Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365591	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interview, self-reported incident (SRI) review, and facility policy review the facility failed to ensure Resident #72, who was on an anticoagulant (blood thinner), was monitored and treated timely for bruising. This affected one resident (#72) out of three residents reviewed for quality of care. The facility census was 66. Findings include: Review of the medical record for Resident #72 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included cerebral infarction, unspecified dementia, polyp of colon, and age-related osteoporosis. Review of the Significant Change Minimal Data System (MDS) assessment dated [DATE] revealed Resident #72 had severely impaired cognition. Review of the care plan dated 10/20/18 revealed Resident #72 was care planned for the potential for bleeding or hemorrhage related to the use of medications that have blood-thinning effects. Interventions included observe for signs of bleeding, black tarry stools, bruising, hematuria, headaches, nosebleeds, and report to physician, protect from falls/injury as possible, review labs and report abnormal immediately to physician, give medication as ordered, and identify condition or medications that could inhibit or enhance anticoagulant action. Review of the physician orders revealed an order dated 08/10/21 for Clopidogrel Bisulfate 75 milligram (mg), an anticoagulant, one tablet at bedtime (HS) and an order to monitor for signs/symptoms of bleeding or bruising due to anticoagulant use. Review of the weekly skin assessment completed on 04/05/24 revealed Resident #72's skin was intact with no new areas observed. Review of the March 2024 Treatment Administration Record (TAR) revealed an order to monitor for signs and symptoms of bleeding or bruising due to anticoagulant use revealed the order was not signed off as completed on 03/29/24. Review of the April 2024 TAR revealed an order to monitor for signs and symptoms of bleeding or bruising due to anticoagulant use revealed the order was not signed off as completed on 04/06/24. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the shower sheets for Resident #72 revealed on 03/29/24 the resident had small bruises on left upper leg, and on right leg above knee on inside by State tested Nurse Aide (STNA) #198 and signed off by Licensed Practical Nurse (LPN) #148, on 04/01/24 the resident had bruises on the inner thighs reported by STNA #198 and signed off by LPN #156, and on 04/08/24 STNA #198 reported bruises on the residents thighs, signed off by LPN #147. There was no documented evidence that the physician was notified. Review of the SRI tracking number 246537 revealed the facility was notified on 04/19/24 via email from the ombudsman, the new facility Resident #72 was transferred to noted bruises on admission (04/11/24) to Resident #72's thighs. An investigation was started and stated the resident was discharged at the time of the notification, so she could not be assessed. Resident #72 did have a skin assessment completed on 04/05/24 that noted no bruising or new areas. Resident #72 also had a daily order to check for signs and symptoms of bleeding or bruising due to anticoagulant use. From these checks, no new signs of bruising were noted until the day of discharge. The resident was seen by facility physician on 04/11/24 with no concern of bruising noted. The SRI failed to include the bruising noted on the 03/29/24 and 04/01/24 shower sheets. The allegation was unsubstantiated stating, chart indicates evidence that no bruises were noted while Resident #72 was a resident in the facility. Interview on 04/14/24 at 9:40 A.M. with LPN #156 revealed she saw bruises on 04/01/24 during a shower but couldn't remember what they looked like and believed she told the wound nurse but wasn't sure. There was no documented evidence that the physician was notified. Interview on 04/14/24 at 9:44 A.M. with LPN #148 verified on 03/29/24 she did not observe Resident #72's skin on shower day like she was supposed. LPN #148 was unaware if Resident #72 had any bruising on her thighs. There was no documented evidence that the physician was notified. Interview on 04/14/24 at 10:03 A.M. with LPN #147 revealed on 04/08/24 she did not observe Resident #72's skin on shower day like she was supposed to. LPN #147 reported to be honest I didn't observe it, honestly got signed off without looking at and definitely my fault. LPN #147 reported she didn't tell anyone because she didn't look at Resident #72's skin like she was supposed to. Interview on 05/21/23 at 7:43 A.M. with Resident #1 (who is related to Resident #72) revealed she saw bruises on Resident #72's thighs the night before her discharge. Resident #72 was discharged on [DATE]. Interview on 05/23/24 at 10:23 A.M. with the Director of Nursing (DON) confirmed the TAR for 03/29/24 and 04/06/24 were not signed off as completed for monitoring for signs and symptoms of bleeding or bruising. Review of the facility policy titled Anticoagulant Therapy, revised 03/08/22, revealed the nurse will observe the resident for signs and symptoms of bleeding and notify the physician of any abnormal findings. This deficiency represents non-compliance investigated under Complaint Number OH00153208.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interview and facility policy review the facility failed to ensure documentation was completed on the treatment administration records (TAR) as required after treatment is provided for Resident #73. This affected one resident (#73) out of three residents reviewed for wounds. The facility census was 66. Findings include: Review of the closed medical record for Resident #73 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included metabolic encephalopathy, type II diabetes mellitus (DM), sleep apnea, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and sepsis. Review of the admission wound assessment dated [DATE] revealed Resident #73 was admitted to the facility with multiple wounds. The wound on the sacrum was a stage IV 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.) measuring 12.9 centimeters (cm) by 9.5 cm x 2.0 cm. He also had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) to his left lateral thigh measuring 1.5 cm by 1.5 cm by unable to determine depth, a suspected deep tissue Injury (SDTI) (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.) to the right fourth toe tip and right plantar foot. He had stage IV pressure ulcers to the left superior leg, right lateral distal leg, and right lateral proximal leg. Review of the baseline care plan dated 03/19/24 for skin impairment included interventions including encouraging Resident #73 to float heels while in bed, pressure reducing mattress and cushion to chair, turn and reposition every two hours and as needed, wound treatments as ordered, evaluate for pain, limit time out of bed, nursing to observe the wound daily to ensure the dressing remains intact and there are no signs and symptoms of infection or increased drainage, refer to dietitian for dietary intervention, and monitor skin with baths and showers and notify nursing of any new areas. