STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, record review, interview and facility policy review, the facility failed to assess wounds and obtain appropriate treatment orders upon re-admission from the hospital, failed to ensure wound care supplies were available, and/or failed to complete pressure ulcer treatments as ordered by the physician for Residents #60, #7, and #79. Actual Harm occurred on 04/11/24 when Resident #60, who was severely cogntively impaired, dependent on staff for all activities of daily living, at risk for pressure ulcer development and had a history of pressure ulcers, was found per Wound Physician #675 to have an unstageable (full-thickness pressure ulcer in which the base was obscured by slough and/ or eschar (dead skin) pressure ulcer to the left sacrum. The facility failed to ensure systems and interventions were in place to prevent the development of the pressure ulcer and to identify the pressure ulcer prior to it being identified as an unstageable ulcer. In addition, staff failed to consistently assess, and complete treatments as ordered resulting a deterioration of the left sacral wound and Resident #60 being transferred to the hospital, per family request, on 04/19/24 and admitted with a diagnosis of osteomyelitis to the left sacral pressure ulcer. This affected three residents (#60, #7, and #79) of four residents reviewed for pressure ulcers. The facility identified 12 residents (#1, #2, #7, #17, #19, #20, #43, #49, #57, #60, #77, and #79) with pressure ulcers. The facility census was 78. Findings include: 1. Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses including anemia, spastic quadriplegic cerebral palsy, intellectual disabilities, pressure ulcer of the sacral region, severe protein calorie malnutrition, and epilepsy. Review of the admission Minimum Data Set (MDS) assessment completed on 03/12/24 revealed Resident #60 had severely impaired cognition, was dependent on staff for all activities of daily living and was always incontinent of bowel and bladder. The MDS further revealed Resident #60 had one Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) to the sacral region and one Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to the right posterior thigh present on admission. (continued on next page)

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
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Review of Wound Physician #675's progress note dated 03/28/24 revealed the Stage II pressure ulcer to Resident #60's left buttock was resolved and the Stage III pressure ulcer to Resident #60's right posterior thigh continued to improve and would be reassessed in seven days by the wound physician. There were no other wounds identified at the time of this assessment. A physician order dated 04/05/24 for wound care to the Stage III pressure ulcer of the right posterior thigh was also present with the following instructions: cleanse with normal saline (NS) or wound cleanser, apply collagen powder mixed with hydrogel, and cover with a dry dressing daily, on day shift. A prior order for the Stage III pressure ulcer of the right posterior thigh was in place from 03/08/24 through 04/04/24 and included cleansing the area with NS or wound cleanser, applying a collagen sheet, and covering with a dry dressing daily on day shift. Review of the treatment administration record (TAR) for April 2024 revealed no evidence the ordered wound care to the Stage III pressure ulcer of Resident #60's right posterior thigh was completed on 04/01/24, 04/03/24, 04/04/24, 04/05/24, or 04/10/24. Review of Wound Physician #675 's progress note dated 04/11/24 revealed an initial evaluation of an unstageable pressure ulcer of Resident #60's left sacrum. (The resident had a previously healed Stage II pressure ulcer on the lower left buttock, identified on admission which healed on 03/28/24. This was not the same area according to Wound Nurse Licensed Practical Nurse (LPN) #553. The new wound measured 5.0 centimeters (cm) by 5.0 cm by 0.3 cm with light serous exudate,100% devitalized necrotic tissue. A new order was written to cleanse with NS, apply Santyl (ointment used to remove damaged tissue) and ComfiTel dressing (silicone dressing that adheres gently to the skin, but not to wounds) daily. Review of the April 2024 TAR revealed no evidence the ordered wound care to the new pressure ulcer on the left buttock/sacral area was completed per physician orders on 04/14/24 or 04/17/24. Further review of the electronic TAR notes revealed wound care was unable to be completed per physician orders on 04/17/24 due to Santyl ointment being unavailable. Review of the TAR for April 2024 revealed no evidence the ordered wound care to the Stage III pressure ulcer of Resident #60's right posterior thigh was completed on 04/14/24 or 04/17/24. Review of Wound Physician #675's progress note dated 04/18/24 revealed the pressure ulcer on Resident #60's left sacrum was exacerbated due to multifactorial and measured 7.5 cm by 6.4 cm by 1.2 cm with moderate serous exudate. Further review revealed a surgical excisional debridement of the wound where 14. 