STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365691	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Mentor	8200 Mentor Hills Drive Mentor, OH 44060

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** 39973 Based on observation, record review, interview, and facility policy review the facility failed to ensure resident treatments were completed and/ or documented as ordered. This affected two residents (#58 and #93) out of four residents reviewed treatments. This had the potential to affect 17 residents (#7, #14, #23, #27, #45, #48, #51, #58, #67, #73, #79, #85, #86, #89, #90, #91, and #99) identified by the facility with a treatment order other than barrier cream. The facility census was 102. Findings included: 1. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses including hypertension, anxiety disorder, abnormalities of gait and mobility, and weakness. Review of the care plan dated 07/18/23 revealed Resident #58 had an alteration in skin integrity due to left ankle arterial ulcer. Interventions included check dressing for placement during the provision of routine care and services, document wound status weekly, heel lift suspension boots to be worn as tolerated, and treatments per order. Review of the Wound Nurse Practitioner (NP) #692 progress note dated 07/12/24 revealed Resident #58 continued to have an arterial ulceration to his left lateral ankle that measured 1.0 centimeter (cm) in length, 0. 9 cm in width and 0.1cm in depth. Wound NP #692 ordered to cleanse Resident #58's left lateral ankle with saline solution, pat dry, apply Tetracyte (a topical antibiotic to help wound healing) along with calcium alginate (dressing when in contact with wound exudates a gel was formed for easier dressing removal), and cover with border foam dressing daily and as needed. There was no order on this progress note to complete the dressing change every other day. Review of the July 2024 treatment administration record (TAR) revealed an order dated 07/13/24 to cleanse Resident #58's left lateral ankle with saline solution, pat dry, apply Tetracyte along with calcium alginate, and cover with border foam dressing daily and as needed. The order also included every evening shift every other day (conflicting with the above frequency). The TAR indicated the treatment was marked to be completed every other day and not daily even though the order had both instructions in it. The TAR indicated his treatment was documented as completed on 07/15/24, 07/17/24, 07/19/24, 07/21/24 and that Resident #58 had refused his treatment on 07/13/24. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the C2) Weekly Ulcer Wound Documentation- V7 dated 07/15/24 and completed by Licensed Practical Nurse (LPN) #691 revealed Resident #58 had an arterial ulcer to his left lateral ankle that measured 1.1 cm in length. 0.9 cm in width, and 0.2cm in depth post debridement. The assessment revealed the following treatment was to be completed: cleanse Resident #58's left lateral ankle with saline solution, pat dry, apply Tetracyte along with calcium alginate, and cover with border foam dressing daily and as needed. (There was nothing on the assessment that the treatment was to be completed every other day). Interview on 07/22/24 at 11:10 A.M. with Wound NP #692 stated that this was the third week coming to the facility and many times the wound dressings were dated indicating the dressing were not completed as ordered. She revealed today, 07/22/24, Resident #58's arterial wound dressing to his leg was the same dressing they had applied on 07/15/24 even though his order was to be changed daily (one week he went without having it changed). She stated, I hope with the new wound nurse things will be fixed as there has been issues with dressings not being changed as ordered. Interview on 07/22/24 at 11:12 A.M. with Registered Nurse (RN)/ Wound Nurse #694 verified Resident #58's dressing was dated 07/15/24, today 07/22/24, when they changed his dressing. She revealed she could not explain why his wound dressing was not completed as ordered as she stated this was her first week employed at the facility. Interview on 07/22/24 at 12:36 P.M. with Resident #58 revealed the nurses did not change his dressing as ordered to his left ankle. He revealed today, 07/22/24, RN/ Wound Nurse #694 and Wound NP #692 had changed his dressing but before that it had been almost a week since anyone had changed it. Interview on 07/22/24 at 4:26 P.M. with Regional RN #696 and the Director of Nursing (DON) revealed LPN #691 had come from another facility to assist with wound rounds. They verified in Wound NP #692 and in the C2) Weekly Ulcer Wound Documentation- V7 completed by LPN #691 he was to have his treatment completed daily. They verified on the TAR that the nurses had documented this was completed every other day. They had no explanation why when RN/ Wound Nurse #694 and Wound NP 692 changed his dressing today, 07/22/24, the dressing on Resident #58's left lateral ankle was dated 07/15/24 even though the nurses had signed off the dressing changes 07/15/24, 07/17/24, 07/19/24, and 07/21/24. 