STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365796	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Healthcare Campus	4401 W 150th Street Cleveland, OH 44135

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** 42013 Based on interview, record review and review of the facility policy the facility failed to ensure Resident #102's wound treatment orders were updated after a physician appointment. This affected one resident (Resident #102) out of three resident reviewed for treatment orders. The facility census was 91. Findings include: Review of Resident #102's Referral Information Form for a long term acute care facility stay from 07/16/24 through 08/12/24 included Resident #102 had a Stage IV Pressure ulcer (a full-thickness tissue loss that exposes bone, tendon, or muscle). Review of Resident #102's medical record revealed an admitted [DATE] and diagnoses included other injury of unspecified body region, human immunodeficiency virus, dementia, and neuromuscular dysfunction of the bladder. Resident #102 was transported to the hospital on 09/06/24 and discharged from the facility on 09/18/24. Review of Resident #102's Weekly Wound Data Collection dated 08/13/24 included Resident #102 had a Stage IV left buttock pressure wound and measurements were length was 11.5 cm, width 3.0 cm, depth 1.5 cm., undermining was present. Review of Resident #102's physician orders dated 08/13/24 revealed wet-to-dry dressing twice a day and as needed when the wound vac was malfunctioning, every twelve hours as needed. Review of Resident #102's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #102 was cognitively intact. Resident #102 was dependent for toileting and personal hygiene, bathing, and chair, bed-to-chair transfer. Resident #102 required substantial to maximal assistance for rolling left and right, sit to lying and lying to sitting on the side of the bed. Resident #102 had an indwelling catheter and her bowel continence was not rated. Review of Resident #102's physician orders dated 08/19/24 revealed Resident #102's FMS (fecal management system) was discontinued. Review of Resident #102's physician orders dated 08/19/24 revealed left upper buttock abrasion, cleanse with normal saline, pat dry, cover with wound vac dressing Monday, Wednesday, Friday and as needed, every day shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #102's physician orders dated 08/19/24 revealed right gluteal fold, cleanse with normal saline, pat dry, apply alginate, cover with bordered dressing daily and as needed, every day shift. Review of Resident #102's physician orders dated 08/19/24 revealed left buttock wound, apply wound vac at 125 mmHg (millimeters of mercury) Monday, Wednesday, Friday and as needed, every day shift. Review of Resident #102's Trauma Clinic Progress Note Assessment and Plan of Care dated 08/29/24 included wound care and to change order to medial wound. Please replace vacuum on the deepest most medial portion of the wound. As the wound moved out laterally it became superficial and areas of the sponge were covering healthy skin. For the lateral areas please use a wet to dry dressing to keep the new tissue moist. Take daily showers, sponge bath as needed but able to wash wounds in shower with gentle soap and water when the wound vac was off. Allow warm soapy water to wash over the wound, do not scrub at the wound, when out of the shower gently pat the surrounding areas. Do not apply lotions, ointments or creams, avoid soaking in bodies of water until wound was completely healed. Packing the wound, lateral wound, after the shower take Kerlix, moisten with sterile saline and insert it into the opening. Please do not cover healthy skin. The Kerlix should be moist, not soaking wet, please make sure to wring it out, cover the packed area with an abdominal pad and tape. Review of Resident #102's progress notes, physician orders and Treatment Administration Record did not reveal evidence Resident #102's wound treatment orders dated 08/29/24 were followed. Review of Resident #102's care plan dated 09/12/24 (Resident #102 was admitted [DATE]) included Resident #102 had bowel incontinence related to wounds and had a fecal management system. Resident #102 would be continent during daytime through the review date. Interventions included check Resident #102 and assist with toileting as needed. Resident #102 had the potential for skin breakdown, pressure ulcer development related to incontinence, immobility. Resident #102 had a left buttock, hip Stage IV pressure ulcer. Resident #102's pressure ulcer would show signs of healing and remain free from infection through the review date. Interventions included follow facility policies, protocols for the prevention, treatment of skin breakdown; obtain and monitor labs, diagnostic work as ordered. Report results to physician and follow up as indicated. Interview on 10/02/24 at 8:45 A.M. of Licensed Practical Nurse (LPN) #206 revealed when a resident returned from an appointment with new orders the nurse on the floor should review the orders. LPN #206 stated but most of the time the floor nurses were too busy to review the orders, and the orders should be reviewed by the Unit Managers, but that did not always happen. LPN #206 stated she did not know anything about Resident #102's new treatment orders from 08/29/24. Interview on 10/02/24 at 8:57 A.M. of the Director of Nursing (DON) revealed the nurse on the cart was responsible to review orders when a resident returned from an appointment, and if that nurse was too busy then the Unit Manager should review the orders. The DON stated he was ultimately responsible for everything. The DON confirmed Resident #102's new wound treatment orders from 08/29/24 were not updated in Resident #102's medical record. Review of the facility policy titled Wound Care revised 10/2010 included the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Verify there is a physician's order for the procedure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00157592.