4 cm of devitalized tissue, necrotic periosteum bone and slough were removed, revealing itself to be a stage four pressure ulcer (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) Review of this note revealed inconsistencies with the wound being described twice as exacerbated and once as not a wound deterioration. Review of a progress note dated 04/19/24 revealed Resident #60's guardian and representative wanted to see the resident's pressure ulcer/wound then requested Resident #60 be sent to the hospital after wound observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Review of the hospital admission progress notes dated 04/19/24 revealed Resident #60 had a sacral decubitus ulcer with erosive changes of the lower sacrum and coccyx consistent with osteomyelitis and a small developing abscess anterior to the sacrococcygeal junction, confirmed by computed tomography (CT) scan of Resident #60's pelvis. Review of the hospital discharge instructions also revealed the sacral wound was to be dressed with a wet to dry Kerlix dressing, covered with a dry dressing at a minimum of daily and when saturated or soiled. The resident was readmitted to the facility on [DATE]. Review of the progress notes, skilled nursing assessments and skin and wound evaluations revealed no documented evidence Resident #60's wound was re-assessed after she returned to the facility from the hospital on 04/26/24. Review of the April 2024 TAR revealed the 04/11/24 pre-hospital treatment of cleanse left buttock (which was the left sacrum wound identified on 04/11/24 per Wound Care LPN #553) with NS or wound cleanser, and Santyl and cover with border gauze was documented as completed on 04/27/24 and 04/28/24. However, there were not appropriate orders for treatment to the recently debrided left sacrum pressure ulcer until Monday, 04/29/24, when assessed by wound care. Review of the nursing progress note dated 04/28/24 stated called clinical phone to advise how to change coccyx (sacral) wound that was debrided in the hospital. Was advised to use calcium alginate dressing and a foam covering until wound care can assess Monday morning, 04/29/24. No new order was written, and there was no documented evidence that the recommended treatment was applied on 04/28/24. Review of the physician orders revealed an order dated 04/29/24 for a wet to dry dressing with instructions to cleanse Resident #60's sacral wound with NS, pack with saline moistened gauze, and cover with an abdominal (ABD) pad every night shift and as needed if it becomes soiled. Review of the orders also revealed an order dated 04/12/24 to cleanse the area to Resident #60's left buttock with NS or wound cleanser, apply Santyl, and cover with a bordered dressing daily. There were no updated sacral wound care orders in Resident #60's physician orders from her re-admission to the facility on [DATE] until 04/29/24. Review of the April 2024 TAR revealed no evidence the wound care to the pressure ulcer/wound on the left buttock/sacral area was completed per physician orders on 04/29/24. Observation of Resident #60's wound care on 04/30/24 from 12:05 P.M. to 12:20 P.M. being performed by Wound Care LPN #553 revealed the old dressing to sacral wound was saturated with pale yellowish to light brown tinged drainage with the written date of the last dressing change faded. At the time of the observation, LPN #533 stated the date looked to be 04/30 and said it may have been changed by the night shift. The wound measured 9.8 cm by 6.6 cm by 0.2 cm with no tunneling and wound care was performed per physician orders at the time of the observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Interview on 04/30/24 at 12:25 P.M. with Wound Care LPN #553 confirmed Resident #60's wound had shown signs of deterioration and was a Stage IV pressure wound. Prior to being hospitalized on [DATE]. Wound Physician #675 did not change wound care orders, despite change in appearance and size of the wound, and that was not typically what she experienced working with other more seasoned wound care physicians who would alter treatments if wounds regressed or did not show adequate signs of improvement. During the interview, LPN #553 confirmed the wound care treatment to which she was referring did not get changed by Wound Physician #675 after his assessment on 04/18/24 was for the left sacral wound, despite the order stating, left buttock, and that the wound to the lower left buttock was healed on 03/28/24. Interview on 04/30/24 at 4:10 P.M. with State tested Nurse Aide (STNA) #660 revealed she reported concerns to staff nurses that Resident #60's pressure ulcer/wound looked like it was getting bigger before she went to the hospital on 04/19/24. LPN #660 further reported Resident #60 was found without a dressing over her pressure wounds on several occasions, which she also said she reported to the nurses on duty who did not always do anything about it. Interview on 04/30/24 at 4:15 P.M. with STNA #562 revealed she had reported the lack of dressings covering Resident #60's pressure ulcer/wound several times and was concerned it was getting bigger and worsening. She further stated she became so concerned she stayed after her shift on 04/17/24 until Resident #60's wound was cleaned, and a new dressing was applied. During this interview, STNA #562 reported the nurse on the unit verbalized she did not know what to do with the wound, so STNA #562 went to another unit and asked that nurse to come look at Resident #60's wound. Per STNA #562, the nurse from the Dogwood unit assessed the wound, sent a photo of the wound to the DON, and provided wound treatment per DON instructions. The STNA informed the surveyor that she wrote a statement on 04/17/24 and one other date, which she could not recall, and placed it in the DON's mailbox. Interview on 05/01/24 at 8:15 A.M. with STNA #644 revealed she reported a concern with