dementia unit. The facility census was 222. Findings include: 1. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive assessment (MDS 3.0) dated 12/19/19 indicated she was severely cognitively impaired and had no signs of [MEDICAL CONDITION] or displayed behavioral symptoms. Resident #46 required the extensive assistance of one person for transfers, toileting and personal hygiene. No falls were indicated. Review of fall risk assessment dated [DATE] indicated she was at risk for falls. Review of the fall care plan initiated on admission revealed interventions included to get the resident up between 7:00 A.M. and 7:30 A.M., put her in the common area and provide music, and to assist the resident to bed between 8:00 P.M. and 9:00 P.M. An intervention dated 05/30/19 indicated staff were to ensure no items on the floor for her to try and pick up, and one dated 06/16/19 indicated staff were to assist her into the recliner and place in a common area when restless in bed. Interventions dated 08/23/19 indicated to assist the resident to the dining room last for monitoring and observe for non-verbal signs of restlessness that may precipitate movement and attempts to stand/walk unattended. An intervention dated 02/24/20 indicated a physical therapy consult for wheelchair seating. Review of the nursing progress notes revealed Resident #46 was known to bend over to pick items off the floor and required frequent redirection. Resident #46 was noted on 05/30/19 at 5:45 P.M. in the dining room with one knee on the floor and the other bent bearing her body weight with both hands touching the floor. She appeared to be picking up a piece of paper off the floor. On 06/18/19 at 6:20 P.M. she was agitated throughout the shift continually trying to get out of her chair. On 09/11/19 at 2:41 P.M. she was on hourly checks due to two recent falls. She was redirected a few times for trying to get out of the chair. An anti-anxiety medication was given to help calm the resident. On 11/19/19 at 07:21 P.M. the resident had an adjustment in her psychotic medication due to her becoming more restless, and constantly trying to get up out of her chair. On 11/25/19 at 06:57 P.M. the resident continued to be very anxious, trying continually to get out of her chair. Nursing progress notes dated 02/24/20 at 8:20 A.M. revealed Resident #46 was found in the dining room laying on her left side with her head in a puddle of blood. Her left arm was tucked underneath her and both legs were flexed. Resident #46 was alert and sent to the hospital. Review of the investigation dated 02/24/20 at 8:20 A.M. indicated Resident #46 was observed in the dining room laying on her left side and her head was in a puddle of blood. Her left arm was tucked underneath her and both legs were flexed resting on the floor. The investigation determined Resident #46 fell trying to reach and pick something off the floor, striking her face, and suffering a laceration. She had bruising and a 0.1 centimeter (cm) x 0.1 cm open area to the forehead. Review of staffing for 02/24/20 indicated there were three State tested Nurse Aides (STNAs) assigned to provide care for 40 residents on Mandel II. One STNA was assigned to the secured dementia unit where Resident #46 resided. The one STNA was assigned to 14 residents. Interview with Licensed Practical Nurse (LPN) #35 on 03/02/20 at 10:00 A.M. revealed Resident #46 recently fell in the dining room during breakfast and sustained a bruise. Interview with LPN #65 on 03/02/10 at 10:00 A.M. reported two aides were necessary on the secured dementia unit. She indicated the residents on the secured unit were very busy and required constant supervision. LPN #65 reported last Monday (02/24/20) there was only one aide on the secured

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F 0725 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) dementia unit and that was when Resident #46 fell . Interview with STNA #115 on 03/02/20 at 10:30 A.M. revealed there were usually two aides on the secured unit but last Monday (02/24/20) there were only three STNAs for the entire floor, and that was when Resident #46 fell . STNA #115 said she and the nurse (LPN #65) were providing care to another resident in their room, leaving no one to supervise Resident #46 and the other residents in the dining room. Resident #46 was observed on 03/02/20 at 12:40 P.M. in the common television lounge with other residents. She was in a custom wheelchair with padded leg rests and a head rest. She was wearing glasses. A yellowing bruise was visible above and below her left eye. There was a nickel sized scab on her forehead. On 03/02/20 at 3:01 P.M. she was observed in a tilt and space wheelchair, reaching forward trying to adjust her pants. 