STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365246	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Wert Manor	160 Fox Rd Van Wert, OH 45891

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** 35031 Based on medical record review, staff and physician interviews, review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), and policy review, the facility failed to timely identify the resident's pressure ulcer until it reached an advanced stage, and failed to accurately assess and provide timely interventions to treat the pressure ulcer. This resulted in Actual Harm to Resident #52 who was at risk for pressure ulcers and the facility found Resident #52's pressure ulcer as an unstageable pressure ulcer (Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar) and required surgical debridement of the pressure wound. This affected one (Resident #52) of one resident reviewed for pressure ulcers. The facility census was 53. Findings include: Review of the medical record of Resident #52 revealed an admitted [DATE]. Diagnoses included quadriplegia, anemia, diabetes mellitus, and diabetic neuropathy. Review of Resident #52's care plan dated 01/13/25 revealed Resident #52 was at risk for skin breakdown due to decreased mobility/quadriplegia, weakness, moisture, prediabetes and dry scalp. Interventions included observing skin for redness and open areas and notifying the nurse, skin assessment as needed, and applying lotion/moisture barrier cream as ordered. On 01/23/25, an intervention was added to apply a bariatric bed with alternating pressure air mattress to maintain skin integrity. On 04/16/25, interventions were added to apply negative pressure wound therapy (NPWT) to left buttock wound to ensure dressing is intact and adhering and was started on a scheduled turning plan. There was no mention of any refusal of care behavior. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively impaired and dependent on staff for all aspects of daily care. Resident #52 did not have any pressure wounds, was at risk for skin breakdown, and had pressure relieving devices for the bed and chair in chair in place. Resident #52 did not have any rejection of care during the review period. From 01/12/25 to 01/27/25, there was no documentation of any skin breakdown and wound measurements in Resident #52's medical record. On 01/22/25, there was a physician order for a low air loss mattress to be applied to Resident #52's bed to prevent any further skin breakdown. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365246	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Wert Manor	160 Fox Rd Van Wert, OH 45891

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	On 01/27/25, there was a physician order to monitor dressing to the left buttocks and coccyx to ensure intact and adhering every shift. May change as needed (PRN). The order did not specify any treatment of the wound. The physician orders were given by Physician (MD) #401. Review of the progress note dated 01/28/25, authored by Director of Nursing (DON), revealed an area of skin impairment to the left buttock. The note indicated the wound appeared to be from the adhesive on the foam dressing had peeled the skin away. There was no documentation as to the size or appearance of the wound. The area was cleansed (no specified cleaning agent mentioned) and had no odor or drainage. A dressing (no specification to what type of dressing) had been applied to the wound and Resident #52 denied pain. There was no mention of a coccyx wound. An update was left for Physician Assistant (PA) #402 for morning rounds. The progress note, dated 01/29/25 and written by PA #402, revealed Resident #52 was seen for some green discharge around his catheter as well as some small ulcerations. The note stated Resident #52 was dealing with wound care for what sounds like a coccyx pressure wound (not specified what stage of pressure wound). The plan was to refer to urology. Nothing was said about the left buttock wound. The progress note dated 02/01/25 at 10:00 P.M., written by Licensed Practical Nurse (LPN) #332, revealed a Certified Nursing Assistant (CNA) had reported the dressing to the left buttock had fallen off and was soiled. LPN #332 had not visualized the dressing as it had been thrown away. LPN #332 documented the wound bed was moist and red with a scant amount of sanguineous (bright red blood mixed with yellow fluid) drainage. On 02/05/25, the Skin Issue note was the first documentation of Resident #52's wound measurements and description of the wound. The DON revealed the wound to the left buttock was now an unstageable pressure ulcer/injury (acquired in-house). The wound was assessed as having 100% (percent) slough (a colored non-viable tissue) and measured one centimeter (cm) in length by three-point four cm in width with a moderate amount of serosanguineous (typically pale, yellow, red, and watery fluid). No odor was noted. A note indicated the wound had begun as a skin tear from removing adhesive dressing but had progressed to pressure injury. The dressing had been heavily saturated with drainage. The area was cleaned with soap and water and covered with foam dressing. Resident #52 was sent to the emergency roiagnom on [DATE] and admitted for urinary tract infection and pneumonia. Resident #52 returned to the facility on [DATE]. The Skin Issue note date 02/14/25 revealed the wound to the left buttock was unchanged. There were no measurements or descriptions of the wound. There was no physician order for treatment of the left buttock wound until 02/19/25. The physician order dated 02/19/25 revealed an order to gently clean the left buttock wound with soap and water, rinse and pat dry, apply foam dressing topically as needed and every Monday and Thursday. The Skin Issue note dated 02/26/25, written by the DON, revealed the left gluteus (buttock) measured one cm in length by one cm in width and indicated as stable. The skin around the wound was attached, fragile, and blanchable with a normal temperature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365246	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Wert Manor	160 Fox Rd Van Wert, OH 45891

