STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365654	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austinwoods Rehab Health Care	4780 Kirk Rd Austintown, OH 44515

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 22653 Based on medical record review, review or residents' rights and interview, the facility failed to ensure they honored a resident's right to choose their plan of treatment. This affected one (Resident #88) of three residents reviewed for change in condition. The facility census was 81. Findings include: Review of Resident #88's closed medical record revealed diagnoses including acute pulmonary edema, type two diabetes mellitus, end stage renal disease, hypotension, chronic congestive heart failure, dependence on renal dialysis, hypercholesterolemia, paroxysmal atrial fibrillation, hypothyroidism, hyperlipidemia, difficulty walking, obesity, thrombocytopenia, non-rheumatic aortic valve disorder, aneurysm of the ascending aorta without rupture, atrial flutter, non-pressure chronic ulcer of the foot, acute kidney failure, aortic valve stenosis, dizziness, cellulitis, anemia and a history of gastrointestinal hemorrhage. Review of a nurse practitioner note revealed on 03/13/24 Resident #88 was alert and in no obvious distress. Resident #88 was sitting in her wheelchair and had no complaints of weakness to her bilateral lower extremities but continued to complain of burning discomfort to both legs. Gabapentin (medication used for neuropathic pain) had been increased recently but nephrology wanted no additional increases of the gabapentin. Resident #88 was concerned her weakness would increase. Treatment options were discussed. Resident #88 did not want to go to the hospital at that time. Nurses would let the physician, nurse practitioner or physician assistant know of any changes. A nursing note dated 03/14/24 at 12:27 A.M. revealed Resident #88 was insisting on going to the hospital to get a Computed Tomography (CT) scan. Resident #88 stated she could have had a stroke days ago. The doctor was already aware. A neurology appointment was scheduled and Resident #88 would continue to be monitored. There was no indication the physician was made aware of the request at that time although that was an option discussed with the nurse practitioner on 03/13/24. A nursing note dated 03/14/24 at 8:23 A.M. revealed Resident #88 was requesting to be sent to the emergency room (ER) for a CT and reported I'm just not feeling right. A nursing note dated 03/14/24 at 9:14 A.M. indicated Resident #88 was transported to the hospital for evaluation. A message was left for Resident #88's daughter. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 03/14/24 at 2:26 P.M. indicated Resident #88 was being transferred back to the facility. A straight catheterization was done and she had a urinary tract infection. An order was received for Omnicef (antibiotic) with the first dose given in the ER. A CT was negative. Review of the Nursing Home Resident's [NAME] of Rights revealed residents had the right to have all reasonable requests and inquiries responded to promptly. During an interview on 05/01/24 at 3:33 P.M., the Administrator stated staff were taught residents and families had the right to have wishes honored regarding treatment, including transfers to the hospital. On 05/01/24 at 4:05 P.M., the Administrator stated the nurse who did not send Resident #88 to the hospital when she was insisting on going worked for agency and the facility no longer permitted her to work at the facility. This deficiency identified noncompliance as an incidental finding during the investigation of Master Complaint Number OH00153187.

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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 0686 Level of Harm - 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** 47570 Based on observation, medical record review, facility policy review and interview, the facility failed to develop and implement an effective and individualized pressure ulcer prevention program to prevent the worsening of a pressure ulcer to the coccyx for Resident #37. Actual harm occurred on 05/01/24 when the facility Wound Nurse (WN) #318 identified Resident #37, who was at risk for pressure ulcer development and dependent on staff for turning and repositioning, had an unstageable (full thickness loss of tissue completely covered by dead tissue) pressure ulcer to the coccyx. The resident had been admitted to the facility on [DATE] with a Stage I (skin intact and redness to skin over a bony prominence) pressure ulcer to the coccyx. The facility failed to ensure adequate and effective interventions (including turning and repositioning) were provided to prevent the deterioration of the ulcer to an unstageable pressure ulcer. This affected one resident (#37) of three residents reviewed for change of condition. The facility census was 81. