STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365825	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE NURSING AND REHAB CTR	**24579 BROADWAY AVE OAKWOOD VILLAGE, OH 44146**

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 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 observation, interview, and record review, the facility failed to implement revisions made to the skin integrity care plan for Resident #42. This affected one (Resident #42) of four residents reviewed for care plans. The facility census was 51. Findings include: Review of the record revealed Resident #42 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Braden Score assessment dated [DATE] revealed Resident #42 was at high risk for development of a pressure ulcer. The resident had a care plan for potential alteration in skin integrity initiated 06/08/20. The admission Minimum Data Set Assessment (MDS) 3.0 dated 06/11/20 indicated the resident was comatose, dependent on two staff for bed mobility, and was always incontinent of bowel and bladder. Review of a transfer form dated 07/18/20 revealed Resident #42 had a change of condition and was sent to the hospital. Resident #42 returned from the hospital on [DATE]. Review of the Admission Assessment with Baseline Care Plan dated 07/24/20 indicated Resident #24 had wounds to the right buttock and right ear. The physician ordered [MEDICATION NAME] ointment (topical antibiotic) apply to the right ear wound topically three times a day and directed nursing staff to cleanse the right buttock wound with normal saline, apply calcium alginate (highly absorbent dressing that promotes healing), and cover with foam dressing every two days and every 24 hours as needed. Review of Resident #42's care plan for potential alteration in skin integrity revealed the plan was revised 07/24/20 to include encouragement to turn and position every two hours and as needed. Review of electronic care documentation in Caretracker for the last 30 days revealed state tested nursing assistants documented Resident #42 was turned and repositioned one time, on 07/16/20. On 07/27/20 beginning at 8:10 A.M., an initial tour of the facility was completed. Observation revealed Resident #42 was in bed, lying flat on her back (supine position) with a pillow under both feet. The resident had a pressure reducing mattress. On 07/27/20 beginning at 9:00 A.M., revealed Resident #42's bed position remain unchanged. She was lying on her back with a pillow under both feet. On 07/27/20 at 10:36 A.M., a dressing change observation was completed. Licensed Practical Nurse (LPN) #100 changed the dressing to Resident #42's right buttock and assessed the wounds to her right ear and buttock. Upon leaving the room, LPN #100 placed Resident #42 back in supine position on her back with a pillow under both feet. During tours on 07/27/20 at 10:52 A.M. and 12:00 P.M., Resident #42 remained in bed, positioned on her back with her feet on the pillow. During an interview on 07/27/20 at 12:10 P.M., LPN #100 confirmed Resident #42 was positioned on her back with a pillow under both feet. The LPN agreed when she changed Resident #42's dressing this morning, the resident was also on her back with pillow under both feet prior to and after the dressing change. On 07/27/20 at 12:22 P.M., an interview with Respiratory Therapist #101 indicated he has been in Resident #42's room twice today providing respiratory care, around 7:45 A.M. and a short time ago. At 7:45 A.M., the resident was positioned in supine position with pillow under her feet. He remembers because Resident #42's heart rate was 148. He immediately informed the nurse. A short time ago, the resident was again positioned in supine position with pillow under both feet. On 07/27/20 at 12:26 P.M., an interview with State tested Nursing Assistant (STNA) #102 revealed she was not assigned to care for Resident #42, the other STNA (STNA #103) had the resident. There are two STNAs on the hall. She and STNA #103 worked as a team caring for residents who needed two staff to assist with care. Resident #42 was totally dependent and needed assistance of two staff for turning and repositioning. She indicated she assisted STNA #103 with Resident #42's care around 8:00 A.M. When they were done, they placed a pillow under the resident's feet. She was unsure whether they placed any other pillows for positioning. She said she and STNA #103 had not been in Resident #42's room since around 8:00 A.M. On 07/27/20 at 12:40 P.M., the director of nursing revealed he corrected Caretracker after surveyor intervention. Caretracker had not been updated to include Resident #42 was to be turned and repositioned every two hours. On 07/27/20 at 1:12 P.M., the director of nursing confirmed turning and repositioning was added to Resident #42's care plan for skin integrity on 07/24/20 upon her return from the hospital.
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 provide turning and reposition for a resident with a pressure ulcer who was dependent on staff for bed mobility. This affected one (Resident #42) of three residents reviewed for pressure ulcers. The facility identified 26 residents as being dependent for bed mobility. Findings include: Review of the record revealed Resident #42 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Braden Score assessment dated [DATE] revealed Resident #42 was at high risk for development of a pressure ulcer. The admission Minimum Data Set Assessment (MDS) 3.0 dated 06/11/20 indicated the resident was comatose, dependent on two staff for bed mobility, and was always incontinent of bowel and bladder. Review of a transfer form dated 07/18/20 revealed Resident #42 had a change of condition and was sent to the hospital. Resident #42 returned from the hospital on [DATE]. Review of the Admission Assessment with Baseline Care Plan dated 07/24/20 indicated Resident #24 had wounds to her right buttock and right ear. The physician ordered [MEDICATION NAME] ointment (topical antibiotic) apply to the right ear wound topically three times a day and directed nursing staff to cleanse her right buttock wound with normal saline, apply calcium alginate (highly absorbent dressing that promotes healing), and cover with foam dressing every two days and every 24 hours as needed. Review of Resident #42's care plan for potential alteration in skin integrity revised 07/24/20 had interventions including encourage to float heels while in bed, encourage to turn and position every two hours and as needed, pressure reducing cushion to chair and mattress to bed, and assist with hygiene including pericare as needed. On 07/27/20 beginning at 8:10 A.M., an initial tour of the facility was completed. Observation revealed Resident #42 was in bed, lying flat on her back (supine position) with a pillow under both feet. The resident had a pressure reducing mattress. On 07/27/20 beginning at 9:00 A.M., revealed Resident #42's bed position remain unchanged. She was lying on her back with a pillow under both feet. On 07/27/20 at 10:36 A.M., a dressing change observation was completed. Licensed Practical Nurse (LPN) #100 changed the dressing to Resident #42's right buttock and assessed wounds to the right ear and buttock. Resident #42 had a dressing to her right buttock dated as last changed 07/26/20. There were two pressure ulcers to the right buttock right next to each other. The nurse measured and described both wounds. The larger ulcer was 3.0 cm (centimeters) long by 3.2 cm wide with yellowish-tan eschar (non-viable tissue) covering the center area surrounded by pink granular tissue. LPN #100 estimated the eschar covered 75% of wound bed. The second smaller wound to right buttock was near the sacrum and measured 1.9 cm long by 1.0 cm wide. The wound bed was pink, granular tissue. After completing the dressing change, the nurse assessed Resident #42's right ear. There were two discolored areas to the right ear. LPN #100 indicated there was a closed reddened area measuring 0.5 cm long by 1.0 cm wide and an open reddened area with no depth measuring 0.6 cm long by 1.1 cm wide. LPN #100 followed appropriate infection control measures during the dressing change. Upon leaving the room, LPN #100 placed Resident #42 back in supine position with a pillow under both feet. During an interview on 07/27/20 at 10:48 A.M., LPN #100 indicated when

