STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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** 35035 Based on record review, review of the facility policy, staff interview, and resident interview, the facility failed to ensure all care was provided to residents with pressure ulcers per thier physician's orders. This affected one (Resident #2) out of four residents reviewed for pressure ulcer care. The current census is 67. Findings include: Record review for Resident #2 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #2 include neuromyelitis, neurogenic bladder, chronic pain, and osteomyelitis. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] revealed upon admission the resident had one unhealed stage 3 pressure ulcer and one unhealed stage 4 pressure ulcer. Review of Resident #2's MDS assessment dated [DATE] revealed the resident had intact cognition and two unhealed pressure ulcers. Review of Resident #2's care plans dated 12/20/24 revealed the resident was at risk for pressure ulcers due to mobility. Interventions included treatment per order, medications per order, monitor for changes and report to physician, and measure and monitor wound healing. Review of Resident #2's wound clinic documentation dated 10/28/24 revealed the resident was being cared for by the community wound physician in the clinic since 03/20/23. Per the wound documentation the resident had multiple chronic pressure ulcers which healed and then were reacquired due to her medical condition. On 10/28/24 the wound physician documented the resident had a stage 4 chronic pressure ulcer to the left buttock measuring 0.4 centimeters (cm) by 0.1 cm by 0.9 cm on 11/24/23. No pain was noted per resident report. Per the documentation the wound physician ordered the dressing change to be cleansing with normal saline, apply Medi honey get into wound bed and cover with gauze, to be changed every other day. Review of Resident #2's wound clinic documentation dated 02/03/25 revealed the resident had acquired a chronic pressure ulcer stage 4 on her right buttock measuring 1.9 cm by 2.5 cm by 1.7 cm depth with a moderate amount of serosanguineous drainage on 12/09/24. Per the documentation the wound physician ordered to have a wound vac placed on 02/05/25 for healing of the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's skin assessment dated [DATE] completed by Licensed Practical Nurse (LPN) #100 revealed on the 38 page assessment there was no documentation of any skin breakdown or wounds on the right buttock or gluteal fold. Review of Resident #2's physician orders dated 12/2024 to 02/2025 revealed on 11/07/24 the physician ordered to cleanse an open area to the right inner gluteal fold with normal saline and cover with dry foam dressing every other day at bedtime. On 12/10/24 the physician ordered to cleanse the right gluteal fold with normal saline, pat dry, and apply collogen and cover with gauze every day and as needed. On 12/16/24 the right gluteal fold dressing was changed to cleanse with normal saline, pat dry, apply Medi honey and cover with a foam dressing, change every other day and as needed. On 01/21/25 the right gluteal dressing order was cleanse with normal saline, pat dry, apply Santyl to wound bed pack with normal saline and cover with foam dressing to be changed every day and as needed. On 12/18/24 the physician ordered the left gluteal dressing order to be cleanse with normal saline, pat dry, apply border gauze every other day. Per the physician orders dated 02/04/25 the facility was to apply the wound vac to the right buttock wound. A large green foam to the wound bed, bridge away from pressure points, 125 mmHg continuous suction and the dressing was to be changed three times a week, Monday at wound clinic, Wednesdays and Fridays at the facility. The wound vac order was active at the time of the survey. Review of Resident #2's Treatment Administration Record (TAR) dated 12/2025 revealed there was no documentation of the resident receiving the dressing changes to the left gluteal fold on 12/11/24. Per the TAR dated 01/2025 Resident #2 did not receive the treatments to the left gluteal fold wound per physician order on 01/07/25, 01/11/25, 01/15/25, 01/17/25, 01/21/25, and 01/29/25. Resident #2 did not receive treatment to the right gluteal wound per physician order on 01/06/25, 01/07/25, 01/11/25, 01/15/25, 01/16/25, 01/17/25, and 01/19/25. Per the TAR dated 02/2025 Resident #2 did not receive the wound vac care on 02/18/25 and 02/19/25 per physician order. No corresponding documentation for the missing treatments was noted elsewhere in the medical records. Interview on 02/19/25 at 1:30 P.M. and on 02/20/25 at 11:15 A.M. with Resident #2 revealed she knew she had open wounds on her backside prior to the wound vac being applied. Resident #2 stated due to her conditions she would probably always have wounds. Resident #2 stated the nurses did not change the dressings daily. Resident #2 stated she hasn't had any increased pain due to the wounds and stated she feels the wounds will heal eventually as long as she continues to see the wound physician in the clinic. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 8:22 A.M. with LPN #100 revealed the nurse was the unit manager for Resident #2's unit. LPN #100 stated she does all the rounding with the in-house wound providers and reviews all the skin assessments and dressing changes for the residents. LPN #100 stated she was not aware of when the dressing changes were to be made for Resident #2's left buttock dressing but stated she knew the wound vac was changed in the wound clinic on Tuesday. The surveyor encouraged LPN #100 to review the orders on the computer to ensure accurate interview. LPN #100 stated Resident #2's wounds were cared for by an outside wound clinic and the dressing changes were to be added to the medical records. LPN #100 denied any reports from Resident #2 regarding her treatments not being completed Interview on 02/20/25 at 12:10 P.M. with Quality Assurance Manager (QAM) and LPN #100 verified there were missing documentation in the treatment records for 12/2024, 01/2025, and 02/2025's dressing changes for both her right and left buttock wounds and the wound vac. Interview on 02/20/25 at 12:30 P.M. with the Physician revealed the primary physician stated due to Resident #2's chronic medical conditions she would always be prone to having pressure ulcers. Per the Physician, all staff are to be careful with transfers and to report any changes in the resident's skin. The Physician stated the resident's wounds are being managed by an outside provider but stated he believed all the treatments were appropriate and to be completed by the nursing staff. Interview on 02/20/25 at 2:50 P.M. with LPN #100 revealed after Resident #2 returned from her wound clinic appointment on 12/09/24 she and the previous DON assessed the resident's right buttock. LPN #100 stated she felt the wound was Moisture-Associated Skin Damage (MASD) and not a pressure ulcer. LPN #100 stated the previous DON contacted the primary physician for orders for the dressing care for the right buttock before the wound clinic had sent their orders to the facility. LPN #100 verified she had documented on the resident's left buttock the day after she returned from the wound clinic but could not recall the right buttock's condition of wound during her assessment. Review of the facility policy titled, Skin Care Managment, dated 11/17/22 revealed the facility staff is to provide care for all skin breakdown to promote healing the pressure ulcers. This deficiency represents non-compliance investigated under Complaint Number OH00162641 and OH00162467.