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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** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #29 and #102's specimens were collected and sent to the lab timely to timely treat infections. This affected two residents (Resident's #29 and #102) out of three residents reviewed for specimen collection. The facility census was 91. Findings include: 1. Review of Resident #102's Referral Information Form for a long term acute care facility stay from [DATE] through [DATE] included Resident #102 had a Stage IV Pressure ulcer. Review of Resident #102's medical record revealed an admitted [DATE] and diagnoses included other injury of unspecified body region, human immunodeficiency virus, dementia, and neuromuscular dysfunction of the bladder. Resident #102 was transported to the hospital on [DATE] and discharged from the facility on [DATE]. Review of Resident #102's Weekly Wound Data Collection dated [DATE] included Resident #102 had a Stage IV left buttock pressure wound and measurements were length was 11.5 cm, width 3.0 cm, depth 1.5 cm., undermining was present. Review of Resident #102's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #102 was cognitively intact. Resident #102 was dependent for toileting and personal hygiene, bathing, and chair, bed-to-chair transfer. Resident #102 required substantial to maximal assistance for rolling left and right, sit to lying and lying to sitting on the side of the bed. Resident #102 had an indwelling catheter and her bowel continence was not rated. Review of Resident #102's physician orders dated [DATE] revealed Resident #102's FMS (fecal management system) was discontinued. Review of Resident #102's physician orders dated [DATE] through [DATE] did not reveal orders for a sacrum wound culture. Review of Resident #102's physician orders dated [DATE] revealed send stool for culture, per CNP (Certified Nurse Practitioner) #200, rule out C-Diff (clostridium difficile), one time only for culture for one day. Review of Resident #102's lab orders dated [DATE] at 1:25 P.M. included Licensed Practical Nurse (LPN) #202 created the lab order and the specimen was for stool culture, comprehensive. There was no documentation the specimen was rule out C-Diff. Further review of Resident #102's lab orders dated [DATE] at 2:09 A.M. created by LPN #201 revealed sacrum wound culture. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #102's physician progress dated [DATE] note written by Certified Nurse Practitioner (CNP) #200 included Resident #102 seen as follow up with large sacral wound, now developing fevers, will send for wound culture. Obtain x-ray to rule out osteomyelitis and start Vancomycin and Zosyn. Review of Resident #102's physician telephone orders dated [DATE] revealed CNP #200 gave a telephone order to re-obtain wound culture. Review of Resident #102's lab report for wound culture of the sacrum (there was no initial physician order in Resident #102's electronic record for a wound culture of the sacrum) stated the specimen was collected on [DATE], the time was unknown and the wound culture was reported on [DATE] at 12:03 P.M. the report included Resident #102's stool culture was not collected, an unidentified nurse was notified and to see requisition. Review of Resident #102's lab requisition dated [DATE] at 4:18 A.M. revealed Licensed Practical Nurse (LPN) #201's name was printed on the lab report in the lab use only area, but there were no details regarding Resident #102's stool specimen. Further review of the lab requisition revealed the specimens were a sacrum wound culture, and a comprehensive stool culture (there was no evidence the specimen was rule out C-Diff). The stool culture had CBM ([NAME] media) written next to it. Review of Resident #102's lab report for stool culture included the specimen was collected on [DATE], time unknown and reported on [DATE]. The specimen was in the wrong container for a stool culture, and to send the stool culture in a CBM container. Stool cultures required a CBM container. The report stated to see requisition for notified nurse's name. Resident #102 was in the hospital. Review of the lab requirement for a comprehensive stool culture included the specimen needed to be placed in a CBM container. Review of Resident #102's care plan dated [DATE] (Resident #102 was admitted [DATE]) included Resident #102 had bowel incontinence related to wounds and had a fecal management system. Resident #102 would be continent during daytime through the review date. Interventions included check Resident #102 and assist with toileting as needed. Resident #102 had the potential for skin breakdown, pressure ulcer development related to incontinence, immobility. Resident #102 had a left buttock, hip Stage IV pressure ulcer. Resident #102's pressure ulcer would show signs of healing and remain free from infection through the review date. Interventions included follow facility policies, protocols for the prevention, treatment of skin breakdown; obtain and monitor labs, diagnostic work as ordered. Report results to physician and follow up as indicated. Interview on [DATE] at 12:09 P.M. of Quality Administrator (QA) #203 revealed the lab was able to input results directly into the residents electronic record, and also faxed results to the facility. QA #203 stated she was not sure who was responsible to make sure all results were returned to the facility, but it was probably the Director of Nursing (DON) and the Unit Managers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 12:24 P.M. of Registered Nurse/Unit Manager (RN/UM) #204 revealed the lab faxed notifications regarding each resident and the specimen they had ordered, and the floor nurses or Unit Managers check for faxes several times a day. RN/UM #204 stated the Nurse Practitioners could also check the results and they mark it as reviewed and that was another way to check to make sure lab results were returned and reviewed by the physician. RN/UM #204 stated the facility had issues with the current lab company and were soon switching to another lab company. Interview on [DATE] at 2:37 P.M. of State tested Nursing Assistant (STNA) #205 revealed Resident #102 had a lot of diarrhea at times, her wound got worse and she did not look good the last time she took care of her. Interview on [DATE] at 3:25 P.M. of CNP #200 revealed Resident #102 had an indwelling catheter and a rectal tube which a family member dislodged when they were transporting her outside. CNP #200 stated she discontinued the rectal tube because Resident #102 did not have the rectal tone to have keep the rectal tube in place. CNP #200 stated Resident #102 had diarrhea and a stool culture for C-Diff was ordered, and a sacrum wound culture was also ordered. CNP #200 stated a wound swab was sent out but it was expired and the facility had to find an unexpired swab and a second specimen was sent out. CNP #200 Resident #102 was started on [DATE] on broad spectrum antibiotics because it had already been a couple days, and the results from the second swab were not back yet and Resident #102 became very sick. CNP #200 stated Resident #102 was sent to the hospital on [DATE] because she had a critically low hemoglobin. CNP #200 stated she was upset about the culture taking so long because she wanted to know what I was treating. CNP #200 indicated the facility tried to get swabs from a second facility and their swabs were expired too, but a specimen was finally sent. CNP #200 stated she did not know when Resident #102's stool culture went out or what the results were. Interview on [DATE] at 3:51 P.M. of the Administrator, the Director of Nursing (DON) and QA #203 revealed the facility had ongoing issues with the current lab, culture swabs were outdated, and culture swabs from a second facility were outdated, the liason from the lab could not find unexpired culture swabs. The Administrator stated QA #203 drove to a sister facility and found unexpired swabs and the specimens were then able to be sent out to the lab via the DON who drove the culture swabs to the lab. The DON stated Resident #29 also had orders for a wound culture and an expired culture swab was used for the culture and sent to the lab, and the lab notified the facility the swab was expired and the culture could not be processed. The DON stated the culture swab should have been checked before it was used, but the lab was responsible to send out culture swabs which were not expired. Interview on [DATE] at 4:32 P.M. of RN/UM #204 revealed the lab did not call about having the wrong container for the stool specimen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:08 A.M. of RN/UM #204 and QA #203 revealed she wanted to clarify Resident #102's wound culture order. RN/UM #204 stated she reviewed her text messages from CNP #200 and found she took a verbal order on [DATE] at 1:00 P.M. to obtain a sacrum wound culture for Resident #102, and this was what prompted CNP #200 to order Vancomycin and Zosyn intravenous. RN/UM #204 stated she forgot to put the verbal order for a sacrum wound culture in the electronic physician orders. RN/UM #204 stated she did not know why there was an order on [DATE] to re-obtain Resident #102's wound culture because it had already been collected and went out on [DATE]. RN/UM #204 confirmed the lab had [DATE] as the date it was collected, but no time was noted. RN/UM #204 and QA #203 stated Resident #102's stool specimen was not placed in the lab system as a stool culture to rule out C-Diff, it was entered in the lab system as a comprehensive stool culture which needed a CBM container. QA #203 stated a specimen for C-Diff did not need a CBM container, but Resident #102's stool specimen was not correctly entered in the lab system by the nurse and the lab did not accept the specimen. 