a foul odor coming from Resident #60's covered pressure ulcer/wounds within a few days before she was sent to the hospital on 04/19/24, but she was unable to confirm to whom she reported or on what date. Interview on 05/01/24 at 9:00 A.M. with the Director of Nursing (DON) revealed wounds had been challenging since she took the job two months ago. She reported the previous wound care nurse was no longer in the facility and the facility had a new one that started two weeks ago. The DON also reported the previous wound care physician who came to the facility weekly was let go due to documenting wounds were improving when they were not and not changing wound care orders when something did not work. She revealed a new physician was starting in the facility on Friday, 05/03/24, and a whole skin assessment of every resident was going to be completed. During an interview on 05/01/24 at 11:00 A.M, the surveyor informed the DON interviews with STNAs revealed concerns with wound care and the worsening of Resident #60's pressure ulcer/wound prior to her hospitalization on [DATE], and a note with those concerns was placed in her mailbox by an STNA on 04/17/24. In addition, the DON was informed there were no updated sacral wound care orders in Resident #60's physician orders from her re-admission to the facility on [DATE] until 04/29/24 and no documented evidence wound care was completed as ordered. The DON nodded her head with an up and down motion (reflecting agreement with the information shared). During this interview, the DON denied ever receiving written statements from any STNA regarding concerns related to worsening of the resident's wound, wound care not being performed, or nurses not reapplying dressings to Resident #60's sacral pressure ulcer when informed by the STNAs the dressing was missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Review of the undated policy titled Pressure Ulcer Prevention Intervention revealed treatments should be administered as ordered and evaluated for effectiveness. 44810 2. Review of the medical record for Resident #79 revealed an admitted [DATE]. Diagnoses included myelodysplastic syndrome, type two diabetes mellitus, and hypertension. Review of the admission MDS assessment dated [DATE] revealed Resident #79 had moderate cognitive impairment. Resident #79 required partial/moderate assistance for eating; substantial maximal assistance for oral hygiene and personal hygiene; and dependent for toileting, shower/bathing, upper body dressing, lower body dressing, and putting on and taking off footwear. Resident #79 had two unstageable pressure ulcers in the wound bed present on admission and was at risk for developing pressure ulcers. Review of the care plan dated 02/15/24 revealed Resident #79 had a pressure ulcer. Interventions included to change the dressing per physician's order and to follow the facility policies/protocols for the prevention/treatment of skin breakdown. Review of the physician's order for Resident #79 dated 04/04/24 revealed an order to clean open area on sacrum with normal saline, apply black foam to wound bed and apply collagen sheet to cover skin on right buttocks and cover with wound vac film and apply wound vac to 125mmhg continuous. Change every Tuesday, Thursday, and Saturday. Review of the TAR for Resident #79 revealed his wound vac was not changed on 04/17/24 because no wound vac supplies were available. Review of the nursing progress note dated 04/17/24 at 6:05 A.M. revealed Resident #79's wound vac dressing was not changed because the wound vac supplies were not available. Review of the nursing progress note dated 04/18/24 revealed a note that Resident #79's wound vac was not changed because the wound vac supplies were not available. Telephone interview on 04/29/24 at 2:47 P.M. with Wound Vac Representative #669 confirmed she was the representative for the facility. She reported the facility keeps an extra stock of wound vac supplies and an extra wound vac on reserve for when one breaks or malfunctions. She also confirmed that the only supplies that were delivered to the facility were on 03/22/24 with five foam dressing kits and five canisters and 04/18/24 with nine foam dressing kits and eight cannisters. Wound Vac Representative #669 reported when wound vacs were delivered, they just contain the vac and not the dressing kits and the canisters because the facility stocks them. She also reported that the wound vac foam dressing kits are only a one-time use. Wound Vac Representative #669 also reported that the facility had never called to state they had run out of supplies, and she was their only representative and they are very good at keeping those items stocked. She reported she has never received a phone call that they ran out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Interview on 04/30/24 at 10:39 A.M. with Wound Care Nurse LPN #553 revealed that she has been the wound care nurse for two weeks. She reported that wound vac supplies were ordered from the supplier. She confirmed that wound vac supplies were in the building when she started on 04/15/24, and they did get another shipment. She reported staff let her know when they run out of supplies and there are extra in the medication rooms. She reported that were also extra supplies in the clinical manager's office. She stated not a single nurse had talked to her about wound vac supplies since she started. She reported that if the nurse was unable to change a wound vac dressing due to being out of supplies and