STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365453	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Oregon	3953 Navarre Ave Oregon, OH 43616

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** Based on observation, medical record review, interview and review of the facility policy, the facility failed to ensure pressure ulcer wound dressings were in place and further failed to ensure pressure ulcer preventative interventions were implemented. This affected one (#25) of three residents reviewed for pressure ulcers. The facility census was 86. Findings include:Review of the medical record for Resident #25 revealed an admission date of 09/24/25. Diagnoses included paraplegia, polyneuropathy, pressure ulcer of right buttocks stage IV, and pressure ulcer of sacral region, stage IV.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Resident #25 had two unhealed stage IV pressure ulcers. Review of the care plan dated 05/21/26 revealed Resident #25 was at risk for impaired skin integrity related to incontinence, decreased mobility, current wounds, and osteomyelitis. Interventions included administering wound care treatments as ordered and report any abnormalities to the doctor. Resident #25 was to wear offloading boots while in bed.Review of the physician's orders dated 04/10/26 revealed Resident #25 had an order for wound care to an open area to the sacrum. The area was to be cleansed with wound cleanser, pat dry, apply collagen to the area, and cover with silicone border Zetuvit (advanced, multi-layer superabsorbent wound dressing designed to pull fluid away from the wound to help prevent the skin from getting soggy and breaking down) daily and as needed. Further review revealed Resident #25 had an order dated 04/10/26 for wound care for the posterior thigh. The area was to be cleansed with wound care wash, pat dry, apply collagen to the area and silicone border Zetuvit once daily and as needed. Lastly, Resident #25 had an order dated 05/07/26 to apply Triad cream to the left foot and cover with silicone border dressing once daily on day shift. Resident #25 was to wear a left foot (offloading) boot at nighttime and encourage the resident to wear the boot during the day if lying down.Observation on 06/02/26 at 10:03 A.M. revealed Resident #25 was lying in bed. Further observation revealed there was no wound dressing to the resident's sacrum wound, posterior right thigh wound, or to the left foot. Additional observation revealed Resident #25 was not wearing the offloading boot to the left foot. Concurrent interview with Resident #25 revealed the facility changed his wound dressings daily; however, they often fell off during care, such as incontinence brief changes and getting out of bed, and the staff did not reapply the dressings when they fell off. Resident #25 further stated that the staff never offered to put his offloading boot on and it was sitting in a box next to his bed.Interview on 06/02/26 at 10:25 A.M. with Licensed Practical Nurse (LPN) #158 confirmed she did not check Resident #25 today to ensure his wound dressings were in place. LPN #158 verified Resident #25 did not have a dressing to his coccyx, right posterior thigh, or left foot and was not wearing the offloading boot while in bed. Review of the facility policy titled, Dressings, Dry/Clean, dated September 2013, revealed the nurse should review the resident's plan of care and orders to determine if there were special resident needs. If the resident refused, or there were any issues with the treatment, report to supervisor and document.Review of the facility policy titled, Skin Management Program, dated April 2023, revealed the purpose of the skin management program guide was to provide an approach in the prevention and management of pressure injuries and skin alterations. Staff were to review and follow (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

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(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	orders to prevent pressure injuries.This deficiency represents non-compliance investigated under Complaint Number 2981965.