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including end stage renal disease, arteriovenous fistula, hyperparathyroidism, disorder of plasma protein metabolism, iron deficiency anemia, hypotension of dialysis, atrial fibrillation, anxiety disorder, hypertrophic disorder of the skin unspecified, coagulation defect, angina pectoris, anemia, gallstone ileus and hip fracture with surgical intervention. Review of the facility document titled Baseline Care Plan, dated 04/19/24, revealed Resident #37 was alert and at times confused, required assistance from two staff for bed mobility, transfers, walking and toileting and used a wheelchair for mobility. Resident #37 was continent of bowel and bladder and had a Stage I pressure wound to her coccyx. Interventions included turning and repositioning every two hours, pressure reducing mattress to the bed, pressure reducing cushion to the wheelchair and a zinc cream with foam dressing to the coccyx wound. Resident #37 had pain present in her right hip (status post fracture with surgical intervention) and coccyx with oxy (oxycodone: a narcotic pain medication) as the pharmacological intervention for the pain. Review of the facility document titled Skin Grid, dated 04/19/24 and authored by Licensed Practical Nurse (LPN) #337, revealed Resident #37 was admitted with a Stage I pressure ulcer to the coccyx. The epithelial tissue was pink, there was no drainage and no odor. There were no wound measurements noted on the skin grid. Review of the facility document titled Braden Scale for Predicting Pressure Ulcers, dated 04/19/24, revealed Resident #37 was at risk for development of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) dated 04/01/24 to 04/30/24, for Resident #37 revealed she was being medicated for pain with Oxycodone-Acetaminophen oral tablet 5-325 milligrams one tablet every six hours as needed for pain which ranged between a pain level of four to seven (the pain scale was zero to 10 with ten being the worst pain) on 11 out of 12 occasions for assessment of pain. The pain medication was noted to be effective at treating the pain. The documentation on the MAR did not specify the location of the pain or specify there was an associated nurse's note to reflect the location of the resident's pain. In addition, review of the medical record/MAR revealed no documented evidence of turning and repositioning being provided for the resident every two hours. Review of the Treatment Administration Record (TAR) dated 04/01/24 to 04/30/24 revealed an order dated 04/19/24 for zinc to the coccyx, pad and protect with silicone border every night shift and every other day. The treatments were signed off as being completed as ordered. Review of the TAR revealed no documented evidence of turning and repositioning being provided for the resident every two hours. Review of the progress notes dated 04/19/24 to 04/30/24 revealed on 04/19/24 Resident #37 was admitted to the facility with a reddened area to coccyx. Zinc was applied and a pad and foam border dressing placed. On 04/25/24 at 6:10 A.M. it was noted Resident #37 was sent to the hospital emergency room due to low blood pressure and increased nausea and vomiting. On 04/25/24 at 5:15 P.M. Resident #37 returned to the facility with no new orders. Further review of the progress notes and medical record revealed a skin assessment was not completed on 04/25/24 upon the resident's return from the emergency room . Review of a progress note dated 04/26/24 at 6:05 P.M. revealed the dressing to the resident's coccyx was soiled. New foam dressing applied. Daughter in facility and concerned about coccyx wound. The note documented the area was present from recent hospital stay. Small slit in skin observed with small amount of redness noted to area. Advised daughter this nurse would notify facility wound nurse. Patient education given on interventions to promote wound healing. There was no information in the progress notes to indicate the resident was noncompliant with wound care or turning and repositioning. In addition, there was no evidence the facility wound nurse had assessed this wound from 04/19/24 through 04/26/24. Review of the facility document titled Skin Grid, dated 05/01/24 and authored by (facility) Wound Nurse (WN) #318 revealed this was the first observation by WN #318. Resident #37 was admitted with a Stage I pressure ulcer and currently had an unstageable pressure ulcer. The description of the wound included the wound had 100 percent light yellow slough (dead skin that impedes healing) covering the wound base. There was a small amount of serosanguinous (fluid containing both blood and liquid part of blood) drainage and no odor. The wound edges were well defined, well attached to the wound base and irregular in shape. The area around the wound had slow blanching (skin that remains white or pale for longer than normal when pressed) erythema (redness) without temperature change. The wound measured 2.0 centimeters (cm) in length, 0.5 cm in width and depth was 0.1 cm. Treatment was changed to cleanse with normal saline, apply Santyl (medication that removes dead tissue from wounds) ointment to the wound base and cover with adaptive dressing and secure with silicon dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the physician order dated 05/01/24 revealed wound treatment orders for Santyl external ointment 250 units per gram (collagenase); apply to sacrum topically every night for wound care and cleanse open area with normal saline solution, apply Santyl to wound base, cover with adaptic, secure with sacral size foam dressing every night shift for open area. Review of a progress note dated 05/01/24 at 11:10 A.M. and authored by WN #318 revealed she saw Resident # 37 due to worsening area to sacrum (coccyx) present on admission. The resident's daughter stated the area started as a skin tear in the hospital before coming to the facility. Resident #37 expressed