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365825	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE NURSING AND REHAB CTR	**24579 BROADWAY AVE OAKWOOD VILLAGE, OH 44146**

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	(continued... from page 1) Resident #42 was sent to the hospital on [DATE], she had no skin alterations except for her ear. The resident developed moisture associated skin damage a few days prior to be hospitalized . Resident #42's right ear had chaffing but was not open. During tours on 07/27/20 at 10:52 A.M. and 12:00 P.M., Resident #42 remained in bed, positioned on her back with feet on pillow. During an interview on 07/27/20 at 12:10 P.M., LPN #100 confirmed Resident #42 was positioned on her back with a pillow under both feet. The LPN agreed when she changed Resident #42's dressing this morning, the resident was also on her back with pillow under both feet prior to and after the dressing change. On 07/27/20 at 12:22 P.M., an interview with Respiratory Therapist #101 indicated he has been in Resident #42's room twice today providing respiratory care, around 7:45 A.M. and a short time ago. At 7:45 A.M., the resident was positioned in supine position with pillow under her feet. He remembers because Resident #42's heart rate was 148. He immediately informed the nurse. A short time ago, the resident was again positioned in supine position with pillow under both feet. On 07/27/20 at 12:26 P.M., an interview with State tested Nursing Assistant (STNA) #102 revealed she was not assigned to care for Resident #42, the other STNA (STNA #103) had the resident. There are two STNAs on the hall. She said she and STNA #103 worked as a team caring for residents who need two staff to assist with care. She said Resident #42 was totally dependent and needed assistance of two staff for turning and repositioning. She assisted STNA #103 with Resident #42's care around 8:00 A.M. When they were done, they placed a pillow under the resident's feet. She was unsure whether they placed any other pillows for positioning. She said she and STNA #103 had not been in Resident #42's room since around 8:00 A.M. and had not turned and repositioned her. On 07/27/20 at 1:12 P.M., the Director of Nursing confirmed turning and repositioning was added to Resident #42's care plan for skin integrity on 07/24/20 upon her return from the hospital. This deficiency substantiates Complaint Number OH 419.