STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365898	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Sylvania	5757 Whiteford Rd Sylvania, OH 43560

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on observations, medical record review, review of hospital medical records, review of the emergency department record, review of the Abuse/Neglect policy and procedure, review of the Wound Treatment Management policy, review of the Skin Assessment policy, resident interview, Medical Director interview and staff interviews, the facility failed to ensure Resident #59, who was admitted to the facility on hospice care, was free from a situation of neglect when facility staff failed to provide ongoing wound assessments, care and services to prevent a significant decline in a wound, and notification to the physician when there was a decline in the wound. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm with negative health outcomes when emergency services were called for Resident #59 on 03/22/24 due to a deteriorating mental status and Hospice Nurse #215 checked the left leg wound and it was getting worse. Consequently, Resident #59 required an inpatient hospital admission from 03/22/24 to 03/29/24 for which Resident #59 was treated for an infected necrotic wound of the left lower extremity. Surgical debridement was required and occurred on 03/25/24 which resulted in a large skin flap on the lateral aspect of the wound to be removed. Cultures revealed polymicrobial, proteus, methicillin-resistant staphylococcus aureus (MRSA) and enterococcus organisms were present in the wound requiring prolonged oral and intravenous (IV) antibiotic therapy through 04/07/24. In addition, the facility failed to provide ongoing wound assessments for Resident #42, including weekly skin assessments with wound measurements and descriptions according to policy, that placed the resident at potential risk for more than minimal harm that was not Immediate Jeopardy. This affected two (#42 and #59) of three residents reviewed for abuse and neglect. The facility census was 85. On 04/04/24 at 12:38 P.M., the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on 03/22/24 when hospice Resident #59 was transferred to the hospital due to an altered mental status and was found to have an infected left lower extremity wound. Upon Resident #59's admission to the facility on [DATE] a blister to the left knee was noted, and there was no documented evidence of ongoing monitoring or documentation related to the blister or to a left lower leg wound contained within Resident #59's medical record. Subsequently, Resident #59 was admitted to the hospital on 03/22/24 for an infected necrotic wound of the left lower extremity requiring surgical intervention, ongoing wound treatments, and IV antibiotic therapy. The Immediate Jeopardy was removed on 04/04/24 when the facility implemented the following corrective actions: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/04/24 at 2:09 P.M., an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting and Immediate Jeopardy (IJ) Review was held with the Administrator, DON, and Medical Director #600 to review the facility polices for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, Change in Condition, Skin Assessment, and Completion of Wound Care. No policy changes were made as a result of the review. On 04/04/24, the DON educated the nurse managers on the policy for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation and the need to report immediately any concerns, on skin assessments and wound monitoring including education on monitoring for weekly skin assessments being completed on all residents and individual wound monitoring for each individual wound a resident has. On 04/04/24, the DON educated the facility nurses and nursing assistants on Skin Assessments being completed weekly on all residents and to document in the resident's medical record the location, appearance, and size of any skin condition, on Wound Management policies, including the management and documentation of a wound to include size, appearance, measurement and drainage, and the documentation of such wounds, and with any new skin conditions the unit managers are to be notified. Education on the policy for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, including how to identify and prevent situations of neglect, identification of change in condition, including how to timely identify situations when care cannot be or is not provided to residents in the facility and to know when to seek medical attention, and completion of wound care per orders. On 04/04/24, the Administrator educated Staffing Coordinator #105, Director of Admissions #107, Business Office Manager #121, Human Resources Director #130, Social Services #131, Receptionist #133 and #213, the DON, Maintenance Supervisor #134 and Maintenance Helper #162, Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #191, Director of Dining Services #190, Maintenance Director #603, Housekeeping Manager #148, Director of Recreation #104, Recreation Assistant #123, and Director of Rehabilitation #132 on the policy for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property. On 04/04/24, Director of Rehabilitation #132 educated one physical therapist, four occupational therapists, two speech therapists, four physical therapy assistants and two occupational therapy assistants on the policy for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property. On 04/04/24, Director of Dining Services #190 educated four cooks and one dietary aide on the policy for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property. On 04/04/24, Housekeeping Manager #148 educated six housekeeping and laundry staff on the policy for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property. On 04/04/24, the DON, Registered Nurse Unit Manager #181 and Licensed Practical Nurse Unit Manager #214 completed head-to-toe body assessments on all 85 current residents to ensure no evidence of negligence in care resulting in skin impairments had occurred. No new skin or wound issues were noted and review of the medical record for skin and wound assessments had been completed and documented in the last seven days; however, Residents #06, #25 and #84 did not have skin assessments documented in the last seven days, so these records were updated to include the head-to-toe assessment completed on 04/04/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 04/04/24, an ongoing audit four times a week for four weeks completed by the DON/Designee to ensure individual wounds have been assessed no less than weekly and any negative change in a wound will have physician notification. Beginning 04/08/24, an ongoing audit will be completed by the Nurse Managers/Designee four to five times a week for four weeks to ensure skin assessments/observations are completed at least weekly, then randomly thereafter. Interviews conducted on 04/08/24 from 6:47 A.M. to 9:10 A.M., with Occupational Therapist #101, Director of Dining Services #190, Housekeepers #104 and #113, Laundry #103, and Director of Recreations #164 verified education received on resident abuse and neglect with all staff able to verbalize the importance of reporting immediately any concerns related to resident abuse and neglect. Interviews with Licensed Practical Nurses (LPN) #110, #128, #140, #167 and #168, State tested Nursing Assistants (STNA) #155, #170, #167 and #168, and Registered Nurses (RN) #138 and #179 verified they received education on monitoring of skin conditions and reporting as well as resident abuse and neglect. The nurses interviewed (RNs and LPNs) also verified education received on the completion and documentation of weekly skin assessments on all residents, wound assessments to include measurements, and with each dressing change a note in regard to a description of the wound needs to be made, and any changes in a resident's skin or wound needs to be reported immediately to the physician. Although the Immediate Jeopardy was removed on 04/04/24, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: 1) Review of the medical record for Resident #59 revealed an admitted [DATE] from the acute hospital. Resident #59 had diagnoses including anemia, sleep apnea, chronic obstructive pulmonary disease, chronic respiratory failure, morbid obesity, hypertension, atrial fibrillation, heart failure, anxiety disorder, depression, type II diabetes mellitus, chronic kidney disease, atherosclerosis of native artery left lower extremity with ulceration of calf, and cardiomyopathy. Review of the hospital record revealed Resident #59 had presented on 03/01/24 with a complaint of not feeling well and a main complaint of left thigh pain and swelling. Resident #59 reported to have experienced several falls, winded with activities of daily living (ADLS), and a concern for inability to care for self. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the wound documentation dated 03/04/24 at 11:12 A.M. (from the resident's hospitalization prior to admission) revealed Resident #59 had five wounds: A right pretibial wound that was bleeding a moderate amount with a pink/red wound bed, tissue around the wound was blanchable, red in color with fragile warm skin, the wound had defined edges and measured 2.8 centimeters (cm) long by 1.9 cm wide by 1.0 cm deep; a right distal pretibial wound with a small amount of drainage with a pale pink, red base with the surrounding tissue warm and intact with defined edges. The measurements for the right distal pretibial wound were 2.2 cm long by 1.2 cm wide by 0.1 cm deep; a left posterior elbow wound which appeared to be a ruptured blister with small amount of drainage, measurements were 6.2 cm long by 7.1 cm wide by 0.1 cm deep; a left lower posterior arm wound with a pink, red wound bed with a small amount of drainage, measurements 2.0 cm long by 3.2 cm wide by 0.1 cm deep; and a left anterior-medial knee wound identified as a fluid filled blister that measured 13.3 cm long by 0.8 cm wide by 0.1 cm deep, fluid filled blister. Review of the continuation of care paperwork for Resident #59 dated 03/05/24 and