slight discomfort when sitting for long periods of time. Resident #37 had expressed discomfort when sitting for long periods in dialysis. The nurse practitioner was notified. Low air loss mattress was to be placed (recommended on 05/01/24) and a gel wheelchair cushion was in place (present from admission). Resident was on a turning schedule, and incontinence program. Resident's daughter agreed. Review of the MAR and TAR for May 2024 revealed on 05/01/24 an order to cleanse open area to sacrum with normal saline solution, apply Santyl to wound base, cover with adaptic, secure with sacral size foam dressing every night shift for open area and Santyl ointment to sacral area every night shift. The treatments were signed off as completed as ordered. The resident's pain level was assessed between a level two to four with Oxycodone-Acetaminophen noted to be effective treatment for the pain. Further review of the medical record revealed no documented evidence of turning and repositioning being provided for the resident every two hours. Interview on 05/01/24 at 11:30 A.M. with facility WN #318 revealed she was not aware of Resident #37's Stage I pressure ulcer that had been present on 04/19/24. WN #318 revealed she was notified by phone to look at Resident #37's skin on 04/26/24 but felt it was not a priority, therefore WN #318 assessed Resident #37's skin on 05/01/24. WN #318 stated because there was not a comprehensive assessment completed upon admission she could not assess if the wound had become better or worse. WN #318 also verified the dialysis center had not been notified Resident #37 had a pressure ulcer and there had been no communication to the dialysis center as to what interventions were needed during treatment. WN #318 also verified she was unaware if Resident #37 was compliant with every two hour turns. Interview with the Director of Nursing (DON) on 05/01/24 at 2:31 P.M. verified WN #318 was notified on 04/26/24 of wound concerns for Resident #37, but the resident was not assessed by the wound nurse until 05/01/24. The DON verified Resident #37 was admitted to the facility with a pressure ulcer Stage I, but a complete skin assessment was not done on 04/19/24. Interview on 05/01/24 at 3:30 P.M. with Director of Dialysis #422 revealed since admission, Resident #37 had received five treatments of dialysis lasting three hours each. Director of Dialysis #422 revealed the facility did not communicate Resident #37 had a pressure ulcer or interventions that were needed. Interview on 05/01/24 at 5:30 P.M. with Resident 37's family member revealed she had requested the wound nurse to evaluate Resident #37 since admission on 04/19/24 because Resident #37 had a tear on the buttocks during the hospital stay before admission. Resident #37's family member stated Resident #37 was not observed to be turned every two hours, and she visited the resident daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #37 on 05/01/24 at 5:30 P.M. revealed she had pain in her tailbone and felt like her wound was not getting better. Interview on 05/02/24 at 9:45 A.M. with LPN #311 revealed skin should be assessed twice a week with a full assessment and documentation on the Skin Grid assessment in the electronic medical record. LPN #311 revealed she notified WN # 318 by phone on 04/26/24 after Resident #37's family approached her with concerns and Resident #37's dressing was soiled. LPN #311 stated she did not think the wound was concerning so she did not do any measurements on it at that time. LPN #311 verified she did not notify any physician regarding Resident #37's skin. LPN #311 said Resident #37 was compliant with the turning and repositioning, but the aides were not required to document when this intervention was performed. Interview on 05/02/24 at 11:00 A.M. with State tested Nursing Assistant (STNA) #420 revealed Resident #37 was compliant with turning and repositioning, but stated staff were not required to document the provision of turning and repositioning. Interview on 05/02/24 at 11:50 A.M. with LPN #337 revealed she did not notify the wound nurse or the physician of Resident #37's Stage I pressure ulcer on admission. LPN #337 also verified she did not document measurements of the wound on admission. Observation on 05/02/24 at 4:30 P.M. with WN #318 revealed Resident #37 had a pressure ulcer to the coccyx. The ulcer contained yellow slough and the dressing in place was observed to be soiled. Review of the facility policy titled Pressure Ulcers Identification and Suggested Treatment Protocols, dated June 2015, revealed pressure ulcers would be identified and treatments would be ordered for proper healing of the wound. This deficiency represents noncompliance investigated under Master Complaint Number OH00153187.