

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 243 Marion Drive Greenville, OH 45331	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035</p> <p>Based on record review, observations, review of the facility policy, review of the Self-Reporting Incident (SRI) database, and staff interviews, the facility failed to report an injury of unknown origin to the State Agency. This affected one (#15) out of 11 residents reviewed for abuse allegations not being reported. The current census is 68.</p> <p>Findings include:</p> <p>Record review of Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #15 include dementia, retrograde amnesia, falls, and asthma. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and was a complete assist for Activities of Daily (ADL).</p> <p>Review of Resident #15's care plans dated 08/16/24 revealed no focus for behaviors. Further review of the care plans revised on 08/19/24 revealed a focus for actual skin impairment to skin integrity of right posterior calf. Interventions included follow protocols for treatments of injury, identify and document potential causative factors to eliminate or resolve where possible.</p> <p>Review of Resident #15's skin assessments dated 08/19/24 revealed the resident had a laceration to her right lower leg measuring 6 centimeters (cm) by 4.8 cm. On 08/27/24 the laceration to the right lower leg measured 3.5 cm by 2.6 cm and was noted as healing. On 09/16/24 the laceration to the lower right leg measured 2.5 cm by 1.2 cm.</p> <p>Review of Resident #15's vital signs on 08/18/24 at 5:00 A.M. Resident #15 complained of pain at a 7 out of 10 level. Per the vital signs the resident denied any pain during further assessments.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #15's progress notes dated 08/18/24 at 5:39 A.M. the nurse documented the aide was conducting bed rounds and called for help to the resident's room. Resident #15 was noted to be on the side of the bed semi-curling up with a 'skin tear' to the posterior right calf. Per the note the resident was unable to verbalize how she got the wound. The nurse assessed the wound and applied a dressing. Per the note the nurse noted the wound was greater than 1 cm deep and was unable to be closed by the skin flap. The nurse then notified the physician and family. Per the note the resident was sent out to the hospital for treatment. Further review of the progress notes revealed on 08/18/24 at 12:04 A.M. the nurse had assessed the resident with no open wounds. Per the note dated 08/18/24 at 8:30 A.M. Resident #15 returned to the facility with a new order for antibiotics. On 08/18/24 at 9:51 A.M. Resident #15 was moved from her current room to a room across from the nurses' station.</p> <p>Further review of the medical record and facility documentation revealed there was no further documentation or investigation as to what caused Resident #15's laceration to her lower posterior calf on 08/18/24.</p> <p>Review of the SRI database revealed the facility had not reported Resident #15's injury of unknown source at the time of the survey on 09/19/24.</p> <p>Observation on 09/19/24 at 9:10 A.M. of Resident #15 revealed the resident sitting in her wheelchair in the dining room after breakfast. Resident #15 did not speak to the surveyor but did not appear to be in any distress or scared at the time of the observation. Observation at 2:15 P.M. Resident #15 sitting in the hallway by the nurses' station with other residents, appeared calm and without distress.</p> <p>Interview on 09/19/24 at 11:27 A.M. with Licensed Practical Nurse (LPN) #111 revealed on 08/18/24 she was working the 10:00 P.M. to 6:00 A.M. shift on Resident #15's unit. Per LPN #111 she was called into the room by another nurse to examine Resident #15's leg wound. LPN #111 stated it did not appear to be a skin tear or wound caused by a fall or the bed frame. LPN #111 stated she was there when another nurse who found scissors on the floor which appeared to have blood on them. LPN #111 stated she was witness to LPN #100 on 08/18/24 reporting the findings to the Director of Nursing (DON) and stating the scissors belonged to the roommate.</p> <p>Interview on 09/19/24 at 1:10 P.M. with Registered Nurse (RN) #400 revealed she was the nurse who assisted LPN #100 after Resident #15 was being transferred to the hospital. RN #400 stated when she arrived for her shift on 08/18/24, LPN #100 was preparing to transport Resident #15 to the hospital and the emergency squad was already in the building prior to 6:00 A.M. RN #400 stated she saw scissors on the floor in Resident #15's room and they appeared to have blood on them. RN #400 stated she examined the bed for sharp areas which could have caused the injury but found none. RN #400 stated she reported to the DON the injury had an unknown cause.</p> <p>Interview on 09/19/24 at 1:20 P.M. with the DON revealed on 08/18/24 in the early morning LPN #100 had reported Resident #15's injury and the scissors being found on the floor. Per the DON, the injury had an unknown cause. The DON verified the facility did not investigate the injury or report it per the facility's policy and regulation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, 'Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating' dated 04/2021 revealed all reports of abuse including injury of unknown source must be reported to the state agencies and thoroughly investigated by the facility. Findings of all investigations must be documented and reported.</p> <p>This deficiency represents non-compliance in regards to the complaint OH00157346.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035</p> <p>Based on record review, observations, review of the facility policy, review of the Self-Reporting Incident (SRI) database, and staff interviews, the facility failed to investigate an injury of unknown origin. This affected one (#15) out of 11 residents reviewed for abuse allegations not being reported. The current census is 68.</p> <p>Findings include:</p> <p>Record review of Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #15 include dementia, retrograde amnesia, falls, and asthma. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and was a complete assist for Activities of Daily (ADL).</p> <p>Review of Resident #15's care plans dated 08/16/24 revealed no focus for behaviors. Further review of the care plans revised on 08/19/24 revealed a focus for actual skin impairment to skin integrity of right posterior calf. Interventions included follow protocols for treatments of injury, identify and document potential causative factors to eliminate or resolve where possible.</p> <p>Review of Resident #15's skin assessments dated 08/19/24 revealed the resident had a laceration to her right lower leg measuring 6 centimeters (cm) by 4.8 cm. On 08/27/24 the laceration to the right lower leg measured 3.5 cm by 2.6 cm and was noted as healing. On 09/16/24 the laceration to the lower right leg measured 2.5 cm by 1.2 cm.</p> <p>Review of Resident #15's vital signs on 08/18/24 at 5:00 A.M. Resident #15 complained of pain at a 7 out of 10 level. Per the vital signs the resident denied any pain during further assessments.</p> <p>Review of Resident #15's progress notes dated 08/18/24 at 5:39 A.M. the nurse documented the aide was conducting bed rounds and called for help to the resident's room. Resident #15 was noted to be on the side of the bed semi-curling up with a 'skin tear' to the posterior right calf. Per the note the resident was unable to verbalize how she got the wound. The nurse assessed the wound and applied a dressing. Per the note the nurse noted the wound was greater than 1 cm deep and was unable to be closed by the skin flap. The nurse then notified the physician and family. Per the note the resident was sent out to the hospital for treatment. Further review of the progress notes revealed on 08/18/24 at 12:04 A.M. the nurse had assessed the resident with no open wounds. Per the note dated 08/18/24 at 8:30 A.M. Resident #15 returned to the facility with a new order for antibiotics. On 08/18/24 at 9:51 A.M. Resident #15 was moved from her current room to a room across from the nurses' station.</p> <p>Further review of the medical record and facility documentation revealed there was no further documentation or investigation as to what caused Resident #15's laceration to her lower posterior calf on 08/18/24.</p> <p>Review of the SRI database revealed the facility had not reported Resident #15's injury of unknown source at the time of the survey on 09/19/24.</p> <p>(continued on next page)</p>		

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