2. Review of the medical record for Resident #93 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypertension, and weakness. Review of the C2) Weekly Ulcer/ Wound Documentation- V7 dated 06/18/24 and completed by LPN #615 revealed Resident #93 bilateral buttocks fungal rash was resolved and there was a treatment to continue to cleanse her bilateral buttocks with soap and water, pat dry, apply antifungal cream and powder every shift. Review of the June 2024 physician orders revealed Resident #93 had an order dated 06/27/24 to cleanse her bilateral buttocks with soap and water, pat dry, apply antifungal cream and powder every shift and as needed. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #93 was rarely and/ or never understood. She was always incontinent of bowel and bladder. She had moisture associated skin damage (MASD). (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the July 2024 TAR revealed there was no documentation that her treatment to cleanse her bilateral buttocks with soap and water, pat dry, apply antifungal cream and powder every shift was completed from 07/01/24 to 07/22/24 every shift. Observation on 07/22/24 at 10:38 A.M. of incontinence care completed by State tested Nurse Aide (STNA) #664 revealed Resident #93's perineal area was pink including a darker pink line where Resident #93's incontinence product laid in her groin area. Interview on 07/22/24 at 4:26 P.M. with Regional RN #696 and the DON verified Resident #93 had a physician order to cleanse her bilateral buttocks with soap and water, pat dry, apply antifungal cream and powder every shift and there was no documented evidence this was completed on the TAR. Review of the facility policy, Medication Administration- General Guidelines dated November 2021 revealed medication were to be administered as prescribed. The policy revealed that topical medications used in treatments were listed on the TAR and the individual who administers the medication records the administration of. Review of the facility policy labeled, Dressing Change (Clean) dated 11/30/23 revealed the purpose of the policy was to protect, prevent irritation, prevent infection, and promote healing. The policy described the procedure for changing the dressing and to document it in the medical record. The policy did not include anything regarding ensuring treatments were completed as ordered and/ or not documenting in the treatment record until after the treatment was completed. Review of the facility policy labeled; Skin Care Management dated 11/30/23 revealed the facility would assess residents for the potential for the risk of developing skin breakdown. Residents with identified skin breakdown would have a documented skin assessment weekly and treatments would be completed as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00155127.

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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** 39973 Based on observation, record review, interview, and facility policy review the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers, to timely identify new pressure ulcers and to ensure wound care was completed as ordered. This affected two residents (#51 and #79) of four residents reviewed for pressure ulcers. The facility census was 102. Actual Harm occurred on 07/12/24 when Resident #51, who had a history of pressure ulcers, was dependent on staff assistance for most all activities of daily living (ADL) including toileting, hygiene, shower, dressing, transfers, and required partial to moderate assistance with rolling left and right in bed, was found to have an in-house acquired Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to his scrotal area that contained 50 percent slough/necrosis (dead tissue) requiring mechanical debridement (remove unhealthy tissue from a wound bed) per Wound Nurse Practitioner (NP) #692. On 07/15/24, Resident #51 was found to have another in-house acquired Stage III pressure ulcer to his coccyx area that also required mechanical debridement. The facility failed to provide documented evidence of effective, comprehensive, and adequate interventions being in place to prevent the development