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 22653 Based on medical record review, review of a laboratory agreement, and interview, the facility failed to obtain laboratory tests in a timely manner. This affected one (Resident #88) of three residents reviewed for change in status. The facility census was 81. Findings include: Review of Resident #88's closed medical record revealed diagnoses including acute pulmonary edema, type two diabetes mellitus, end stage renal disease, hypotension, chronic congestive heart failure, dependence on renal dialysis, hypercholesterolemia, paroxysmal atrial fibrillation, hypothyroidism, hyperlipidemia, difficulty walking, obesity, thrombocytopenia, non-rheumatic aortic valve disorder, aneurysm of the ascending aorta without rupture, atrial flutter, non-pressure chronic ulcer of the foot, acute kidney failure, aortic valve stenosis, dizziness, cellulitis, anemia and a history of gastrointestinal hemorrhage. On 03/01/24 an order was written STAT (one time order which that should be prioritized because it was of urgent nature) to obtain labwork including a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP). Review of a nursing note dated 03/02/24 at 12:29 A.M. indicated at the beginning of the shift (7:00 P.M. - 7:00 A.M.) Resident #88 complained of pain and nausea. A blood pressure of 100/50 was recorded. Resident #88's daughter was at bedside concerned Resident #88's sodium level might be low. A call was placed to the nurse practitioner with new orders for a stat CBC and CMP or offer to send Resident #88 to the emergency room (ER). Resident #88 refused to go to the ER. Lab had not been in to draw the bloodwork for the laboratory tests. Review of a nursing note dated 03/02/24 at 2:58 P.M. revealed Resident #88's daughter called to inquire about pending blood work. Review of a nursing note dated 03/02/24 at 3:38 P.M. indicated a call was placed to the lab regarding the stat CBC and CMP. The lab stated they never received the order so the stat lab was ordered at that time. Review of the laboratory report from 03/02/24 revealed the stat lab was drawn on 03/02/24 at 4:50 P.M. Review of a nursing note dated 03/02/24 at 6:32 P.M. revealed laboratory results were returned with results including a hemoglobin value of 6.2 grams per deciliter (reference range 11.5-15.5) and hematocrit of 20.3% (reference range of 34-48). A new order was received to send Resident #88 to the ER for evaluation and treatment. Resident #88 and her daughter were aware. A nursing note dated 03/02/24 at 8:19 P.M. revealed Resident #88 left the facility via stretcher for transfer to the hospital at 7:40 P.M. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Laboratory Services Agreement revealed the agreement was made on 05/02/22 and STAT phlebotomy services would be available/provided seven days a week, 24 hours a day within four hours of the request. During an interview on 04/30/24 at 3:02 P.M., the Director of Nursing (DON) stated when stat labs were ordered the expectation was they would be obtained within four hours. The DON verified the stat labs ordered 03/01/24 were not obtained until 03/02/24 at 4:50 P.M. On 04/30/24 at 4:36 P.M., the Director of Nursing (DON) verified the stat lab orders received on 03/01/24 were not obtained timely. This deficiency represents noncompliance as an incidental finding during the investigation of Master Complaint Number OH00153187.

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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. 22653 Based on medical record review, review of job responsibilities and interview, the facility failed to ensure nurse practitioners provided visit notes in a timely manner and dated notes in a consistent manner to permit the determination of when the visit was made. This affected one (Resident #88) of three residents reviewed for change in condition. The facility census was 81. Findings include: Review of Resident #88's closed medical record revealed diagnoses including acute pulmonary edema, type two diabetes mellitus, end stage renal disease, hypotension, chronic congestive heart failure, dependence on renal dialysis, hypercholesterolemia, paroxysmal atrial fibrillation, hypothyroidism, hyperlipidemia, difficulty walking, obesity, thrombocytopenia, non-rheumatic aortic valve disorder, aneurysm of the ascending aorta without rupture, atrial flutter, non-pressure chronic ulcer of the foot, acute kidney failure, aortic valve stenosis, dizziness, cellulitis, anemia and a history of gastrointestinal hemorrhage. During an interview on 05/02/24 at 10:20 A.M., the Director of Nursing (DON) verified there was only one progress note from Nurse Practitioner (NP) #501 dated 01/31/24 in the medical record. The DON stated she knew NP #501 visited Resident #88 more often than that and she would call and have her load her notes into the electronic health record. The DON verified when NP #501 or the doctor visited the resident the date of the visit should be recorded. On 05/02/24 additional notes from NP #501 regarding Resident #88 were loaded into the electronic health record including two from a previous stay at the facility (12/01/23 and 12/06/23), four notes which did not contain the date of the visit, and notes from 02/05/24, 02/12/24, 02/19/24, 12/21/24, 02/28/24, 03/01/24, 03/06/24, and 03/13/24. On 05/02/24 at 1:33 P.M., the DON verified although multiple notes from NP #501 had been put into the system that day multiple notes did not reveal the dates of the visits. Review of the facility's Physician Services Policy, effective August 2015, indicated the physician was responsible for reviewing each resident's total program of care during visits, including medications and treatments at each visit. The physician should also sign and date all orders and write, sign new orders and date progress notes at each visit, so care and services were provided according to the most recent order. This deficiency identified noncompliance as an incidental finding during the investigation of Master Complaint Number OH00153187.

