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 _____	09/09/2020

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** - 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, staff interview, medical record review, and review of facility policy, the facility failed to ensure interventions for pressure reduction were consistently implemented, ensure skin assessments were conducted under assistive devices to ensure no breakdown was occurring, failed to timely obtain a treatment once skin breakdown occurred, and failed to provide continuous ongoing monitoring and assessment of a pressure injury which became open. This resulted in actual harm when staff did not consistently apply a pressure reducing boot and when the boot was applied staff did not complete assessments of the skin under the boot, which resulted in the development of a pressure injury/deep tissue injury to the right heel for one (#1) out of four residents reviewed for skin breakdown. Additionally, staff failed to provide repositioning to prevent skin breakdown for one (#3) out of four residents reviewed for skin breakdown. The facility census was 51. Findings include; 1. Review of the medical record revealed Resident #1 admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment, dated 06/09/20, identified Resident #1 as alert, oriented, able to make needs known, and dependent on two staff for the completion of activities of daily living including transfer and positioning. The assessment noted the resident with one unstageable deep tissue injury. Pressure relieving measures were documented to the bed, chair and a turning repositioning program was in place. Review of the activity of daily living plan of care, updated 10/30/17, addressed the need for assistance with activity of daily living. Intervention at that time included to provide skin care to keep clean and prevent skin breakdown. Apply specialized boots to bilateral feet while in bed. Review of the plan of care,dated 12/01/17, addressed the resident's risk for skin breakdown due to incontinence, decreased bed mobility and [MEDICAL CONDITION]. Interventions included: applying protective skin ointment following incontinent care, observe skin daily with care and bathing, if redness, areas of pressure or a rash are present notify nurse, pay special attention to heels. Review of the medical record revealed no evidence indicating the specialized boots were applied as indicated in the plan of care. Review of a nurses' note dated 07/12/20 at 2:32 A.M. documented State tested Nursing Assistant (STNA) #400 stated the resident had a wound on the right heel. Upon further evaluation of the resident, the nurse documented the resident with a pressure wound measuring one inch diameter and black in color on the right heel. The resident denied pain at the time. The nurse documented the specialized boots were on and the residents legs elevated. Review of the physician orders [REDACTED].M. when the physician ordered skin prep to be applied to the resident's bilateral heels. Additionally, the physician ordered to keep soft heel suspension boots on at all times and use pillows to suspend heels in bed. Review of the right heel assessment on 07/14/20 described the wound to be a deep tissue injury(DTI). The DTI measured 3.0 centimeters (cm) long by (x) 3.5 cm wide with 0 (zero) depth. The medical record contained no documentation of ongoing skin assessments being conducted regarding the skin condition under the resident's boots or of the boots being consistently applied prior to the discovery of the DTI on 07/12/20. Review of wound center physician documentation on 07/20/20 revealed Resident #1 was evaluated for chronic wounds to the buttocks, hip and the deep tissue injury to the right heel. Further review of the medical record noted the resident to be transported to the hospital for evaluation on 07/20/20 at 8:50 P.M. The resident did not return to the facility until 07/30/20. There was no documented assessment of the right heel upon return to the facility. Review of wound center physician documentation on 08/10/20 noted the resident was assessed by the wound center physician and the right heel ulcer measured 2.5 cm by 3.0 cm by 0.1 cm in depth. There was no description of the wound's color, any drainage, or the stage of the wound. Review of wound center physician documentation on 08/24/20 noted the resident was assessed by the wound center physician and the right heel ulcer measured 2.3 cm by 2.9 cm by 0.1 cm in depth. There was no description of the wound's color, any drainage, or the stage of the wound. Review of the facility wound status report for 08/25/20 identified Resident #1's right heel to be a pressure ulcer measuring 2 cm by 2 cm with depth increased to 0.2 cm deep. The report did not identify the stage of the pressure ulcer or a description of the ulcer. Review of the medical record revealed the facility was not completing an assessment and obtaining measurements of Resident #1's right heel on a weekly basis. Interview on 09/09/20 at 9:30 A.M., the Director of Nursing (DON) verified no documentation could be provided indicating skin assessments were being conducted under the resident's boots until a DTI was discovered on 07/12/20 to the right heel. There was no documentation the right heel wound was timely evaluated and treatment applied until 07/14/20. The DON verified there was no evidence of any assessment of the right heel by the facility staff once the resident began being treated by the wound care center. The DON verified the wound care center notes did not contain a description of the wound on Resident #1's right heel. Review of the undated facility policy titled Skin Risk Prevention, revealed skin inspections will be completed during showers per STNA, who will report alterations in skin integrity to the nurse. The nurse will make an observation of the area and initiate treatment per physician notification. 2. Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment, dated 07/03/20, identified Resident #3 with moderate cognitive impairment and required extensive assistance of one staff for transfer and positioning. The assessment also indicates the resident is not at risk for developing pressure ulcers or injuries with a turning and repositioning program in place. Review of the plan of care, revised 04/24/19, identified Resident #3 to be at risk for skin breakdown related to immobility. Interventions included, educating to move off right side, encourage repositioning routinely and as needed, and follow facility policies/protocols for prevention/treatment of [REDACTED].M. revealed State tested Nurse Aide (STNA) #101 repositioned Resident #3 to the left side. Continued observations at 12:10 P.M. and 1:30 P.M. noted the resident remained in bed positioned to the left. Interview on 09/08/20 at 1:30 P.M., STNA #101 verified she had not repositioned Resident #3 since 9:50 A.M. STNA#101 then proceeded to the resident's room and repositioned the resident to the right. Observation of the resident's skin identified red areas to the left hip, buttock, ankle, forehead and elbow. Observation on 09/08/20 at 1:40 P.M. with Licensed Practical Nurse (LPN) #201 verified the red areas to Resident #3's left hip, buttocks, ankle, forehead, and elbow. Review of a Skin Observation Tool noted on 09/08/20 at 3:22 P.M. Resident #3 was identified to have a reddened are to the left elbow, front of the left knee, the left lateral knee, and the left hip all measuring 1 centimeter (cm) in diameter. Review of the undated facility policy titled Skin Risk Prevention, revealed prevention included turning and repositioning the resident. This deficiency substantiates Complaint Number OH 557.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to follow physician orders [REDACTED].#2) of three residents reviewed for the use of urinary catheters. The facility identified a total of four residents utilizing indwelling urinary catheters. The facility census was 51. Findings include; Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set