timed at 11:16 A.M., revealed the following treatment orders dated 03/06/24 for each of the wounds: left forearm, cleanse with saline, pat dry, apply skin prep to the wound edge, apply foam dressing, every three days; left posterior elbow, cleanse with saline, pat dry and apply skin barrier to wound edges, apply foam dressing, change every three days for wound healing; right distal pretibial, cleanse with normal saline, pat dry, apply skin barrier to wound edges, apply foam dressing, change every day shift every other day and as needed; right proximal pretibial, cleanse with saline, pat dry, apply barrier cream to around the wound, cover with calcium alginate and apply foam dressing, change every day shift every other day and as needed; and left medial knee blister, cleanse with saline, pat dry, cover with Adaptic gauze, cover with abdominal pad and secure with roll gauze. Change every other day shift and as needed. Review of the nursing admission assessment completed on 03/05/24 at 6:45 P.M., revealed Resident #59 had an unstageable vascular wound to the left lower extremity with measurements of 13.5 cm long by 1 cm wide; the assessment noted Resident #59 was unable to tolerate range of motion to the left lower leg due to pain and the leg had discoloration. The assessment also noted a stage II pressure ulcer to the right shin measuring 2.7 cm long by 1.8 cm wide by 0.9 cm deep, a right outer ankle blister 2.5 cm long by 2.0 cm wide, a left elbow pressure ulcer, stage II, measurements 6.3 cm long by 7.9 cm wide., and a left lower arm pressure ulcer, stage 1 with measurements 2 cm long by 3.2 cm wide. Review of Admission orders for Resident #59 dated 03/06/24 included the left forearm to be cleansed with saline, patted dry, skin prep applied to the wound edge, and covered with foam dressing every three days, the left forearm was to be cleansed with saline, patted dry, skin prep to the wound edge, and covered with a foam dressing every three days, the left elbow was to be cleansed with saline, patted dry and skin barrier to wound edges and covered with foam dressing every three days, the right proximal pretibial (right shin) had orders to cleanse with saline, pat dry, apply barrier cream to peri-wound, cover with calcium alginate and cover with foam dressing every day shift every other day and as needed, and for the left medial knee blister to be cleansed with saline, patted dry, covered with Adaptic and abdominal pad and secured with roll gauze every other day shift and as needed. Review of the History and Physical completed on 03/07/24 at 2:10 P.M. for Resident #59 was incomplete, not signed, and did not reference any skin conditions or wounds. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact, required maximal assistance for activities of daily living and moderate to maximal assistance for mobility with functional impairments to both lower extremities. Resident #59 was noted to have no pressure ulcers and did not have the application of nonsurgical dressings and had Hospice services for chronic respiratory failure. Review of the Care Area Assessment (CAA) Summary revealed ADL functional potential, urinary incontinence, psychosocial well-being, mood, activities, falls, nutritional status, psychotropic drug use and pressure ulcers triggered. Review of both the admission and the comprehensive care plan revealed no mention of skin conditions or wounds. Review of the assessment completed for skin breakdown on 03/06/24 and 03/15/24 revealed Resident #59 was at risk for skin breakdown. Review of the progress notes from 03/05/24 to 03/22/24 revealed no skin concerns, and no mention of wounds. Review of the medical record for the weekly skin assessments revealed they were absent. Review of the medication and treatment administration records for March 2024 revealed treatments were documented as administered as ordered. Review of Nurse Practitioner #216's medical visit dated 03/18/24 at 2:06 P.M., noted a hematoma to the left knee with dressing clean dry and intact and a recommendation to continue pressure bandage over wound. Review of the Hospice notes (sent to the facility on [DATE]) revealed Hospice Nurse #215 was called for an unplanned visit to reassess a stage 4 pressure wound to the left knee. Hospice Nurse #215 visited on 03/18/24 at 6:30 P.M. and wrote orders to cleanse the wound area with normal saline, pat dry, apply [NAME] honey to open wound (until honey alginate arrives), cover necrotic area with Adaptic dressing and cover with abdominal pad and secure with border gauze every two days or as needed if dressing is soiled, saturated, or loosened. Hospice Nurse #215 returned on 03/19/24 to reassess the left knee wound dressing and found a moderate amount of bright red dried blood saturated on the gauze dressing. A dressing change was completed, and redness noted to the outer edge of the wound. The wound measured 2 cm with tunneling at 12 to 3 o'clock and outer edges of open wound were beefy red. Review of the Hospice notes by Hospice Nurse #215 dated 03/20/24 revealed the left knee wound measured 12 