| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365607 | A. Building<br>B. Wing | 04/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ayden Healthcare of Piqua | 275 Kienle Drive<br>Piqua, OH 45356 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical records, observation, staff interviews, review of employee training records, review of employee personnel files, review of manufacturer guidelines for a sit-to-stand lift, and review of facility policy, the facility failed to safely transfer a resident using a sit-to-stand lift. This affected one (#30) resident of the three residents reviewed for transfers. The facility identified three residents were dependent on staff for transfers. The facility census was 80.<br><br>Findings included:<br><br>Review of the medical record for Resident #30 revealed an admission date 11/25/24. Diagnoses included metabolic encephalopathy, muscle weakness, unsteadiness on feet, type two diabetes, and multiple fractures of ribs.<br><br>Review of Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was severely cognitively impaired as evidence by a Brief Interview of Mental Status (BIMS) of 02. Resident #30 was dependent on staff for transfers and required substantial to maximal assistance for other activities of daily living (ADLs).<br><br>Review of the plan of care for Resident #30 dated 02/26/25, revealed the resident had ADL self-care performance deficit related to Alzheimer's and limited mobility. Interventions included transfer with assistance from staff.<br><br>Observation of a transfer for Resident #30 on 04/17/25 at 11:30 A.M. with Certified Nursing Assistant (CNA) #245 and CNA #200, revealed Resident #30 was assisted to a sitting position on the side of the bed. CNA #245 then placed a yellow (medium sized for residents weighing between 121 and 165 pounds) sit-to-stand sling around the resident. The sling was situated approximately one inch under the right arm and approximately three inches under the left arm. The sling could not be secured properly across the resident's chest as there was an approximate eight-inch gap between the sides of the sling and the straps were directly on the resident's bare chest.<br><br>Interview on 04/17/25 at 11:45 A.M. with CNA #245, verified the yellow sling used on Resident #30 did not fit correctly which could have led to the resident slipping out the sling during the transfer. CNA #245 verified the yellow sling was a medium and the resident required a large sling.<br><br>(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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 04/17/25 at 1:33 P.M. with Physical Therapy Assistant (PTA) #219, revealed she provided training to the staff for the sit-to-stand lift when Resident #30 was assessed for needing therapy. PTA #219 stated she demonstrated the proper techniques to the staff, then had the staff sign a form verifying they were educated. PTA #219 stated Resident #30 required a large sling for safe transfers. PTA #291 stated the yellow sling used on the resident was a medium and it was too small for Resident #30.<br><br>Interview on 04/17/25 at 1:51 P.M. with CNA #200, verified Resident #30 was placed in a yellow sling which was too small and not the appropriate size for Resident #30.<br><br>Interview on 04/17/25 at 4:30 P.M. with Assisted Director of Nursing (ADON) #322, revealed the staff should have used the large green sling which was to be used on residents weighing between 154 to 254 pounds. ADON #322 verified Resident #30 was 249 pounds.<br><br>Review of the facility policy titled Mechanical Lift Transferring dated 08/2021, revealed two nursing staff members will be used for all mechanical lift transfers and transfers that were done smoothly and safely using the appropriate equipment.<br><br>Review of a facility form titled Mechanical Sling Lift for CNA #245, revealed staff would place a sling under a resident and visually check that sling is not too large or too small. CNA #200 was checked off for properly completing a sit-to-stand lift transfer on 01/05/24.<br><br>Review of a facility form titled Mechanical Sling Lift for CNA #200, revealed staff would place a sling under a resident and visually check that sling is not too large or too small. CNA #200 was checked off for properly completing a sit-to-stand lift transfer on 09/09/24.<br><br>Review of employee personnel file for CNA #245, revealed a hire date of 07/13/23. The employee personnel file contained a documented titled Employee Disciplinary Program indicated STNA #245 was given a verbal counseling for improperly transferring a resident using the sit-to-stand on 03/28/25<br><br>Review of the facility document titled Sling Color and Size Guide undated, revealed adults that weighed between 154 and 254 pounds, should have the green sling utilized when being transferred via the sit-to-stand lift.<br><br>Review of manufacturer instructions for the sit-to-stand lift titled SARA 3000, revealed the residents will be placed in the appropriate fitting sling for safe and effective transfer.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164223. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, observation, review of online resources from Centers for Disease Control and Prevention (CDC), and review of facility policy, the facility failed to provide adequate infection control techniques during a resident's dressing change. This affected one (#20) resident of the three residents reviewed for infection control. The facility also failed to ensure staff properly discarded personal protective equipment (PPE) after completing a resident's dressing change who was in Enhanced Based Precautions (EBP). This had the potential to affect the 19 other residents (#01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, #12, #13, #14, #15, #16, #17, #18, and #19) housed on the 100-hall who the facility identified as not being in EBP. The facility census was 80.<br><br>Findings included:<br><br>Review of record revealed Resident #20 had admission date on 03/17/25. Diagnoses included orthopedic aftercare from surgical amputation left leg below knee, acute osteomyelitis in left ankle and foot, and left leg below the knee, and acute kidney failure.<br><br>Review of a physician order for Resident #20 dated 03/18/25, revealed the resident was ordered to have his coccyx wound cleansed with saline wound wash, patted dry, calcium alginate applied and covered with a superabsorbent dressing every day.<br><br>Review of a Minimum Data Set (MDS) dated [DATE] revealed Resident #20 had a Brief Interview of Mental Status (BIMS) of 14 which indicated he was cognitively intact. Resident #30 required substantial to maximal assistance for activities of daily living (ADLs).<br><br>Review of a physician order for Resident #20 dated 03/25/25, revealed the resident was ordered to be in Enhanced Barrier Precautions (EBP) due to pressure wounds and a wound on the right leg.<br><br>Review of the plan of care dated 04/13/25, revealed Resident #20 had a pressure ulcer (a pressure ulcer is a localized injury of the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) to the coccyx related to immobility. Interventions included administer medication as ordered, administer treatments as ordered, stay in EBP related to wounds, weekly treatment documentation to include measurement of each area of skin breakdowns.<br><br>Review of a weekly skin assessment dated [DATE], revealed Resident #20 had a pressure ulcer on his coccyx which measured 2.1 centimeters (cm) in width by 1.1 cm in length by 0.1 in depth and categorized as a stage three pressure ulcer (full-thickness skin loss in which adipose [fat] is visible). The resident had a second wound on his left thigh related to a surgical incision which measured 8.3 cm in width by 1.2 cm in length by 0.2 cm in depth.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation of wound care for Resident #20 on 04/29/25 from 10:58 A.M. through 11:14 A.M. with Registered Nurse (RN) #288, revealed the resident was able to turn himself to his right hip and assist with positioning. RN #288 washed her hands, applied personnel protective equipment (PPE) and gloves. RN #288 cleansed the resident's coccyx wound with four-by-four gauzes and normal saline spray. RN #288 placed the contaminated four-by-four gauzes on top of the resident's uncovered bedside table. RN #288 then took her scissors and cut the new calcium alginate dressing and applied it to the resident's wound bed. RN #288 never removed her contaminated gloves nor completed any hand hygiene before moving from a dirty area to a clean when completing the dressing change. Interview at the same time, RN #288 verified she didn't change gloves nor completed any hand hygiene when going from an area of dirty to clean wound care. RN #288 discarded the wound dressing items, removed her gloves and discarded, and exited the resident's room with her PPE (gown) in place. RN #228 placed her gown in the housekeeper's cart trash can located in the 100-hallway and RN #288 continued down the 100-hall.<br><br>Interview on 04/29/25 at 11:15 A.M. with Housekeeper Director #300 verified RN #288 placed her gown in the mobile housekeeping cart trash bag after leaving Resident #20's room.<br><br>A subsequent interview on 04/29/25 at 11:45 A.M. with RN #288, verified Resident #20 was in EBP. RN #288 stated she was not thinking when she exited the resident's room and discarded the PPE gown in the housekeeper's mobile cart trash bag. RN #288 stated she should have taken off her gown inside the resident's room and discarded it.<br><br>Interview on 04/29/25 at 1:05 P.M. with Regional Nurse (RN) #350, revealed her expectations would be for all nurses to follow the appropriate infection control techniques. RN #350 stated she would expect a nurse to change their gloves and perform hand hygiene, when going from an area of dirty to clean, while completing dressing changes. RN #350 stated staff should not be discarding their PPE outside of a resident's rooms who were in EBP.<br><br>Review of facility policy titled Enhanced Barrier Precautions dated 04/01/24, revealed the facility was required to have PPE including gowns and gloves available. PPE must be removed and discarded in the residents' room. Position a trash can inside the resident's room and near the exit for discarding PPE after removal and prior to exit of the room.<br><br>Review of the facility policy titled Wound Care dated 08/2024, revealed staff shall complete wound care/ dressing changes using the appropriate infection control techniques. Remove old dressing and appropriately discard then wash and dry hands thoroughly before starting the new dressings.<br><br>Review of the web site titled https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html dated 03/20/24 revealed that hand washing matters, and recommended immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handing invasive medical devices, between working on a soiled body site and a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. |