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Wound Care note dated 03/20/24 authored by the wound care physician revealed the sacral wound was classified as a stage IV pressure ulcer with 90% granular tissue and 10% slough. The wound measured 12.5 cm by 9.0 cm by 2.0 cm with 3.0 cm tunneling from 3-6 o'clock, 5.5 cm tunneling from 1-2 o'clock, and 1.2 cm tunneling from 9-11 o'clock. The wound was previously debrided in the hospital prior to admission. Continue Wound Vac at 125 millimeters of mercury (mmHg), change three times weekly on Monday, Wednesday, and Friday. The right lateral leg top wound was a stage IV pressure ulcer measuring 6. 0 cm by 1.5 cm by 0.2 cm with exposed muscle. The wound was debrided at the hospital. The treatment included silver alginate (antimicrobial dressing), abdominal (ABD) pad, and Kerlix gauze daily and as needed. The right lateral leg bottom was a stage IV pressure ulcer measuring 1.5 cm by 05.cm by 0.2 cm with 90% granulation tissue and 10% slough. The treatment included silver alginate, ABD pad, and Kerlix gauze daily and as needed. The left lateral leg bottom was a stage IV pressure ulcer measuring 10.0 cm by 3. 0 cm by 0.3 cm with 90% granulation tissue and 10% slough. The treatment included silver alginate, ABD pad, and Kerlix gauze daily and as needed. The left lateral leg top was a stage IV pressure ulcer measuring 1.5 cm by 0.5 cm by 0.1 cm with 90% granulation tissue and 10% slough. The treatment included silver alginate, ABD pad, and Kerlix gauze daily and as needed. The right plantar foot was a SDTI measuring 13.5 cm by 3.5 cm by unable to determine depth. The treatment included Betadine solution (antiseptic), ABD pad, and Kerlix gauze daily and as needed. The right lateral thigh was a non-pressure blister measuring 1.5 cm by 1.5 cm. The treatment included Betadine solution and a foam dressing daily and as needed. Follow-up in one week. Review of the Wound Care note dated 03/20/24 authored by the wound care physician revealed the sacral wound was classified as a stage IV pressure ulcer with 50% granular tissue and 40% slough, necrotic tissue. The wound measured 13.0 cm by 14.5 cm by 3.2 cm with 4.3 cm tunneling from 12-1 o'clock and 1.0 cm tunneling from 9-11 o'clock. The wound was previously debrided in the hospital prior to admission. Hold the Wound Vac and schedule a follow-up at the hospital for wound management. Use quarter-strength Dakins (antiseptic) wet to dry dressing. The sacral wound declined. The right lateral leg top wound was a stage IV pressure ulcer that had 100% granular tissue and measured 7.0 cm by 1.4 cm by 0.2 cm with exposed muscle. The wound was debrided at the hospital prior to admission. The treatment was changed to Xeroform (non-adherent gauze), ABD pad, and Kerlix gauze daily and as needed. The right lateral leg bottom was a stage IV pressure ulcer was healed. The left lateral leg bottom was a stage IV pressure ulcer measuring 10.0 cm by 3.5 cm by 0.6 cm with 90% granulation tissue and 10% slough. The wound status remained unchanged. The treatment was changed to Xeroform, ABD pad, and Kerlix gauze daily and as needed. The left lateral leg top was a stage IV pressure ulcer measuring 2.0 cm by 0.5 cm by 0.1 cm with 90% granulation tissue and 10% slough. The wound remained unchanged. The treatment was changed to Xeroform, ABD pad, and Kerlix gauze daily and as needed. The right plantar foot was a SDTI measuring 14.5 cm by 3.5 cm by unable to determine depth. The wound remained unchanged. The treatment included Betadine solution, ABD pad, and Kerlix gauze daily and as needed. The right lateral thigh was healed. Follow-up in one week. The wound physician had the initial encounter with the left fourth toe medial (present on admission) was a SDTI measuring 0.8 cm by 0.5 cm by unable to determine depth. Treatment included Betadine solution and leave open to air. Follow-up in one week. Review of the Treatment Administration Records (TAR) for March 2024 revealed the treatments for Resident #73's wounds were not signed off as completed for 03/21/24 and 03/29/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 05/22/24 at 10:00 A.M. confirmed Resident #73's wound care treatments were not signed off as completed on the March 2024 TAR for 03/21/24 and 03/29/24. The DON stated process after doing treatments, nurses were to sign off the TAR or at least put in the progress notes. The DON stated, the wound treatments were completed; however, the nurses forgot to sign off on them. Interview with the wound care physician on 05/22/24 at 10:27 A.M. verified the wound to the left fourth toe was a SDTI present on admission. Interview with Licensed Practical Nurse (LPN) #157on 05/22/24 at 10:44 A.M. revealed she worked on 03/21/24 and did treatments for Resident #73, but she forgot to sign them off as complete. Interview via phone with LPN #145 on 05/22/24 at 10:49 A.M. stated she worked on 03/29/24 and did Resident #73's treatments. When asked why they were not signed off as complete, she stated It must have slipped my mind. Review of the facility policy titled Wound Care, revised 11/2018, revealed to document the wound assessments, care, and treatments administered. Review of the facility policy titled Documentation in Medical Record, revised 01/01/24, revealed documentation will be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred. This deficiency represents non-compliance investigated under Complaint Number OH00153063.