cm by 4 cm by 2 cm (length by width by depth), was irregular in shape, and had distinct edges with 51 to 75 percent of the tissue necrotic. There was a moderate amount of bloody drainage and the skin surrounding the wound was red with nonpitting edema. The treatment order was changed to cleanse the wound with normal saline, pat dry, apply 4-inch ribbon of Medi honey to the open wound, cover open area with oil emulsion dressing and apply iodine solution with a gauze to the eschar area of the wound, cover with abdominal dressing and wrap with gauze dressing and secure with tape. The wound dressing was ordered to be changed daily and if soiled or saturated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a follow up and reassessment of the wound by Hospice Nurse #215 on 03/21/24 revealed the left leg wound had been deteriorating and the dressing to the left leg was in place but appeared to be soiled with bloody drainage. The dressing was removed, and the wound was odorous with large dark eschar within the deep wound bed that had dark bloody drainage with clots that appeared to be jelly-like. Wound edges were red and macerated with slough present with edema around the wound. The dressing was replaced, and a new order was written to cleanse the left knee wound with quarter strength Dakin's solution, pat dry, apply betadine to the eschar areas, paint around pink wound edges with Medi honey and loosely pack the wound bed with calcium alginate, cover wound with abdominal pad, wrap with kerlix and secure with tape, change every 48 hours and as needed if soiled. Review of the nurse progress notes on 03/22/24 revealed at 3:26 A.M. Resident #59 experienced increased agitation, was climbing out of bed and confusion was noted. At 8:17 A.M., Resident #59 was found on the floor, and noted to have confusion. At 9:19 A.M., Resident #59 was again agitated and attempted to climb out of bed, Ativan 0.5 mg was administered. At 1:20 P.M., Resident #59 was sent to the hospital for evaluation. Review of the Emergency Department (ED) medical record dated 03/22/24 revealed Resident #59 was sent for a wound check and evaluation of deteriorating mental status. Resident #59 was alert only to person and place upon arrival to the ED. Review of the ED Physician assessment dated [DATE] and timed 2:45 P.M., revealed Resident #59 had a large wound to the left knee with surrounding erythema, with a foul smell. In assessing the wound an attempt to remove the dressing noted the gauze that had clotted and appeared entangled in the wound, at which time the wound was recovered without gauze removed due to concerns of heavy bleeding. Resident #59 was started on antibiotics (intravenous Rocephin and Vancomycin) and given fluids due to concerns for sepsis and encephalopathy. Review of the radiography (X-ray) of the left knee completed on 03/22/24 revealed a large region of soft tissue prominence and subcutaneous air medial thigh indicating substantial cellulitis and potential subcutaneous abscess. Review of the hospital medical record dated 03/22/24, revealed Resident #59 was admitted to the hospital with diagnoses that included toxic metabolic encephalopathy, necrotic soft tissue of the left medial thigh and calf with infectious disease, and vascular and wound care consults made for surgical debridement of the wound. Review of the computed tomography (CT) scan of the left knee of Resident #59 completed on 03/23/24 revealed the presence of a complex gas containing fluid collection in the medial soft tissues of the distal thigh extending past the knee joint into the proximal lower leg measurements at least 19.8 cm in length. In addition, there was a soft tissue laceration extending to the fluid collection with no involvement of the muscular compartments seen, with a mass effect upon the vastus medialis muscle of the distal thigh. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the operative note for Resident #59 dated 03/25/24 revealed a diagnosis of infected necrotic wound, left lower extremity with an excisional debridement completed. The wound extended from the mid distal thigh to the proximal calf and involved the medial aspect of the thigh and knee. Large eschar over the wound with purulent drainage. The procedure involved a large skin flap on the lateral aspect of the wound was removed, tunneling seen proximally at the 12 o'clock position about 5 cm, and after debridement the wound measured 15 cm x 9 cm x 1 cm (length by width by depth). Cultures revealed polymicrobial, proteus, methicillin-resistant staphylococcus aureus (MRSA) and enterococcus organisms. Review of the Infectious Disease progress note dated 03/27/24 and times 3:33 P.M., recommended treatment of Levaquin 500 milligrams (mg) once a day by mouth and intravenous vancomycin 2,000 mg once daily through 04/07/24. Review of the hospital discharge summary and the continuation of care paperwork dated 03/29/24 and timed 5:16 P.M., revealed Resident #59 was to return to the facility with treatment that included a wound vacuum to the left medial knee. Orders included for the left