

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Westerville Post Acute.		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 Eastwind Drive Westerville, OH 43081	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interview and facility policy review, the facility failed to ensure dressing changes were completed as ordered by the physician. This affected one (Resident #16) out of three residents reviewed for wound care. The facility census was 84. Findings include: Review of the medical record for Resident #16 revealed an admission date of 10/16/24 with diagnoses including mild cognitive impairment, borderline personality disorder, type II diabetes mellitus, non-pressure chronic ulcer of the right foot, paraplegia, chronic kidney disease, anxiety, depression and osteomyelitis of the vertebra. Review of the care plan dated 10/26/24 revealed Resident #16 has an alteration in skin integrity with an unstageable pressure injury (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 the right buttock and a deep tissue injury (DTI) (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 left heel. Interventions included administering medications per physician orders, documenting wound status weekly and as needed, elevating heels, monitoring wounds for signs or symptoms of infection, and completing treatments per order. Review of a physician order dated 07/03/25 revealed a left heel DTI with directions to apply Skin-Prep (forms a protective barrier) to the peri-wound, paint the DTI with Betadine (disinfectant), cover with an absorbent dressing, and wrap with Kerlix gauze. Dressing changes were to occur every shift and as needed for soiled or dislodged dressings. Review of a wound care provider progress report dated 07/17/25 revealed treatment orders for: Left midline heel: Paint the area with Betadine, cover with an absorbent pad dressing, and wrap with rolled gauze twice daily (BID) and as needed (PRN). Right medial gluteal fold: Cleanse with Dakin's solution (disinfectant), pat dry, apply medical-grade honey (antimicrobial to promote healing) and calcium alginate (dressing for wounds with moderate to heavy drainage), and cover with a foam dressing BID and PRN. Review of a physician order dated 07/18/25 revealed an unstageable right buttock pressure injury with directions to cleanse with Dakin's solution, pat dry, apply Medi-Honey, and cover with calcium alginate and a sacral foam dressing. The dressing was to be changed every shift and as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed 07/18/25 revealed Resident #16 is cognitively intact, had impairments in both lower extremities, requires substantial to maximal assistance with bathing, and has one unstageable wound and one DTI. Review of the Braden Assessment (tool to predict the risk of pressure ulcers) completed 07/25/25 revealed Resident #16 had no sensory perception impairment, very moist skin, was chairfast, completely immobile, had adequate nutrition, and showed no apparent problem with friction or shear placing the resident at risk for pressure sores. Review of the Treatment Administration Record (TAR) for 07/26/25 through 07/31/25 revealed dressing changes to the left heel DTI and unstageable right buttock pressure injury were not marked as completed or refused on 07/26/25 or 07/27/25. Review of progress notes dated 07/26/25 through 07/27/25 revealed no documentation of refusal or completion of the left heel DTI or right buttock dressing changes for Resident #16. Resident #16 expressed concerns regarding missed wound care during the night shifts on 07/26/25 and 07/27/25. She stated that nursing staff neither offered nor provided the scheduled dressing changes, and she did not refuse the care. Interview conducted on 07/31/25 at 10:20 A.M. with the Director of Nursing (DON) confirmed Resident #16's medical record did not contain evidence the resident received the physician-ordered dressing changes on 07/26/25 and 07/27/25. The DON confirmed if a treatment was refused, it should be documented on the TAR and followed up with a progress note that included notification to the wound nurse and physician. The DON confirmed Licensed Practical Nurse (LPN) #118 was assigned to complete the dressing changes for Resident #16 on those dates. Interview conducted on 07/31/25 at 1:22 P.M. with LPN #118 confirmed if dressing changes were completed, they should be documented on the TAR. If refused, it should also be documented on the TAR with a corresponding progress note. Review of the facility's dry/clean dressing policy (undated) revealed that documentation should include the date and time the dressing was changed, the name and title of the person who changed the dressing, type of dressing and wound care provided, any problems or complaints, and if the resident refused treatment the reason for refusal, the explanation of risks and benefits, alternative options, and the signature and title of the person recording the data. This deficiency represents non-compliance investigated under Complaint Number 2566099.</p>		