of these pressure ulcers and to ensure the pressure ulcers were identified before being found at a Stage III. Actual Harm occurred on 07/15/24 when Resident #79, who was dependent on staff for most all ADL care including toileting, hygiene, shower, dressing, transfers, and required partial to moderate assistance with rolling left and right in bed, was found to have an in-house acquired Stage III pressure ulcer to her right buttock that also required mechanical debridement to remove the devitalized tissue to healthy bleeding tissue. Observation of wound care on 07/22/24 revealed Resident #79's dressing was dated 07/19/24 indicating her daily wound care dressing was not completed on 07/20/24 or 07/21/24 as ordered by the physician. The facility failed to provide documented evidence of effective, comprehensive, and adequate interventions being in place to prevent the development of this pressure ulcer and to ensure the pressure ulcer was identified before being found at a Stage III. Findings include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including diabetes, chronic pain syndrome, dysphagia, and glycogen storage disease (a rare condition that changes the way the body uses and stores sugar or glucose). Review of the care plan dated 12/18/23 revealed Resident #51 had an alteration in skin integrity as he had pressure ulcers to his ischium, sacrum, and buttocks. Interventions included checking dressing placement during routine care and services, encouraging the resident to get out of bed as tolerated, monitoring wounds for signs of infection, treatments as ordered, and document wound status weekly or as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan dated 03/17/24 revealed Resident #51 had the potential for altercation in skin integrity related to bruises easily, immobility, and incontinence. Interventions included administering treatments as ordered, offloading heels as tolerated, pressure redistribution cushion to chair, turning and repositioning as needed, and skin assessment weekly. Review of the care plan dated 04/01/24 revealed Resident #51 had an ADL self-care/ mobility/ functional ability performance deficit related to impaired mobility. Interventions included providing extensive assistance with bed mobility, dressing, and bathing, assist resident with proper body alignment while in bed using positioning devices as needed, and providing total assistance with a mechanical lift for transfers. Review of the C2) Weekly Ulcer/ Wound Documentation- V7 dated 05/02/24 and completed by Licensed Practical Nurse (LPN) #615 revealed Resident #51's coccyx (sacrum) wound was resolved. Review of the Quarterly Skin assessment dated [DATE] and completed by Registered Nurse (RN)/ Minimum Data Set (MDS) #650 revealed Resident #51 was at mild risk for developing pressure ulcers as he was occasionally moist, chairfast, slightly limited with mobility, and had a problem with friction and shear. Review of the C2) Weekly Ulcer/ Wound Documentation- V7 dated 06/06/24, 06/13/24, 6/20/24, 06/28/24, and 07/03/24 revealed no documented evidence that Resident #51 had any skin impairment to his coccyx (sacrum) or his scrotal area. Record review revealed the resident was receiving treatment for a pressure ulcer to the left ischium during this time period . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition. The assessment revealed the resident was dependent on staff assistance for most all ADL care, including toileting, hygiene, shower, dressing, and transfers. He required partial to moderate assist with rolling left and right in bed. The assessment revealed the resident was at risk for pressure ulcers and had two Stage IV pressure ulcers (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.), and one was identified on admission. (The Stage IV pressure ulcers were noted to be the resident's ischium). Review of the C2) Weekly Ulcer/ Wound Documentation- V7 dated 07/12/24 and completed by Licensed Practical Nurse (LPN) #691 revealed on 07/12/24 Resident #51 was identified to have a Stage III pressure ulcer on his scrotal area that measured 8.4 centimeters (cm) length by 5.2 cm width with 0.2 cm depth post mechanical debridement. The wound contained 50 percent granulated tissue, 50 percent slough/ necrosis, and moderate drainage. A treatment was ordered to cleanse with wound cleanser, pat dry, apply tetracyte (a topical antibiotic to help wound healing) to wound bed followed by Medi honey (a medical- grade honey intended for wound care), oil emulsion, calcium silver alginate (dressing when in contact with wound exudates a gel was formed for easier dressing removal), and cover with abdominal (ABD) pad. There was no documented evidence that Resident #51 had any skin impairment to his sacrum/ coccyx area at this time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Wound NP #692's progress note dated 07/12/24 revealed Resident #51 had a new Stage III pressure ulcer to his bilateral midline scrotal area that measured 8.39 cm length by 5.22 cm width with 0.1cm depth. Wound NP #692 evaluated the wound and noted the wound bed had full thickness that contained 50 percent (%) granulated tissue and 50% necrosis. Wound NP #692 mechanically debrided the devitalized tissue to the level of healthy bleeding tissue and ordered a treatment. Resident #51 had no documented evidence he had a pressure ulcer to his coccyx area at this time. Review of the C2) Weekly Ulcer/ Wound Documentation- V7 dated 07/15/24 and completed by LPN #691 revealed on 07/15/24 Resident #51 was identified to have a Stage III pressure ulcer to his coccyx area that measured 0.1 cm length by 0.3 cm width with 0.3 cm depth post mechanical debridement with 100 percent granulated tissue. A treatment was ordered to cleanse the wound with wound cleanser, pat dry, apply tetracyte drops, Medi honey, calcium alginate, and cover with border foam daily and as needed. Resident #51 continued to have a Stage III pressure ulcer to his scrotal area at this time. Review of the Wound NP #692 progress note dated 07/15/24 revealed Resident #51 had a Stage III pressure ulcer to his bilateral midline scrotal area that measured 7.83 cm length by 4.09 cm width with 0.1cm depth. Wound NP #692 evaluated the wound and noted the wound bed was full thickness and contained 50 percent granulated tissue and 50 percent necrotic tissue. Wound NP #692 mechanically debrided the devitalized tissue to the level of healthy bleeding tissue and ordered a treatment. Resident #51 was found to have a new Stage III pressure ulcer to his coccyx area that measured 0.1 cm length by 0.3 cm width with 0.2 cm in depth. Wound NP #692 evaluated and noted the wound bed was full thickness with 100 percent granulated tissue. A treatment was ordered to cleanse with wound cleanser, pat dry, apply tetracyte to wound bed followed by Medi honey, oil emission, calcium silver alginate, and cover with foam dressing. Observation on 07/22/24 at 1:27 P.M. revealed Resident #51 was lying in bed. An interview with the resident revealed he was unable to provide any details of how often and/or where he had wounds/pressure ulcers. Review of Wound NP #692's progress note dated 07/22/24 revealed Resident #51 continued to have a Stage III pressure ulcer to his scrotal area that measured 6.69 cm length by 2.97 cm width, with 0.1 cm depth. The wound contained 86 percent granulated tissue and 13 percent necrosis. NP #692 documented the wound was unchanged and mechanically debrided the devitalized tissue to the level of healthy bleeding tissue and ordered to continue the same treatment. There was no progress note regarding the evaluation of Resident #51's coccyx wound on 07/22/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/23/24 at 3:23 P.M. with Regional RN #695 and the Director of Nursing (DON) verified per documentation on the C2) Weekly Ulcer/ Wound Documentation- V7 completed by LPN #691 and Wound NP #692's progress note on 07/12/24 Resident #51 was found to have a Stage III pressure ulcer to his scrotal area that contained 50 percent slough necrosis and needed mechanically debrided per Wound NP #692. Regional RN #695 and the DON indicated they believed Resident #51 had the pressure ulcer since admission to his coccyx/sacrum area but then verified on the C2) Weekly Ulcer/ Wound Documentation- V7 and the weekly wound NP #692 and #696 progress notes dated 6/06/24, 06/13/24, 6/20/24, 06/28/24, 07/03/24 and 07/12/24 there was no documented evidence he had any skin impairment to his coccyx/sacrum area. Regional RN #695 and the DON verified on 07/15/24, per documentation, Resident #51 was found to have a new Stage III pressure ulcer to his coccyx area per the C2) Weekly Ulcer/ Wound Documentation- V7 completed by LPN #691 and Wound NP #692's progress note. Regional RN #695 stated just going to be honest it all fell through the cracks and could not explain why except that there had many multiple changes in wound NPs and wound nurses at the facility. Interview on 07/24/24 at 11:10 A.M. with Wound NP #692 revealed she had identified Resident #51's Stage III pressure ulcer to his scrotal area on 07/12/24 during rounds when they turned him over to check his skin, the area was noted, and the wound nurse that she was rounding with had not known of him having this wound prior. She revealed