there was not an as needed order in place the physician should be notified. Interview on 04/30/24 at 2:30 P.M. with the DON reported she did not have documentation that the wound vac dressing was changed and verified that the nurses documented wound care supplies were not available for Resident #79 on 04/17/24, and 04/18/24. The DON reported that the facility does not have a policy on wound vacs or the supplies. Interview on 05/01/24 at 9:00 A.M. with the DON revealed wounds have been challenging since she took the job two months ago. She reported the previous wound care nurse was no longer in the facility, and the facility had a new one start two weeks ago. The DON also reported the previous wound care physician who came to the facility weekly was let go due to documenting wounds were improving when they were not and not changing wound care orders when something did not work. She revealed a new physician was starting in the facility on Friday, 05/03/24, and a whole skin assessment of every resident was going to be completed. Review of the undated facility policy pressure ulcer prevention intervention revealed the resident's skin will be assessed and monitored on a routine basis as is outlined skin assessment protocols. 3. Review of the medical record for Resident #7 revealed an admitted [DATE]. Resident #7 was in the hospital from 04/20/24 to 04/26/24. Diagnoses included human immunodeficiency virus, sepsis, tracheostomy status, stage four pressure ulcer of the sacral region, and psychoactive substance abuse uncomplicated. Review of the admission assessment dated [DATE] revealed Resident #7 had a 10.0 cm length by 10.0 cm width by 6.0 cm depth Stage IV pressure ulcer to his coccyx. Review of the admission MDS assessment dated [DATE] revealed Resident #7 had severe cognitive impairment. Resident #7 was dependent for oral hygiene, toileting, showering, dressing upper body, dressing lower body, and putting on and taking off footwear. Resident #7 had one unhealed Stage IV pressure ulcer. Review of the care plan dated 04/16/24 revealed Resident #7 had a potential for impaired skin integrity. Interventions included to keep skin clean and dry and changing the dressings as ordered by the physician. Review of the nursing progress note dated 04/20/24 revealed at 6:22 A.M. Resident #7 was found with his tracheostomy tube pulled out. The DON, the physician, and Resident #7's mother were notified, and he was sent to the hospital for further treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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 Note: The nursing home is disputing this citation.	Review of nursing progress note dated 04/26/24 revealed Resident #7 returned from the hospital at 2:45 P. M. He was assessed and the wounds to his right hip and coccyx had clean and dry dressings. Resident #7 was situated in bed and made comfortable. Review of the hospital discharge paperwork for Resident #7 dated 04/26/24 revealed no documentation regarding his right hip wound. Review of the nursing reassessment dated [DATE] revealed that Resident #7 had a pressure injury to his coccyx and right hip. No other documentation was available. Review of the physician's order dated 04/28/24 revealed an order to not apply a brief to Resident #7 until groin and bilateral inner thighs heal. Review of physician's order dated 04/30/24 revealed an order to clean Resident #7's coccyx wound with [NAME] (cleansing agent) and apply wet to dry dressing daily and as needed. The facility may use normal saline until the [NAME] was available. On 04/29/24 at 9:01 A.M. Resident #7 was observed lying in bed. Observation on 05/01/24 at 7:45 A.M. of wound care for Resident #7 with Wound Care Nurse LPN #553 and STNA #636 revealed Resident #7's inner thighs and scrotal were macerated and red. Trace marks of barrier cream were observed on the areas. The resident's coccyx dressing was saturated and beginning to peel off. An old dressing was dated 04/30/24. The dressing was saturated with serous drainage with no odor. The coccyx wound base and small areas of bowel movement in the wound bed. The edges were dry, and no areas of necrosis were observed. Wound Care Nurse LPN #553 cleansed the wound with normal saline and the wound bed appeared to have a small amount of slough, and the rest of the wound bed was beefy red. Wound Care Nurse LPN #553 then applied a wet to dry dressing. After the wound care was completed a foam boarder dressing was discovered on Resident #7's right hip. Wound Care Nurse LPN #553 reported she did not know why that dressing was there. STNA #636 confirmed Resident #7 returned from the hospital with it. STNA #636 exited the room and Wound Care Nurse #553 then removed the dressing to the right hip. The dressing had no date and time marked on it. An area of pressure was observed to his right hip. There was moderate serous drainage to the dressing and the base was beefy red. No odors were observed. Wound Care Nurse #553 reported she was not made aware of this area and confirmed there were no treatments in place for it (from readmission from the hospital on 04/26/24). Review of the undated facility policy pressure ulcer prevention intervention revealed the resident's skin will be assessed and monitored on a routine basis as is outlined skin assessment protocols. This deficiency represents non-compliance investigated under Master Complaint Number OH00153218 and Complaint Number OH00153238 and is an example of continued non-compliance from the survey completed on 04/11/24.