2. The secured dementia unit staff identified two residents (#46 and #128) who required the use of a stand up lift for transfers that required two staff to operate safely, two residents (#47 and #131) who required a mechanical lift for transfers that required two staff to operate safely, five residents who required frequent observations (#18, #38, #46, #71 and #84) one resident who required two staff assistance for ADLs (#78) and one resident who had a private sitter (#47). The staff acknowledged that agency staff had been utilized. The nurse assigned to the secured dementia unit was also responsible for residents outside of the unit. Interviews from 03/02/10 through 03/05/20 during various shifts with LPN #37, STNA #106, STNA #167 and STNA #195 revealed there was often just one STNA assigned to the secured dementia unit with an STNA with an assignment on another floor being assigned to two or three of the residents. The nurse assigned to the secure dementia unit was assigned to residents off the unit. Those interviewed agreed this was not enough staff to meet the care needs of the residents on the secured dementia unit. Staff interviewed said they had expressed concerns to administrative staff. Interviews from 03/02/10 through 03/05/20 at various times with Residents #31, #46, #47, #60, #71, #125, and #188 revealed concerns related to insufficient facility staffing. On 03/04/20 at 5:43 A.M. interview with STNA #106 revealed sometimes she was the only one working on the dementia unit. When that happened the resident showers were not done. When she worked by herself on the secured dementia unit she kept doors open when providing resident care so she could hear the other residents. When working alone she had to leave the unit to get assistance. She said she also carried a personal [MEDICATION NAME] to blow if things got too bad for her to handle. Interview on 03/04/20 at 9:05 A.M. with Scheduler #500 revealed the facility staffed based on census. For Mendel II, which included the secured dementia unit, there were always two STNAs assigned to the secured dementia unit on the day shift and afternoon shift with two nurses who were also assigned to additional residents on the adjacent unit. On the third shift there were four STNAs and one nurse scheduled. However, how they assigned staff, and decided who would work on the secured dementia unit, was up to the nurse on the unit. The nurse assigned to the dementia unit on third shift was also assigned to residents on the adjacent unit. On 03/04/20 at 11:08 A.M. agency STNA #600 was observed on the secure dementia unit. She was asked about the care needs of the residents. She simply said she was agency and was not sure. On 03/04/20 at 3:30 P.M. STNA #167 reported occasionally she was the only STNA assigned to the secured dementia unit. She reported the residents on the dementia unit frequently needed redirection when they attempted to stand unassisted. She acknowledged an STNA outside of the unit had two to three residents in the secured dementia unit in addition to her assigned residents off the unit. However, that STNA was not usually on the dementia unit very much. On 03/05/20 at 2:00 P.M. the Director of Nursing and Assistant Director of Nursing were informed about concerns with not enough staff to properly supervise and provide care to the residents who resided on the secured dementia unit. They verified they had been supplementing their staff with agency staff to attempt meet the residents' needs. This deficiency substantiates Complaint Number OH 459.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview the facility failed to ensure food was served in a sanitary manner. This affected three residents (#39, #49, and #276) in the small dining room on the 100 unit and had the potential to affect 52 residents (Residents #1, #39, #40, #49, #50, #80, #81, #82, #114, #135, #136, #144, #145, #151, #164, #166, #178, #180, #182, #185, #190, #194,#195, #212, #214, #215, #216, #220, #274, #275, #276, #277, #278, #279, #280, #281, #282, #283, #284, #285, #286, #287, #288, #289, #290, #291, #292, #293, #294, #296, #297, and #298) currently residing on the first floor. The facility census was 244. Findings include: 1. Observation on 03/02/20 at 12:35 P.M. of the noon meal in the small dining room on the 100 unit revealed the tray line server, Dietary Aide (DA) #250, dropped an empty package from a sanitizer wipe he'd used to clean the thermometer onto the floor. With his gloved hands, he picked it up and put it the trash can. His hand made contact with the swinging trash lid. DA #250 then went back to the steam table and grabbed a dessert bowl. He was instructed by the surveyor to cease serving and wash his hands and re-glove. Three residents (#39, #49, and #276) were currently in the dining room for the lunch meal. DA #250 verified he had picked up the packaging off the floor and placed it in the trash without changing gloves and washing his hands. He verified he would have served the three residents wearing contaminated gloves. 