the ulcer was definitely a Stage III pressure ulcer as the wound was full thickness and contained 50 percent slough that she had to mechanically debride down to the healthy tissue. She revealed on 07/12/24 Resident #51 did not have a pressure ulcer to his coccyx area at the time of her evaluation. She revealed she then consulted again on 07/15/24 and noted he continued to have the Stage III to his scrotal area as well as a new Stage III to his coccyx area. She revealed she felt Resident #51 possibly could have had a pressure ulcer at this site as he had scar tissue but when she asked the rounding wound nurse, she was unable to locate in his medical record any evidence that he had had one. She revealed she then had to classify this wound as a new wound instead of a re-opened wound and staged the wound as she had observed on 07/15/24 as a Stage III pressure ulcer. She revealed she had taken over the facility wound care just for the last three weeks and had found it very difficult as there had been multiple wound NPs and wound nurses at the facility, the documentation was not clear, and the wound nurses did not seem to know the residents well to provide thorough and accurate information. 2. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including chronic kidney disease, diabetes, chronic obstructive pulmonary disease, and major depression. Review of the care plan dated 02/08/23 revealed Resident #79 required assistance for transferring from one position to another due to impaired mobility. Interventions included two staff assist with bed mobility and use of a mechanical lift for transfers. Review of the care plan dated 05/20/24 revealed Resident #79 had an alteration in skin integrity due to moisture associated skin damage (MASD) to back of left leg and a left leg laceration. Interventions included document wound status weekly and as needed, treatments as ordered, and refer to wound treatment specialist. Review of the quarterly skin assessment dated [DATE] and completed by RN/ MDS #667 revealed Resident #79 was at mild risk for developing pressure ulcers as she had occasionally moist skin, had limited mobility, was chairfast, and had a problem with friction and shear. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the July 2024 physician orders revealed an order dated 07/16/24 to cleanse open area to right buttocks with wound cleanser, pat dry, and apply dry dressing, an order dated 07/17/24 to cleanse bilateral buttocks with soap and water, pat dry, and apply protective barrier cream with nystatin cream daily and as needed, and an order dated 07/17/24 to clean her right buttock with normal saline, pat dry, apply tetracycline, Medi honey, oil emulsion and calcium alginate, cover with border foam dressing daily and as needed. She also had orders that included pressure redistribution cushion while in chair that was initiated 10/24/23, protective moisture barrier topically to perineal area every shift that was initiated 10/24/23, turn and reposition as tolerated and as needed using lift pad to minimize friction and shear that was initiated 10/24/23, and a low air loss mattress that was initiated on 12/18/23. Review of the quarterly MDS assessment dated [DATE] revealed Resident #79 had intact cognition. The assessment revealed the resident was dependent on staff assistance for most of her ADL care, including toileting hygiene, showers, and transfers. She required partial to moderate assistance with rolling left and right in bed. The assessment revealed the resident was at risk for pressure ulcers but had no pressure ulcers at the time of the assessment. Review of the weekly wound note dated 07/12/24 at 4:23 P.M. and completed by LPN #691 revealed Resident #79 continued to have a laceration to her left posterior knee. There was no documented evidence Resident #79 had any skin impairment to her buttocks. Review of the weekly wound note dated 07/15/24 at 2:23 A.M. and completed by LPN #691 revealed Resident #79 was found to have a Stage III pressure ulcer to her right buttocks that measured 0.9 cm length by 1.0 cm width with 0.2 cm depth post debridement. The note revealed mechanical debridement was completed and the wound base was visible with 100 percent granulation tissue present with minimal amount of thin, red drainage. Review of Wound NP #692's progress note dated 07/15/24 revealed Resident #79 had a new Stage III pressure ulceration to her right midline buttock that measured 0.9 cm length by 1.0 cm width with 0.1cm in depth. The wound was full thickness with 100 percent granulating tissue. The note revealed Wound NP #692 mechanically debrided, and the devitalized tissue was