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	The Skin Issue note dated 03/05/25, written by the DON, revealed the wound to the left gluteus had increased in size and now measured three-point five cm in length by one-point two cm in width. The wound was covered 100% with eschar (a brown or black non-viable tissue) with moderate amount of seropurulent (mixture of purulent and serous) drainage and had an odor after cleaning. The wound bed was a dark colored eschar, the wound felt boggy and had increased in odor with purulent drainage. There was an order for consultation with MD #403. There was no documentation found in Resident #52's medical record indicating MD #403 had been notified. A progress note dated 03/07/25, written by Certified Nurse Practitioner (CNP) #405, revealed he had been contacted to do a wound check on Resident #52. The wound was to the left buttock. Nursing reported having first identified the wound about a month ago. Resident #52 reports having some pain in the wound and has been repositioned in the chair and/or bed to help with the pain. The physical examination revealed a wound to the left buttock approximately three cm in length by one cm in width with mild erythema (reddened tissue) with area of four cm in length and two cm in width. Partial thickness skin loss and yellow sloughing tissue in the wound bed. The assessment stated the wound needs debridement (surgical removal of non-viable tissue). The plan was to perform an incision and drainage of the left buttock wound under local anesthesia in the operating room with MD #403. An Interval History and Physical dated 03/13/25, written by MD #403, revealed Resident #52 has a pressure ulcer, unstageable at this time, as a result of quadriplegia. It is appropriate to proceed with the planned procedure of debridement with wound closure of left buttock. The wound measured three cm in length by one-point six cm in width and had eschar flush to skin level. The post debridement measurements before primary closure of the wound were three-point eight cm in length, two cm in width, and two-point five cm in depth. The area was injected with lidocaine (a local anesthesia) and the entire eschar area was sharply debrided with a scalpel. The underneath tissue appeared as non-healthy appearing fat, rather chronically ischemic. The tissue was sharply debrided to healthy fat, thankfully somewhat superficial. MD #403 attempted a primary closure, and a Penrose drain (a soft, flat, flexible latex tube used in surgery to promote drainage of fluids, like blood or lymph, from the surgical site) was placed into the wound bed. A progress note dated 03/21/25 revealed the left gluteus wound was deteriorating with dehiscence (partial or complete separation of a surgical wound). The incision measured five cm in length and had a heavy amount of seropurulent drainage. The dressing had a moderate amount of dark tan drainage and MD #403 was notified. A progress note dated 03/21/25, written by CNP #405, revealed nursing staff reported an increase in drainage and a reddened area to the top left of the wound. The wound appeared to have maceration to the superior lateral portion. The wound measured approximately four-point five cm in length, one-point three cm in width and two cm in depth. The wound bed had granulation tissue with little residual non-healthy fat. The sutures were removed as well as the Penrose drain. The wound was rinsed with peroxide and packed with one-inch iodoform, covered with gauze. A new order to apply zinc oxide cream to the macerated skin and change the iodoform packing daily with a dry dressing. Resident #52 was hospitalized from 03/25/25 to 03/27/25 and 04/03/25 to 04/11/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365246	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Wert Manor	160 Fox Rd Van Wert, OH 45891