medial knee wound that included to cleanse the wound and the area around the wound with soap and water after removing old dressing. Dry intact skin completely, apply skin prep to peri-wound then drape, using black foam to cover wound bed, including to make sure the foam is tucked into the tunneling noted at 12 o'clock. The wound vacuum is to be set at 125 millimeters of mercury (mmHg) continuously, at medium intensity, with the track pad to be placed off the wound to a non-pressure area. The dressing was ordered to be changed twice a week and as needed with the wound vacuum machine kept in upright position, and the cannister changed weekly and as needed. Additional orders included Levaquin 500 mg once a day by mouth and intravenous vancomycin 2,000 mg once daily through 04/07/24 and to follow up with wound care. Observation on 04/03/24 at 9:15 A.M. of Resident #59 revealed staff at bedside due to an increase in the confusion. Resident #59 was sitting on the side of the bed talking to self, dressing noted to the left knee was dated 04/03/24 and was clean dry and intact with black foam visible in the center of the wound with tubing extended out the left side of the dressing connected to a portable wound vacuum under Resident #59's bed. The wound vacuum was set at 125 mmHg per orders. Interview on 04/03/24 at 12:23 P.M. with the facility Medical Director #600, who is Resident #59's primary physician, verified knowledge of Resident #59 having a blister to the left knee upon admission. Medical Director #600 stated no other communication had been received in regard to Resident #59's left knee blister/wound. Medical Director #600 further verified no knowledge of the left knee blister breaking open and had he been called he would have seen the resident. Interview on 04/03/24 at 2:35 P.M. with the DON revealed she could not find documentation in Resident #59's medical record reflecting the monitoring and ongoing assessments of Resident #59's wounds and further verified the medical record for Resident #59 lacked documentation of the wound measurements, wound changes, or notification of change in condition. The DON stated Resident #59 did not have a care plan for either skin alterations or wounds. Observations on 04/04/24 at 11:00 A.M. and 3:00 P.M. found Resident #59 in bed, with head of bed elevated, call light within reach and dressing to left knee clean dry and intact with wound vacuum under the left side of the bed draining brownish colored fluid. The wound vacuum was functioning at 125 mmHg. On 04/08/24 at 9:00 A.M., Resident #59 was observed in bed on the right side with a wound vacuum intact and functioning at 125 mmHg. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/04/24 at 3:00 P.M. with Licensed Practical Nurse (LPN) #156 verified Resident #59 had a fluid filled blister on left knee with skin surrounding the blister red in color. LPN #156 stated she never had to call a provider about the wound, remembered the specifics related to the dressing changes and verified dressing changes were completed. LPN #156 verified she did not complete wound documentation when completing the dressing change and further verified the weekly skin assessments for Resident #59 were not completed and the care plan did not reflect the care needs related to the skin conditions Resident #59 had. 2) Review of the medical record for Resident #42 revealed an admitted [DATE]. The resident had diagnoses including acute kidney failure, acute respiratory failure, hypertension, heart failure, diarrhea, morbid obesity, and perforated intestine requiring surgical intervention. Review of the nursing admission assessment dated [DATE] revealed Resident #42 had an abdominal surgical incision that measured 15 cm by 0.3 cm by 0 cm (length, width, depth). Review of the quarterly MDS assessment dated [DATE] revealed Resident #42 had mild cognitive impairment, required maximal assistance for activities of daily living and had a surgical wound. Review of the care plan for Resident #42 revealed an actual impairment to skin integrity due to a surgical wound. Interventions included to follow facility protocols for treatment of injury, encourage good nutrition, and weekly treatment documentation to include measurement of each area of skin breakdown to include length, width and depth, type of tissue and exudate and any other notable changes or observation. Review of the current physician order for Resident #42's surgical incision was written on 02/24/24 for the abdominal incision to be cleansed with normal saline, pat dry, apply calcium alginate with silver wound dressing to the wound bed and cover with transparent adhesive dressing once daily and as needed. Review of the treatment record for Resident #42 revealed treatments were documented as being completed as ordered. Review of the weekly nursing skin assessments and wound assessments for Resident #42 revealed the following: on 01/16/24, the abdominal surgical wound measured 6.0 cm by 4.0 cm by 0.1 cm with no description; on 01/19/24, the assessment references three abrasions to the abdomen with no measurements or description; on 01/26/24, the abdominal surgical incision had granulation tissue present and measured 12. 