2. Review of Resident #29's medical record revealed an admitted [DATE] and diagnoses included subacute osteomyelitis, left ankle and foot, infection following a procedure, type two diabetes mellitus with hyperglycemia and diabetic peripheral angiopathy without gangrene. Review of Resident #29's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 was cognitively intact. Resident #29 required supervision or touching assistance for toileting, bathing and personal hygiene. Resident #29 required partial to moderate assistance for mobility. Review of Resident #29's physician orders dated [DATE] at 9:01 P.M. revealed obtain wound culture related to odor, one time only for monitoring for three days. Review of Resident #29's lab report dated [DATE] revealed an unknown collection time and Resident #29's specimen was received on [DATE] at 9:28 A.M. Resident #29's wound transport swab was expired on [DATE] and the sample was not viable. Review of Resident #29's lab report dated [DATE] revealed an unknown collection time and was received on [DATE] at 7:29 A.M. The report stated Resident #29's wound transport swab was expired on [DATE]. The lab was unable to accept the specimen due to sample integrity. Review of Resident #29's progress notes dated [DATE] at 2:21 P.M. included wound culture obtained and expiration date was ,d+[DATE]. Resident #29 was sleeping and when nurse explained and attempted to remove the dressing to expose area to be cultured Resident #29 stated her dressing was just completed by the floor nurse and I really don't want it touched until 4:00 P.M. when I can have my oxy again. Resident #29 indicated she understood the culture would be delayed. The DON and CNP #200 aware. Review of Resident #29's lab report dated [DATE] revealed the collection time was 2:30 P.M., it was received on [DATE] at 3:21 P.M. The report stated the specimen was missing the DOB (date of birth) on the wound transport swab, given [DATE] on label. The specimen was received without two patient identifiers on the specimen container Received affidavit from the DON verifying Resident #29's birth date was [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's care plan dated [DATE] included Resident #29 had actual impairment to skin integrity related to surgical wound right stump amputation. Resident #29 would have no complications with skin through the review date. Interventions included to obtain bloodwork, blood cultures and C&S (culture and sensitivity) of open wounds as ordered by the physician. Observation on [DATE] at 8:55 A.M. revealed Resident #29 sitting in a wheelchair in the common area. Resident #29 expressed no concerns. Interview on [DATE] at 3:25 P.M. of CNP #200 stated a wound swab was sent out but it was expired and the facility had to find an unexpired swab and a second specimen was sent out. CNP #200 stated she was upset about the culture taking so long because she wanted to know what I was treating. CNP #200 indicated the facility tried to get swabs from a second facility and their swabs were expired too, but a specimen was finally sent. Interview on [DATE] at 1:27 P.M. of QA #203 and the DON revealed Resident #29's culture swab was expired, and CNP #200 brought a culture swab from another facility and it was expired. QA #203 stated she called the lab, but the lab could not find unexpired culture swabs. QA #203 stated she drove to a sister facility, picked up an unexpired swab, brought it back to the facility, and Resident #29's wound was cultured. The DON stated after the wound culture was completed he drove the specimen to the lab and dropped it off, but the specimen did not have Resident #29's birthday on it, he sent an affidavit to the lab and the lab was then able to process the specimen. The DON stated CNP #200 ordered antibiotics on [DATE] for Resident #29 because she said she wanted to get some broad spectrum antibiotics going. Review of the facility policy titled Lab and Diagnostic Test Results Clinical Protocol dated ,d+[DATE] included physicians or nurses who had concerns about how test results have been handled or reported should communicate such concerns to the DON and, or the Medical Director. Such concerns or disagreements should not prevent timely, clinically appropriate management of a current result or clinical situation. This deficiency represents non-compliance investigated under Complaint Number OH00157592.