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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** 22653 Based on observation, medical record review, policy reviews and interview, the facility failed to implement Enhanced Barrier Precautions while providing wound care and incontinence care for Resident #37, and failed to appropriately use Personal Protective Equipment (PPE) while caring for Resident #44. This affected two residents (#37 and #44) out of three residents reviewed for infection control. The facility census was 81. Findings include: 1. Review of Resident #37's medical record revealed diagnoses including end stage renal disease and dependence on renal dialysis. On 05/01/24 an order was written to cleanse an open area on Resident #37's sacrum with normal saline, apply santyl (debriding agent) to the wound base, cover with adaptic and secure with a sacral size dressing every night shift. A wound assessment dated [DATE] revealed the open area was an unstageable pressure ulcer and was not infected. On 05/02/24 at 4:15 P.M., State tested Nursing Assistant (STNA) #376 was observed providing incontinence care to Resident #37. No gown was worn. On 05/02/24 directly after incontinence care was provided Licensed Practical Nurse (LPN) #393 (the infection control preventionist and wound nurse) was observed changing the dressing which was placed across the buttocks and coccygeal area. An unstageable pressure ulcer with the wound bed covered with slough (dead tissue). The dressing change was performed without the use of a gown. On 05/02/24 at 4:20 P.M., LPN #393 verified gowns had not been worn during incontinence care and wound care. LPN #393 indicated the facility used a Quality and Safety Oversight group(QSO) memo in determining when to initiate Enhanced Barrier Precautions. Review of QSO-24-08-NH memo dated 03/20/24 revealed in July 2022 the Centers for Disease Control (CDC) released updated enhanced barrier precaution recommendations for implementation of personal protective equipment (PPE) use in nursing homes to prevent the spread of multi-drug resistant organisms. The new recommendations now included the use of enhanced barrier precautions during high contact care activities for residents with chronic wounds or indwelling medical devices regardless of their multi-drug resistant organism status. Wounds included chronic wounds. Examples of chronic wounds were pressure ulcers. Examples of indwelling medical devices included feeding tubes. Review of the Implementation of PPE from CDC dated 07/12/22 revealed examples of high contact care activities such as changing briefs and providing wound care required the use of gowns and gloves at a minimum. 2. During the interview with LPN #393 on 05/02/24 at 4:20 P.M., a non-pervious gown was observed hanging on the door of Resident #44. Resident #44 was observed lying in her bed with a feeding tube pump. LPN #393 indicated Resident #44 was on enhanced barrier precautions and the gown was on the outside of the door so staff could use the gown for more than one use. LPN #393 stated she believed guidance from CDC was unclear regarding the re-use of gowns. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's medical record revealed diagnoses of moderate protein calorie malnutrition and gastrostomy status. Review of Resident #44's care plan initiated 11/24/20 revealed Resident #44 had anoxic brain injury, inability to receive anything by mouth, and enteral nutrition use (tube feeding). Resident #44 did not have any urinary or bowel infections. A care plan dated 12/04/20 indicated Resident #44 was totally incontinent of bowel and bladder. On 05/02/24 at 4:30 P.M., LPN #393 informed the Administrator of discussions about non-compliance related to the re-use of gowns for multiple encounters for residents on enhanced barrier precautions. The Administrator insisted the facility could re-use gowns multiple times because CDC guidelines were unclear. Review of CDC Updated Guidance of Enhanced Barrier Precautions for Nursing Homes published 07/12/22 revealed one of the sources related to the guidance was a CDC Letter to nursing home staff which indicated the gown and gloves used for each resident during high contact resident care activities should be removed and discarded after each resident care encounter. This deficiency identified noncompliance as an incidental finding during the investigation of Master Complaint Number OH00153187.