2. Observation in the resident servery on the first floor on 03/02/20 at 1:09 P.M. revealed State tested Nurse Aide (STNA) #401 dropped the cap from a two liter ginger ale bottle onto the floor. STNA #401 picked it up and placed it back on the bottle, then placed the bottle of ginger ale in the reach in cooler in the servery. STNA #110 who was present at the time, verified the observation and identified STNA #401 as agency staff. STNA #110 then educated STNA #401 that if he dropped anything on the floor again, he was to just throw it away. STNA #110 verified all the residents on the first floor received foods and beverages from the servery. The facility identified 54 residents currently residing on the first floor, who could potentially be affected by lack of proper handling and storage of foods and beverages by staff.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy on hand hygiene the facility failed to ensure staff washed or cleansed their hands between the dirty and clean phases of dressing changes to prevent potential cross-contamination. This affected three (Residents #34, #170, and #219) of four residents observed for dressing changes (Residents #34, #42, #170, and #219). The facility census was 222. Findings include: 1. Review of the record revealed Resident #219 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of a progress note dated 11/15/19 indicated the nurse observed Resident #219 to have purplish-black colored area to both heels. The resident reported the areas were slightly painful. On 11/15/19, the nurse practitioner ordered to cleanse bilateral heels with normal saline, apply ABD pad, and wrap with Kerlix daily and prn (as needed). On 02/19/20, the wound care consultant changed the treatment order to the left heel to cleanse with normal saline, dry, apply Xeroform to fit. Cover with ABD pad and Kerlix daily. Review of the wound care consultant's assessment dated [DATE] indicated Resident #219's heels were suspected deep tissue injuries. The left heel was 100% fibrotic tissue with yellow slough (nonviable tissue) moist, and with scant clear drainage. The area measured 1.4 centimeters (cm) long by 1.7 cm wide by 0.2 cm deep. The right heel was black (necrotic tissue), hard, and without drainage. The area measured 3.0 cm long by 4.8 cm wide by 0.1 cm deep. During an observation on 03/04/20 at 7:20 A.M., Licensed Practical Nurse (LPN) #36 changed Resident #219's dressings to both heels. The LPN washed her hands and donned gloves. She removed the old dressing. She washed her hands and left the room to obtain additional supplies. LPN #36 returned to the room and washed her hands and donned gloves. She cleaned the wound bed with normal saline then described the wound to the left heel as having yellowish-white colored slough covering 50% of the wound bed. Using scissors, the nurse cut a piece of the Xeroform gauze and placed in onto the wound bed, covered it with an ABD pad, then wrapped the area with Kerlix. She secured it with tape. LPN #36 did not wash or cleanse her hands after cleaning the pressure ulcer to Resident #219's left heel and prior to cutting the Xeroform gauze then placing it directly on the open wound bed. During an interview on 03/04/20 at 7:50 A.M., LPN #36 verified she did not wash or cleanse her hands and don new gloves between cleaning the left heel and cutting the Xeroform gauze and placing it on the open wound bed. 2. Review of the record revealed Resident #34 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of a physician order [REDACTED]. Change every 24 hours and prn for pilonidal cyst. (A pilonidal cyst is an abnormal pocket of skin and hair that is almost always located near the tailbone and can become easily infected.) The wound care consultant changed the treatment orders on 02/09/20 and 02/25/20. Review of a wound care consultant assessment dated [DATE] indicated the sacral wound was in an old pilonidal cyst cavity and measured 6.0 cm long by 2.0 cm wide by 3.0 cm deep. He described the wound bed as 10% slough and 90% exposed tissue. The wound care consultant changed the treatment order on 02/26/20 to pack wound with Kerlix moistened with 1/4 strength Dakins solution and cover with ABD pad two times a day. During an observation on 03/04/20 at 10:40 A.M., Wound Care Consultant #425 changed the dressing to Resident #34's wound. The wound care consult washed his hands prior to

