STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365836	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at St Edward Nrsg Care	3131 Smith Rd Fairlawn, OH 44333

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record, review of facility policy, and interview with staff, the facility failed to provide privacy during wound care to Resident #1. This affected one resident (Resident #1) of one observed for wound care. Findings included: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, diabetes, pulmonary hypertension, atrial fibrillation, coronary atherosclerosis, flaccid neuropathic bladder, insomnia, dementia, depression, and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had moderately impaired cognition. Review of Resident #1's physician orders revealed the resident had treatment orders for a right heel wound dated 03/13/25 to cleanse the wound with normal saline, apply Santyl ointment to the wound, and cover it with a foam dressing daily and as needed. Observation of wound care on 04/09/25 at 10:00 A.M. revealed Licensed Practical Nurse (LPN) #100 provided wound care to Resident #1 with the assistance of Registered Nurse #102. During the observation, the staff failed to close the door to the residents room or pull the privacy curtain. The resident was able to be observed receiving wound care by anyone in the hallway. On 04/09/25 at 10:30 A.M. an interview with LPN #100 confirmed she did not close the door or the privacy curtain to provide privacy during wound care to Resident #1. Review of the undated facility policy titled, Privacy, revealed before performing assessments or procedures, the staff should close the doors or pull the privacy curtains to prevent others from seeing or overhearing, thereby respecting the residents privacy and dignity.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365836	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - 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** 35765 Based on observations, review of the medical record, interview with staff, and review of policy and procedure, the facility failed to maintain infection control during wound care for Resident #1's pressure ulcer. This affected one resident (Resident #1) of three reviewed for pressure ulcers. Findings included: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, diabetes, pulmonary hypertension, atrial fibrillation, coronary atherosclerosis, flaccid neuropathic bladder, insomnia, dementia, depression, and congestive heart failure. Review of the physician's order revealed Resident #1 had an order to cleanse the right heel with normal saline, apply Santyl ointment to the wound, cover with a foam dressing daily and as needed dated 03/13/25. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 had moderately impaired cognition and had a one unstageable pressure ulcer not present on admission. Observation of wound care on 04/09/25 at 10:00 A.M. revealed Licensed Practical Nurse (LPN) #100 provided wound care to Resident #1 with the assistance of Registered Nurse #102. LPN #100 did not sanitize the over-the-bed table prior to placing a paper towel (obtained from the paper towel dispenser in the room) onto the table, then she placed the dressing supplies on the paper towel. LPN #100 then soaked the four-by-four gauze in normal saline and laid it on the paper towel. The gauze soaked through the paper towel onto the unsanitized over-the-bed table below. She removed the old dressing from Resident #1's right heel. LPN #100 proceeded to pick up the normal saline soaked four-by-four gauze to clean the right heel wound, when the surveyor intervened. LPN #100 verified at this time the gauze had soaked through, onto the unsanitized table below, and the four-by-fours were now contaminated. On 04/09/25 at 10:30 A.M. an interview with LPN #100 confirmed she did not sanitize the over-the-bed table prior to placing her clean dressing supplies on the table. She further confirmed she placed the normal saline soaked four-by-four gauze on the paper towel and it soaked through the thin paper towel onto the unsanitized over-the-bed table below, contaminating the gauze that she had attempted to use for Resident #1's wound care. Review of the undated facility policy titled, Dressing Change, revealed the policy was to provide a clean wound covering to promote healing. All dressings, unless otherwise specified by a physician, were performed using clean rather than sterile technique. This deficiency represents non-compliance investigated under Master Complaint Number OH00161663 and Complaint Number OH00161643.