

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  07/02/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, and review of facility policy, the facility failed to ensure the physician was updated regarding a wound change affecting Resident #10. The facility also failed to ensure wound treatments and assessments were obtained timely affecting two (#10, #13) of three reviewed for wounds. The facility census was 63.1. Review of medical record for Resident #10 revealed an admission date of 04/16/25. Diagnoses included malignant neoplasm of mouth, tracheostomy and gastrostomy tubes, and skin graft to the right forearm. The resident was discharged on 05/09/25 to the hospital and did not return. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 10 indicating impaired cognition. Resident #10 was dependent on eating and required maximum assistance for toileting hygiene, bed mobility and moderate assistance for transfers. Resident #10 was documented to be frequently incontinent of bowel and occasionally incontinent of urine and was noted to have a surgical wound. Review of Resident #10's care plan contained no reference to the resident having a surgical wound and contained no information regarding Resident #10's dressing changes. Review of the physician orders to start 04/19/25 revealed Resident #10's right forearm surgical graft site was to be cleansed daily with normal saline, covered with xeroform followed by a nonadherent surgical dressing and wrapped with rolled bandage. The right arm was then to be wrapped with a Coban wrap (an adherent wrap used to secure and protect primary dressing). Review of the weekly nurse skin assessments revealed Resident #10 had a surgical graft site to the right forearm, however the assessments contained no description of the graft site. Review of a wound assessment note completed by the wound nurse dated 05/02/25 revealed Resident #10 had a right forearm surgical skin graft, the wound measured 5.2 centimeters (cm) by 2.6 cm. The wound description stated the wound had a pink base with scattered slough. Review of the 05/08/25 hospital documentation revealed Resident #10 was sent to the Emergency Department (ED) for altered mental status changes. Resident #10 was documented as alert and oriented to person at the time of arrival in the ED. The ED assessment revealed a wound to the right forearm with purulent drainage. The right forearm wound was cleansed and redressed. Resident # 10 was given an oral antibiotic and returned to the nursing facility with an antibiotic prescription. The ED discharge summary revealed Resident #10 was diagnosed with cellulitis of the right arm and altered mental status changes. Interview on 07/01/25 at 1:32 P. M. with Wound Nurse Licensed Practical Nurse (WNLPN) #101 revealed she had been off on medical leave and had not assessed Resident #10's wound until 05/02/25. WNLPN #101 verified the right forearm wound had a pink base with scattered slough during her assessment. WNLPN #101 verified previous wound assessments completed by nursing contained measurements but no description of the wound. WNLPN #101 stated she had not communicated with the physician regarding her assessment of Resident #10's right forearm wound. Interview on 07/02/25 at 1:12 P.M. with the Director of Nursing (DON) revealed the facility wound physician had not seen Resident #10 and added, the wound physician had seen a limited number of residents because the facility had obtained another wound company, and that company was scheduled to start in a few weeks. The DON verified the treatment and monitoring for Resident #10's wound were grouped together as one task on the Treatment Administration Record. The DON explained the expectation there should be a task for completing the wound care treatment ordered and another task for monitoring the wound site for signs and symptoms of infection. The DON verified Resident #10's progress notes and the weekly skin assessments did not contain a description of the wound and acknowledged it would be difficult to know if there were changes to a wound without such information. The DON also verified WNLPN #101 was not wound certified, however, stated WNLPN #101 did have wound care experience because she rounded with the wound physician. Interview on 07/02/25 at 3:26 P.M. with Physician #115 revealed he was unaware the wound physician had not seen Resident #10 and further stated the staff had not contacted him with any concerns regarding Resident #10's wounds. 2. Review of medical record for Resident #13 revealed admission date of 11/14/21 with diagnoses including diabetes mellitus type II, morbid obesity, depression and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. Resident #13 required supervision for meals and was dependent upon staff for bed mobility, transfers and toileting hygiene. Review of the 06/30/25 skin assessment completed by Registered Nurse (RN) #106 revealed documentation of a stage two pressure area to Resident #13's left buttocks. The assessment documented the area was not new</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on record review, observation, staff interview and policy review the facility failed to ensure proper infection control practices were followed during incontinence care. This affected one (#13) of three residents reviewed for incontinence care. The facility census was 63. Review of medical record for Resident #13 revealed an admission date of 11/14/21 with diagnoses including diabetes mellitus type II, morbid obesity, depression and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #13 dated 04/09/25 revealed a Brief Interview Mental Status (BIMS) score of 15, indicating intact cognition. Resident #13 required supervision for meals and was dependent upon staff for bed mobility, transfers and toileting hygiene. Observation on 07/01/25 at 2:42 P.M. of incontinence care by Certified Nursing Assistant (CNA) #108 for Resident #13 revealed CNA #108 donned required personal protective equipment (PPE) prior to entering the room, Resident #13 was found lying on her back in bed. CNA #108 unfastened the incontinence product and used a wipe to cleanse her peri area. Resident #13 had also been incontinent of stool. CNA #108 disposed of the wipe and assisted Resident #13 onto her left side. A soiled bordered dressing was observed on the left buttock. CNA #108 peeled the dressing off with her right hand and disposed of it in a clear trash bag. A shallow open area, approximately quarter-sized was observed. CNA #108 proceeded to grab a wipe from the package and cleanse the resident of stool. Using her right-hand CNA #108 wiped stool from resident and was observed to fold the wipe with her left hand and wiped the resident again before disposing the soiled wipe into the clear trash bag. CNA #108 then obtained another wipe from the package and was observed to wipe stool from resident #13's buttocks, fold the wipe with her left hand and then wipe over the open area on the left buttock. Just prior to the completion of care, CNA #108 wiped both the anal area and open left buttock wound in one motion with the same wipe before disposing of the wipe. CNA #108 then asked Resident #13 to return to her back and explained she would find the nurse to reapply the dressing. CNA #108 then removed her gloves, disposed of them in the trash bag, and removed the bag from the can. CNA #108 tied the trash bag and proceeded into the hallway where she opened the door to the soiled utility room and disposed of the trash bag. CNA #108 stepped back into the hall and then into Resident #13's room beside the soiled utility room and applied hand sanitizer. Interview with CNA #108 immediately after this observation, verified the dressing removed from Resident #13's left buttock had been soiled, but was intact when she removed it. CNA #108 also verified she did not perform hand hygiene immediately after care, prior to leaving Resident #13's room as she should have and further verified hand hygiene was completed after she returned to Resident #13's room after disposing of the soiled items into the soiled utility room. Interview on 07/02/25 at 1:12 P.M. with the Director of Nursing (DON) revealed CNA's have been educated not to remove a dressing during incontinence care. She shared it was the expectation the CNA to provide incontinence care and then get the nurse to remove the dressing, clean the area if needed and replace the dressing. The DON explained this would reduce the risk of contamination. The DON also verified hand hygiene should be completed immediately after providing care and prior to leaving a resident's room. Review of the facility policy, Incontinence Care, revised 04/28/25 documented if a resident was incontinent of feces at the time of the care, enclose the feces in a fold of incontinent product using toilet tissue, then cleanse, rinse and dry area thoroughly and remove soiled gloves and perform hand hygiene. This deficiency represents non-compliance investigated under Complaint Number 1383066.</p>		