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	Review of the hospital records revealed on 04/04/25, a sharp debridement of skin, subcutaneous fat, muscle mass and fascia were performed. Resident #52 has had continual progression of wound compromise from the initial surgical debridement on 03/13/25 and non-healing due to stool soiling the wound, causing persistent wound infection. Resident #52 needed another debridement and a diverting colostomy for wound care management. The Eliquis will need to be held. Resident #52 returned to the facility on [DATE] and the wound has been healing. Interview on 05/08/25 at 2:50 P.M. with the DON confirmed there was no physician order in place to treat Resident #52's left buttock wound from 01/27/25 to 02/19/25. The DON stated she was sure she had measured the wound and described the wound to the MD and received the order but apparently forgot to write it on 01/27/25. Interview on 05/08/25 at 3:00 P.M. with the Regional Director of Clinical Services (RDCS) #400 stated the dressing to the left buttock wound would have been changed due to Resident #52 being incontinent but confirmed there was no documentation located in Resident #52's medical record that a dressing was changed. Interview on 05/08/25 at 3:20 P.M. with MD #401 revealed he had not given the order to clean the left buttock wound as he had not been on-call that week and was unaware of Resident #52 having a wound. MD #401 stated he normally relies on the wound nurse for recommendations for treatments and was surprised to learn the fact the facility did not have a wound nurse. MD #401 stated cleaning the wound with soap and water and applying a foam border dressing was not an inappropriate treatment to treat Resident #52's wound. Review of the NPUAP guidelines dated 2014 revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. Review of the policy titled Pressure Ulcer Policy dated 04/29/16, revealed the wound will be monitored at least weekly and should have documentation including location and staging, size, drainage, pain and description of wound bed and surrounding tissue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365246	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Wert Manor	160 Fox Rd Van Wert, OH 45891

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, record review, and staff interview, the facility failed to ensure oxygen was provided with humidification per physician order. This affected one (#108) of one resident reviewed for oxygen use. The facility identified three (#13, #26, and #28) additional residents who received oxygen with humidification. The facility census was 53. Findings include: Review of the medical record for Resident #108 revealed an admitted [DATE] and a discharge date upon death of 05/07/25. Diagnoses included lung cancer and chronic obstructive pulmonary disease. Resident #108 was admitted to the facility under the care of Hospice. Review of the Clinical Admission Assessment, dated 05/01/25, revealed Resident #108 was alert and oriented to person, place, and time. Resident #108 received oxygen via nasal cannula with humidification. Review of the physician order initiated 05/02/25 revealed Resident #108 received oxygen at two liters per minute via nasal cannula. The physician order dated 05/02/25 revealed Resident #108's oxygen concentrator should be wiped down weekly and the water jug should be changed weekly. Observation on 05/06/25 at 9:14 A.M. revealed Resident #108 lying in bed, wearing a nasal cannula and the oxygen concentrator had no humidifier attached. Interview and observation on 05/06/25 at 3:16 P.M. with Certified Nursing Assistant (CNA) #353 revealed Resident #108 lying in bed awake, wearing a nasal cannula. CNA #353 confirmed the oxygen concentrator had no humidifier attached. Interview and observation on 05/07/25 at 9:39 P.M. with CNA #381 revealed Resident #108 lying in bed, wearing a nasal cannula. CNA #381 confirmed the oxygen concentrator had no humidifier attached. Interview on 05/07/25 at 9:52 A.M. with Licensed Practical Nurse (LPN) #371 confirmed Resident #108 had a physician order for oxygen with humidification and confirmed she added humidification to his concentrator after talking with CNA #381.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365246	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Wert Manor	160 Fox Rd Van Wert, OH 45891

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 51516 Based on record review and staff interviews, the facility failed to have a Registered Nurse (RN) on duty for eight consecutive hours every day. This had the potential to affect all 53 residents residing in the facility. Findings include: Review of the staffing schedules dated 04/27/25 through 05/03/25 revealed the facility did not have an RN scheduled on 05/03/25. The staffing schedules dated 04/19/24 through 04/20/24 revealed the facility did not have an RN scheduled on 04/19/25. Interview on 05/07/25 at 12:20 P.M. and 1:40 P.M. with the Director of Nursing (DON) stated she (DON) worked 05/03/25 between the hours of 2:30 P.M. and 9:00 P.M., for a total of 6.5 hours. The DON verified there were no RN hours on 04/19/25. Interview on 05/07/25 at 12:10 P.M. with Administrator verified there was only 6.5 RN hours who worked on 05/23/25.