STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365860	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence House	1000 Independence Rd Fostoria, OH 44830

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a resident's care plan was revised for advanced directive orders. This affected one (#12) of 13 residents reviewed for care planning. The facility census was 37. Findings include: Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included end stage renal disease, polyneuropathy, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had intact cognition. Review of the plan of care, initiated 10/12/23 and revised on 10/26/23, revealed Resident #12 had elected a full code (cardiopulmonary resuscitation) status. Review of the physician orders revealed dated 08/15/24 revealed the resident's code status orders were changed from Full Code to Do Not Resuscitate Comfort Care (DNRCC). Review of a DNR order form dated 08/15/24 revealed Resident #12 had elected DNRCC. Review of a nurse's note dated 08/14/24 at 9:04 A.M., revealed Resident #12 had changed her code status from full code to DNRCC. Interview on 09/04/24 at 12:49 P.M. with Licensed Practical Nurse (LPN) #212 verified Resident #12's care plan had not reflected the code status changed from full code to DNRCC. Review of the facility policy titled Care Plan -- Comprehensive dated 05/15/15 revealed the care plan would be updated when there was a significant change in resident condition, when a desired outcome was not met, when the resident had been readmitted to the facility from a hospital stay and at least quarterly.

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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(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** 35033 Based on medical record review, resident and staff interviews, observations, and policy review, the facility failed to timely obtain physician orders for a wound dressing change and complete wound dressing changes as physician ordered. This affected one (#23) of one resident reviewed for skin conditions. The facility census was 37. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included hypertension, chronic obstructive pulmonary disease, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had impaired cognition. Review of a nursing progress note dated 08/22/24 at 12:05 P.M., revealed dietary staff reported Resident #23 got bit by something in the dining room during lunch. The resident's left forearm was noted to have a raised reddened area. The physician was notified and gave a verbal order for Benadryl 25 milligrams every six hours as needed. Review of a nurse's note dated 09/02/24 at 5:11 P.M. revealed the physician was notified of a new skin issue on left forearm. Awaiting response. Review of a wound assessment dated [DATE] revealed the resident had drainage from a wound on her left forearm. Review of a wound assessment dated [DATE] revealed the resident had a skin tear on her left forearm. Observation and interview on 09/03/24 at 8:39 A.M. revealed Resident #23 had a gauze dressing applied to her left forearm. Resident #23 slid the dressing down and there was a nonadherent dressing underneath covering a wound with two steri-strips in place. The dressing was not dated. Resident #23 stated she thought she got bit by a bug and the facility had been placing a dressing on her left forearm for three to four days. Review of the physician orders on 09/03/24 at 1:00 P.M. revealed there were no orders in place for the dressing to Resident #23's left forearm. Review of the treatment administration record (TAR) revealed no documentation of the dressing applied to the wound. Review of a physician order dated 09/03/24 at 3:00 P.M. revealed an order for antibacterial ointment to the left arm wound and tear topically two times a day for wound care. Observation on 09/04/24 at 7:41 A.M., revealed Resident #23 told Licensed Practical Nurse (LPN) #200 the wound dressing to her left arm was too tight. LPN #200 unwrapped a layer of self-adherent wrap then a layer of gauze wrap from around the left forearm revealing a nonadherent dressing covering a skin tear closed with two steri-strips. LPN #200 then cleansed the wound with normal saline, applied a new nonadherent dressing before wrapping the wound with new gauze and a self-adherent wrap. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/04/24 at 7:53 A.M. with LPN #200 verified she had removed an undated wound dressing from Resident #23's left forearm. LPN #200 verified she had not checked for a physician order prior to applying the dressing. LPN #200 then checked the physician orders and verified there was no order in place for a wound dressing to the resident's left forearm. LPN #200 verified there was an order for antibacterial ointment to be applied to the wound. LPN #200 verified she had not applied the ordered antibacterial ointment. LPN #200 revealed she would call the physician for an order for the wound dressing. Interview on 09/05/24 at 7:02 A.M. with the Director of Nursing (DON) revealed she called the physician last night and clarified orders for the wound dressing. The DON stated a nurse had received wound care orders from the physician but forgot to enter the orders. The DON revealed the nurses applying the resident's wound dressing should have first ensure there was an order in place before changing the wound dressing and they should have documented the completion of the wound dressing change. Review of the policy titled Skin Care and Ulcer Prevention dated 05/11/21 revealed the physician would be notified to obtain treatment orders for skin impairments. Daily monitoring of the wound dressing and site around wound as well as the wound if visible would be completed.