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

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assessment, dated 08/10/20, identified the resident as alert, oriented, able to make needs known, and required supervision with activities of daily living. The resident had an indwelling urinary catheter in place. Review of a physician order [REDACTED]. Observation on 09/08/20 at 9:37 A.M. identified Resident #2 to be in a chair at the bedside. The indwelling urinary catheter bag was suspended hanging from a walker. The indwelling urinary catheter bag was draining amber urine with sediment and dated 08/15/20. Interview with Licensed Practical Nurse (LPN) #202 on 09/08/20 at 12:45 P.M. revealed she was unaware the indwelling urinary catheter bag had not been changed in accordance with physician orders [REDACTED].
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, review of Center for Disease Control and Prevention (CDC) guidelines, and review of facility policy for infection prevention and control for COVID-19, the facility failed to utilize appropriate personal protective equipment (PPE) and implement correct isolation precautions for newly admitted residents under quarantine to mitigate the spread of COVID-19. This deficient practice had the potential to affect 13 residents (#5, #6, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21) residing on the 100 Hall in a facility census of 51. Findings include: Review of the medical record for Resident #5 revealed an admission to the facility on [DATE]. [DIAGNOSES REDACTED]. According to the medical record the resident tested as negative for COVID-19 on 08/30/20. Review of the medical record for Resident #6 revealed an admission to the facility on [DATE]. [DIAGNOSES REDACTED]. According to the medical record the resident was not tested for COVID-19 prior to being admitted to the facility. Observation on 09/08/20 at 10:45 A.M. of the 100 Hall revealed isolation carts outside the rooms of Resident #5 and Resident #6. The isolation carts were equipped with disposable isolation gowns and gloves. No protective goggles, face shields, or N95 masks were available on the carts. Each room had a sign near the entry reading Contact Isolation and See nurse before entering room. A Pastoral Care staff was observed to enter Resident #6's room wearing a gown, gloves, and surgical mask. Interview on 09/08/20 at 10:55 A.M. with Licensed Practical Nurse (LPN) #205 revealed Resident #5 and #6 were new admissions and have been placed into contact isolation for a 14 day quarantine. LPN #205 stated gloves, a standard mask (surgical), and gown are required to enter these rooms. Review of the CDC guidelines titled Responding to Coronavirus (COVID-19) in Nursing Homes, dated 04/30/20 revealed under consideration for new admissions to the facility whose COVID status is unknown, these residents should be placed in an observation area for a 14 day time period for monitoring. All COVID-19 PPE should be worn during care, including a N95 or higher respirator and eye protection. Review of facility policy titled Infection Prevention and Control Policy [DIAGNOSES REDACTED]-CoV-2 Coronavirus Disease 2019, revised 08/31/20, revealed new admissions or internal movement of suspected COVID-19 residents are to adhere to standard and transmission based precautions. Healthcare personnel who enter resident rooms with known or suspected COVID-19 residents must utilize approved N95/KN95 mask, gown, gloves, and eye protection. Interview on 09/09/20 at 9:40 A.M. with the acting Director of Nursing revealed she was unaware the facility was not following the facility infection control policy and applying the appropriate PPE. Interview on 09/09/20 at 10:10 A.M. with Nurse Consultant Registered Nurse (RN) #301 verified the facility should implement droplet precautions with new admissions and not contact precautions as observed with Residents #5 and #6. The facility identified 13 residents (#5, #6, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21) residing on the 100 Hall.