7 cm by 5.2 cm by 0.1 cm; on 02/02/24 and 02/09/24 an abdominal surgical incision was noted, no measurements or description; on 02/02/24, the surgical wound measurement was 11.8 cm by 4.8 cm by 0.1 cm without a description; on 02/09/24, measurements were 12.6 cm by 5 cm by 0.1 cm with the wound well approximated; on 02/16/24, the abdominal surgical incision measured 13.2 cm by 6.5 cm by 0.1 cm; on 02/16/24 the surgical incision measured 13.2 cm by 6.5 cm by 0.1cm; on 02/23/24 the weekly skin assessment was blank; on 02/23/24, stated the overall impression was unchanged and measurements were 14 cm by 5 cm by 0.1 cm; on 02/29/24, stated the wound was well approximated and the tissue surrounding the wound was intact, measurements were 14 cm by 4.2 cm by 0.1 cm; on 03/01/24, the assessment referenced abdomen with no description on measurements present; on 03/08/24, the assessment was blank; on 03/19/24, the assessment listed a surgical incision, no measurements; and on 03/28/24 the skin assessment was blank. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nurse Practitioner note dated 03/08/24 documented the midline abdominal wound dressing was saturated with serosanguineous fluid. Review of the Nurse Practitioner note dated 03/27/24 documented the skin around the surgical incision was excoriated. Observation on 04/04/24 at 10:30 A.M. of Resident #42 revealed a clean dry transparent dressing with a white material laying underneath the transparent dressing dated 04/03/24 on the left abdomen and a colostomy draining brown liquid to the right abdomen. The skin around both the ostomy and the dressing were noted to be red and excoriated. Interview with Resident #42, at the time of the observation, revealed skin is excoriated from the colostomy breaking open and leaking. Resident #42 stated different bags are being used and doing better and the staff are applying a cream to the abdomen. Interview on 04/04/24 at 4:00 P.M. with the Director of Nursing verified weekly skin assessments, wound monitoring including the measurements, and appearance of Resident #42's surgical wound did not occur and further verified the last assessment of Resident #42's wound was on 02/29/24. Review of the undated policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property revealed neglect was defined as failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the undated policy titled Wound Treatment Management, noted wound treatments are completed to promote wound healing by providing evidenced based treatments in accordance with current standards of practice and physician orders. Wound dressings will be provided in accordance with physician orders, including cleansing method, type of dressing and frequency of dressing change. Wound treatments will be documented in the treatment administration record or in the electronic health record. The effectiveness of treatments will be monitored thorough ongoing assessment of the wound. Considerations for needed modifications include lack of progression toward healing, changes in characteristics of the wound and changes in the resident's goals and preferences. Review of the undated policy titled Skin Assessment, directed full body assessments are part of the systematic approach to pressure injury prevention and management. Full body assessments, head to toe skin assessment will be conducted by a licensed nurse upon admission, re-admission, daily for three days and then weekly thereafter. The assessment may also be performed after a change in condition or after any newly identified pressure injury. Documentation of the skin assessment includes the date and time of the assessment, documentation of observations, document of wounds, description of wound including measurement, color, type of tissue in the wound bed, drainage odor, pain, and any other information as indicated and appropriate. Review of the undated policy titled Notification of Changes, directed the resident's physician should be notified promptly of any circumstance which requires a need to alter treatment, including the initiation of a new treatment, or a negative or decline in a wound presentation. This deficiency represents non-compliance investigated under Complaint Number OH00152361.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365898	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Sylvania	5757 Whiteford Rd Sylvania, OH 43560