removed to the level of healthy bleeding tissue. NP #692 ordered the wound to her right buttock to be cleaned with normal saline, pat dry, apply tetracycline, Medi honey, oil emulsion, and calcium alginate, cover with border foam dressing daily and as needed. Review of the care plan dated 07/17/24 revealed Resident #79 had a potential for alteration in skin integrity related to immobility. Intervention included dry thoroughly between skin fold after cleansing, monitor between fold for redness, irritation, and bleeding, keep linens clean, dry, and wrinkle free, pressure redistribution cushion to chair, pressure redistribution mattress to bed, and moisturizing lotion. Review of the July 2024 Treatment Administration Record (TAR) revealed Resident #79's treatment dated 07/17/24 to clean her right buttock with normal saline, pat dry, apply tetracycline, Medi honey, oil emulsion and calcium alginate, cover with border foam dressing daily and as needed was signed off as completed daily from 07/17/24 to 07/21/24. (continued on next page)

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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	Observation of wound care for Resident #79 on 07/22/24 at 11:03 A.M. completed by RN/ Wound Nurse #694 and Wound NP #692 revealed Resident #79's dressing to the right buttock was dated 07/19/24. RN/ Wound Nurse #694 and Wound NP #692 verified Resident #79's daily dressing had not been completed on 07/20/24 or 07/21/24 as ordered. Wound NP #692 assessed the right buttock pressure area stating previously it was a full thickness wound and now was partial thickness measuring 0.7 cm length by 0.6 cm width with 0.1 cm in depth. Wound NP #692 revealed no changes to the current treatment were necessary at this time. Interview on 07/22/24 at 11:07 A.M. and 11:10 P.M. with RN/ Wound Nurse #694 revealed this was her first week at the facility and first-time observing Resident #79's right buttocks wound. She was unable to provide any details regarding how Resident #79's wound was found except that per the documentation, the first documentation was that the wound was found as a Stage III pressure ulcer. Interview on 07/22/24 at 11:10 A.M. with Wound NP #692 revealed this was her third week coming to the facility and many times she had identified wound dressings (for residents) in place were dated indicating the dressings were not completed as ordered. She revealed today, 07/22/24, Resident #58's arterial wound dressing to his left ankle was the same dressing they had applied on 07/15/24 even though his order was to be changed daily (one week he went without having it changed). She verified Resident #79's wound was found at Stage III as the pressure ulcer (was full thickness) and she debrided the wound on her last visit. She stated, I hope with the new wound nurse, things will be fixed as there has been issues with dressings not being changed as ordered. Interview on 07/23/24 at 10:41 A.M. with Resident #79 revealed the nurses did not do her dressing all weekend (07/20/24 and 07/21/24) as stated it was supposed to be done daily. She revealed if her regular nurse was not working that her dressing change does not get done. Review of the facility policy labeled, Dressing Change (Clean) dated 11/30/23 revealed the purpose of the policy was to protect, prevent irritation, prevent infection, and promote healing. The policy described the procedure for changing the dressing and to document it in the medical record. The policy did not include anything regarding ensuring treatments were completed as ordered and/ or not documenting in the treatment record until after the treatment was completed. Review of the facility policy labeled; Skin Care Management dated 11/30/23 revealed the facility would assess residents for the potential for the risk of developing skin breakdown. Residents at risk for developing skin breakdown would be managed. Residents at minimum risk would have a daily evaluation and daily skin care. Residents with identified skin breakdown would be documented on the skin assessment weekly including wound description including measurements. This deficiency represents non-compliance investigated under Complaint Number OH00155127.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365691	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Mentor	8200 Mentor Hills Drive Mentor, OH 44060

