STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365626	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellbrook Health and Rehab	1957 North Lakeman Drive Bellbrook, OH 45305

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, record review, facility staff interview, and policy review the facility failed to timely repositioning and turn one resident (#36) of three reviewed for pressure ulcers. The facility census was 42. Findings Included: Review of medical record for Resident #36 revealed a re-admitted [DATE], and an initial admitted [DATE]. Diagnoses included anoxic brain damage, stage four pressure ulcer of left elbow and sacrum which were documeted to be present on admission to the facility. Review of plan of care dated 06/18/24 revealed that Resident #36 had actual stage four pressure ulcer to the left elbow. Interventions included turning and repositioning schedule per assessment, turn side to side in bed every one to two hours, and treatments as ordered. Resident #36 also had a stage four pressure ulcer to right sacrum plan of care that included interventions of pillows for positioning, low air loss mattress, turning and repositioning and weekly wound assessment. Resident #36 was at risk for pressure ulcers due to impaired mobility. Interventions included weekly skin inspection, and repositioning schedule per assessment. Review of Braden Scale for predicting pressure ulcer risk dated 08/11/24 revealed Resident #36 was at high-risk to develop pressure ulcer with a score of 10.0. The Braden scale scoring criteria was severe risk scored 9 or less, high risk scored 10 through 12, moderate risk scored 13 through 14, mild risk scored 15 through 18, and no risk scored 19 through 23. Observation on 08/14/24 from 9:40 A.M. through 11:42 A.M. revealed Resident #36 was laying in bed on their left side. At 11:42 A.M. Registered Nurse #329 and State tested Nursing Assistant (STNA) #405 were observed to provide Resident #36 incontinence care, wound care and repositioning. Interview on 08/14/24 at 10:50 A.M. with STNA #405 confirmed she was caring for Resident #36 and verified she had not turned or repositioned Resident #36 on the day shift on 08/14/24. STNA #406 stated she clocked in later due to being called in to work. Interview on 08/14/24 at 1:43 P.M. with STNA #284 who stated Resident #36 was on her assignment and verified she worked the day shift but left the facility around 8:30 A.M. due to not feeling well. STNA #284 verified she had not provided any care, repositioning or turning to Resident #36 on 08/14/24. (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
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/24 at 3:37 P.M. with STNA #369 who worked the overnight shift verified stated Resident #36 was changed and repositioned in bed at 5:00 A.M. on 08/14/24 to his left side. STNA #369 stated she remembered that time, because she assisted the nurse with treatments. This was the only repositioning care staff remembered providing the resident on 08/14/24 from 5:00 A.M. through 11:42 A.M. when RN #329 and STNA #405 were observed to provide incontinent care, wound care and repositioning for Resident #36. Review of policy titled Prevention of Pressure Injuries with a revision date of April, 2020 revealed The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Reposition the resident as indicated on the care plan. This deficiency represents non-compliance investigated under Complaint Number OH00156007.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observations, interview, and facility policy review the facility failed to ensure enhanced barrier precautions were followed for one resident (#36) and failed to ensure soiled gloves were removed prior to touching clean items for one (#36) of three residents reviewed. The facility census was 42. Findings Included: Review of medical record for Resident #36 revealed a re-admitted [DATE], and an initial admitted [DATE]. Diagnoses included anoxic brain damage, stage four pressure ulcer of left elbow and sacrum which were documeted to be present on admission to the facility. Observation on 08/14/24 at 11:42 A.M. Registered Nurse (RN) #329 and State tested Nurse Aide (STNA) #405 enter Resident #36 room to perform incontinence care, repositioning, wound care, and to check urinary catheter for position. The staff were observed to bring the wound treatment cart into Resident #36's room and the staff were observed to put on gloves to provide care to the resident. No other personal protective equipment (PPE) was used by the staff during the observation. STNA #405 was observed to uncover the resident, reposition the resident and open the incontinent brief prior to assisting RN #329 with wound care. STNA #405 had touched Resident #36's linens, and incontinent brief. RN # 329 asked STNA # 405 to get an additional four-by-four dressing out of the treatment cart during wound care. STNA #405 did not remove her soiled gloves, perform hand hygiene and don new gloves prior to searching in the treatment cart's first and second drawers to grab another four-by-four sterile dressing. STNA #405 was observed to open the first and second drawer of the treatment cart with her soiled gloves on, locate a four-by-four dressing and give it to the RN #329 to finish cleansing Resident #36 coccyx wound. Interview on 08/14/24 at 1:00 P.M. with Director of Nursing (DON) confirmed the treatment cart should have not been taken into Resident #36's room, due to the resident being in enhanced barrier precaution. Interview on 08/14/24 at 1:42 P.M. with DON confirmed she expected staff to use correct ppe when taking care of a resident. Interview on 08/14/24 at 5:00 P.M. with RN #329 stated yes, that STNA #405 should have never reached into the treatment cart for supplies when having dirty gloves while caring for Resident #36 in his room for personal, and wound care. Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 08/2022 revealed that the facility enhanced barrier precaution are used as a infection prevention and control interventions to reduce the spread of multi-drug resistant organisms (MDRO) to residents. 2. EBP employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. EBP use of gown and gloves is required for high contact care activities including toileting, wound care, and device care including urinary foley care.