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	365046	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEFIORE HOME THE	**ONE DAVID N MYERS PARKWAY BEACHWOOD, OH 44122**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) beginning the dressing change. Nurse Manager #203 removed the old dressing. Wound Care Consultant #425 removed the packing from the wound. With the gloved hand, he used a four by four gauze pad soaked in wound wash solution to clean the wound bed by rubbing the wound area. The nurse practitioner left the room to obtain additional supplies, leaving State tested Nursing Assistant (STNA) #149 in the room with the wound care consultant. Wound Care Consultant #425 measured the wound from the pilonidal cyst as being 4.5 cm long by 2.5 cm wide by 4.3 cm deep. He indicated there was yellow slough in the wound bed. The consultant took a four by four pad soaked in Dakins solution and packed the wound with his gloved hand. He then covered the wound with a [MEDICATION NAME] border dressing. After completing the dressing change, Wound Care Consultant #425 washed his hands. The wound care consultant did not wash or cleanse his hands between the dirty and clean phases of the dressing change. During an interview on 03/04/20 at 10:46 A.M., STNA #149 confirmed Wound Care Consultant #425 never left Resident #34's bedside and did not cleanse or wash his hands until finishing the dressing change. 3. Review of the record revealed Resident #170 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Nursing Admission Screen dated 10/04/19 indicated the resident returned from a hospitalization with a pressure ulcer to the coccyx/sacral area. The ulcer measured 5.0 cm long by 3.25 cm wide. The Skin Tool Wound Nurse assessment dated [DATE] described the wound as a Stage II pressure ulcer (superficial skin break into the skin layer only) measuring 6.0 cm long by 3.5 cm wide by 0.1 cm deep. The nurse practitioner ordered a wound consult. Review of the most recent treatment order dated 01/22/20 indicated to wash sacral wound with wound wash, cover base of wound with Silver Alginate (a healing agent) and place a four by four gauze pad over the Silver Alginate. Cover with [MEDICATION NAME] border dressing every day shift and as needed for wound care. Review of the wound care consultant assessment dated [DATE] indicated the sacral wound was a Stage IV pressure ulcer (extending below the subcutaneous fat into the deep tissues). The pressure ulcer measured 4.0 cm long by 3.8 cm wide by 1.2 cm deep. The wound bed was 90% granulation and 10% exposed structures. During an observation on 03/04/20 at 11:01 A.M., Wound Care Consultant #425 changed the dressing to Resident #170's sacral wound. The wound care consult washed his hands and donned gloves prior to beginning the dressing change. With gloved hands, the wound care consultant and Nurse Manager #207 moved a full size mattress located on the floor next to the resident's bed. Nurse Manager #207 washed her hands and donned gloves and removed the old dressing to Resident #170 sacrum. Wound Care Consultant #425 removed the packing from the wound then measured the wound. He indicated the pressure ulcer measured 2.4 cm long by 2.5 cm wide by 2.4 cm deep. With the gloved hand, he used a four by four gauze pad soaked in wound wash solution to clean the wound bed by rubbing the wound bed. Nurse Manager #207 folded the [MED] Silver and handed it to the consultant who placed it in the wound bed. He then covered it with a four by four gauze pad and [MEDICATION NAME] border dressing. The consultant washed his hands after completing the dressing. The wound care consultant did not wash or cleanse his hands after moving the mattress or between the dirty and clean phases of the dressing change. During an interview on 03/04/20 at 11:08 A.M., Nurse Manager #207 confirmed Wound Care Consultant #425 did not wash his hands until after he completed the dressing change. She agreed he moved the mattress which had been on the floor and did not wash or cleanse his hands. Review of the facility's Hand Hygiene Policy and Procedure (reviewed September 2017) indicated hand hygiene should be performed including after contact with a resident's mucous membranes, body fluids, or excretions, after handling soiled or used linens, dressings, bedpans, catheters, and urinals, and before and after performing an invasive procedures.