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 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** 39973 Based on observation, record review, interview, and facility policy review the facility failed to ensure medical records were maintained in an accurate manner including not documenting the completion of treatments that were not done as ordered. This affected two residents (#58, and #79) out of eight residents medical records reviewed for accuracy. The facility census was 102. Findings include: 1. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses including hypertension, anxiety disorder, abnormalities of gait and mobility, and weakness. Review of the care plan dated 07/18/23 revealed Resident #58 had an alteration in skin integrity due to left ankle arterial ulcer. Interventions included check dressing for placement during the provision of routine care and services, document the wound status weekly, heel lift suspension boots to be worn as tolerated, and treatments per order. Review of the Wound Nurse Practitioner (NP) #692 progress note dated 07/12/24 revealed Resident #58 continued to have an arterial ulceration to his left lateral ankle that measured 1.0 centimeter (cm) in length, 0. 9 cm in width and 0.1cm in depth. Wound NP #692 ordered to cleanse Resident #58's left lateral ankle with saline solution, pat dry, apply Tetracyte (a topical antibiotic to help wound healing) along with calcium alginate (dressing when in contact with wound exudates a gel was formed for easier dressing removal), and cover with border foam dressing daily and as needed. There was no order on this progress note to complete the dressing change every other day. Review of the July 2024 treatment administration record (TAR) revealed an order dated 07/13/24 to cleanse Resident #58's left lateral ankle with saline solution, pat dry, apply Tetracyte along with calcium alginate, and cover with border foam dressing daily and as needed. The order also included every evening shift every other day. The TAR indicated the treatment was marked to be completed every other day and not daily even though the order had both instructions in it. The TAR indicated his treatment was documented as completed on 07/15/24, 07/17/24, 07/19/24, 07/21/24, and Resident #58 had refused his treatment on 07/13/24. Review of the C2) Weekly Ulcer Wound Documentation- V7 dated 07/15/24 and completed by Licensed Practical Nurse (LPN) #691 revealed Resident #58 had an arterial ulcer to his left lateral ankle that measured 1.1 cm in length. 0.9 cm in width, and 0.2cm in depth post debridement. The assessment revealed the following treatment was to be completed: cleanse Resident #58's left lateral ankle with saline solution, pat dry, apply Tetracyte along with calcium alginate, and cover with border foam dressing daily and as needed. (There was nothing on the assessment that the treatment was to be completed every other day). (continued on next page)

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	365691	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Mentor	8200 Mentor Hills Drive Mentor, OH 44060

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/22/24 at 11:10 A.M. with Wound NP #692 stated that this was the third week coming to the facility and many times the wound dressings were dated indicating the dressing were not completed as ordered. She revealed today, 07/22/24, Resident #58's arterial wound dressing to his left ankle was the same dressing they had applied on 07/15/24 even though his order was to be changed daily (one week he went without having it changed). She stated, I hope with the new wound nurse things will be fixed as there have been issues with dressings not being changed as ordered. Interview on 07/22/24 at 11:12 A.M. with Registered Nurse (RN)/ Wound Nurse #694 verified Resident #58's dressing was dated 07/15/24, today 07/22/24, when they changed his dressing. She could not explain why his wound dressing was not completed as ordered as she stated this was her first week employed at the facility. Interview on 07/22/24 at 12:36 P.M. with Resident #58 revealed the nurses did not change his dressing as ordered to his left ankle. He revealed today, 07/22/24, RN/ Wound Nurse #694 and Wound NP #692 had changed his dressing, but before that it had been almost a week since anyone had changed it. Interview on 07/22/24 at 4:26 P.M. with Regional RN #696 and the Director of Nursing (DON) revealed LPN #691 had come from another facility to assist with wound rounds. They verified in Wound NP #692 and in the C2) Weekly Ulcer Wound Documentation- V7 completed by LPN #691 he was to have his treatment completed daily. They verified on the TAR that the nurses had documented this was completed every other day. They had no explanation why when RN/ Wound Nurse #694 and Wound NP 692 changed his dressing today, 07/22/24, Resident #58's left lateral ankle was dated for 07/15/24 even though the nurses had signed off the dressing as being changed 07/15/24, 07/17/24, 07/19/24, and 07/21/24. 2. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including chronic kidney disease, diabetes, chronic obstructive pulmonary disease, and major depression. Review of the care plan dated 05/20/24 revealed Resident #79 had an alteration in skin integrity due to moisture associated skin damage (MASD) to the back of the left leg and a left leg laceration. Interventions included document wound status weekly and as needed, treatments as ordered, and refer to the wound treatment specialist. Review of the July 2024 Physician Orders revealed an order dated 07/17/24 to clean Resident #79's right buttock with normal saline, pat dry, apply tetracycline, Medi honey, oil emulsion and calcium alginate, cover with border foam dressing daily and as needed. Review of the July 2024 TAR revealed Resident #79's treatment dated 07/17/24 to clean her right buttock with normal saline, pat dry, apply tetracycline, Medi honey, oil emulsion and calcium alginate, cover with border foam dressing daily and as needed was signed off as completed daily from 07/17/24 to 07/21/24. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 had intact cognition. She was dependent on staff assistance for most of her activities of daily living (ADL) including toileting, hygiene, showers, and transfers. She required partial to moderate assistance with rolling left and right in bed. She was at risk for pressure ulcers but had no pressure ulcers at the time of the assessment. (continued on next page)

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	365691	A. Building B. Wing	07/25/2024

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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	Review of Wound NP #692's progress note dated 07/15/24 revealed Resident #79 had a new stage three pressure ulceration (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to her right midline buttock that measured 0.9 cm in length, 1.0 cm in width, and 0.1cm in depth. The wound was full thickness, with 100 percent granulating tissue. The note revealed Wound NP #692 mechanically debrided, and the devitalized tissue was removed to the level of healthy bleeding tissue. Wound NP #692 ordered the wound to be cleaned to her right buttock with normal saline, pat dry, apply tetracycline, Medi honey, oil emulsion and calcium alginate, cover with border foam dressing daily and as needed. Observation and interview of wound care for Resident #79 on 07/22/24 at 11:03 A.M. and completed by RN/ Wound Nurse #694 and Wound NP #692 revealed Resident #79's dressing was dated 07/19/24. RN/ Wound Nurse #694 and Wound NP #692 verified Resident #79's daily dressing had not been completed on 07/20/24 and 07/21/24 as ordered. Interview on 07/22/24 at 11:10 A.M. with Wound NP #692 stated that this was the third week coming to the facility and many times the wound dressings were dated indicating the dressing were not completed as ordered. She stated, I hope with the new wound nurse things will be fixed as there have been issues with dressings not being changed as ordered. Interview on 07/22/24 at 4:26 P.M. with Regional RN #696 and the DON revealed they had no explanation why when RN/ Wound Nurse #694 and Wound NP #692 changed her dressing today, 07/22/24, Resident #79's right buttock was dated for 07/19/24 even though the dressing was ordered daily, and the nurses had signed off the dressing as being changed 07/20/24 and 07/21/24. Interview on 07/23/24 at 10:41 A.M. with Resident #79 revealed the nurses did not do her dressing all weekend (07/20/24 and 07/21/24), and they were supposed to be done daily. She revealed if her regular nurse was not working, her dressing change does not get done. Review of the facility policy, Medication Administration- General Guidelines dated November 2021 revealed medication were to be administered as prescribed. The policy revealed that topical medications used in treatments were listed on the TAR and the individual who administers the medication records the administration of. Review of the facility policy labeled, Dressing Change (Clean) dated 11/30/23 revealed the purpose of the policy was to protect, prevent irritation, prevent infection, and promote healing. The policy described the procedure for changing the dressing and to document it in the medical record. The policy did not include anything regarding ensuring treatments were completed as ordered and/ or not documenting in the treatment record until after the treatment was completed. This deficiency represents non-compliance investigated under Complaint Number OH00155127.