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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** 45445 Based on record review, observation, staff interview and review of policy, the facility failed to provide appropriate care, assessments, and ongoing monitoring of a pressure ulcer. This affected one (#9) of three residents reviewed for wounds. The facility census was 85. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE], diagnoses included an unspecified injury of thoracic spinal cord, paralytic syndrome, protein calorie malnutrition, paraplegia, mood disorder, major depressive disorder, heart failure, and peripheral vascular disease. Resident #9 had an indwelling catheter and a colostomy and an unhealed stage IV pressure ulcer to the coccyx. Review of the annual Minimum Data Set (MDS) Assessment Resident #9 was cognitively intact, had functional impairments to bilateral upper and lower extremities, was dependent for transfers, toilet use, personal hygiene, and dressing. Review of the care plan for Resident #9 revealed a deficit in activities of daily living related to paraplegia, weakness, pain, and decreased mobility. Interventions included low air loss mattress to bed, pressure relieving cushion to wheelchair, staff dependence for showering and bathing, and the assistance of two for transferring and repositioning in bed, and the requirement of skin inspections to observe for redness, open areas, scratches, cuts, bruises and for any changes to be reported to the nurse. A care plan created on 05/09/23 with revision dates of 07/05/23 and 11/13/23 revealed Resident #9 had a left ischium stage IV pressure ulcer related to immobility. Interventions included treatments to be administered as ordered and monitored for effectiveness, weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth and type of tissue and exudate (drainage). Review of the physician orders for the left ischium stage IV pressure ulcer from 12/14/23 to the current order written on 02/29/24 revealed from 12/14/24 until 01/04/24 the left ischium was to be cleansed with normal saline, patted dry, skin prep applied to the skin around the wound and alginate with silver to fill the wound, cover with border gauze daily and as needed. From 01/04/24 to 02/06/24, the order to the left ischium read clean with normal saline, pat dry, apply skin prep to the skin surrounding the wound, apply calcium alginate with silver to fill the wound and cover with foam dressing every day and as needed. On 02/06/24, the order changed to cleanse the wound with soap and water, pat dry, cover with alginate and then foam with silicone border daily and ad needed. The treatment order changed on 02/29/24, stating clean wound with soap and water, pat dry, gently pack calcium alginate then border foam with silicone border. The current treatment order for Resident #9's left ischium wound written on 03/05/24 stated cleanse with soap and water, rinse well, pat dry, cover with collagen after applying a few drops of normal saline onto the collagen, cover with silicone foam border dressing every other day and as needed. Review of the treatment record for December 2023, January 2024, February 2024, March 2024, and April 2024 revealed dressings were completed as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing assessment dated [DATE] and timed revealed Resident #9 had a left ischium stage IV pressure ulcer, measurements were 1.3 centimeters (cm) long by 6.2 cm wide by 0.6 cm deep. Review of a history and physical completed 01/23/24 revealed nothing regarding a pressure ulcer. Review of weekly wound evaluations completed on 02/02/24, 02/09/24, 02/23/24, and 02/29/24 stated Resident #9 had a pressure wound to the left ischium. Measurements on 02/02/24 were 3.8 cm long by 1.3 cm wide the wound described to be unchanged with slough and no drainage. On 02/09/24 the wound was described with 100% necrosis with no drainage and measurements of 3.8 cm long by 1.3 cm wide. On 02/23/24, the stage IV pressure wound was 3.8 cm long by 1.2 cm wide and on 02/29/24 the wound measured 3.2 cm long by 1.2 cm wide and 0.2 cm deep with 50 percent necrosis and a small amount of serosanguineous drainage. Review of the wound care notes dated 01/09/24 and 01/16/24 stated the stage IV pressure ulcer to the left ischium of Resident #9 was healed. The next wound care note was dated 02/06/24 revealed a stage IV pressure ulcer to the left ischium with measurements of 2.8 cm in length, 0.6 cm in width and 0.5 cm in depth. The pressure ulcer was noted to have a moderate amount of serosanguineous drainage with the area around the wound pink and with induration. Further review of wound care notes revealed on 03/05/24 Resident #9 had left ischium stage IV pressure ulcer measuring 3.5 cm in length, 2.5 cm in width and 0.4 cm in depth with a moderate amount of tan drainage. On 04/02/24 the stage IV pressure ulcer to the left ischium was 0.5 cm in length, 2.3 cm in width and 0.2 cm in depth with a scant amount of pink, red drainage. The medical record did not contain weekly nursing skin assessments. Interview on 04/04/24 at 4:00 P.M., with the Director of Nursing verified weekly skin assessments, had not been completed for Resident #9 and should have been. Observation of the left ischium dressing change completed on 04/03/24 at 12:00 P.M., by Licensed Practical Nurse (LPN) #167 revealed no concerns. LPN #167 removed the old dressing that was dated 04/03/24 and appeared to be clean, dry, and intact. Hand hygiene completed, followed by LPN #167 cleansing the wound with wound cleanser and a gauze moving from the center of the wound outward, then dried the wound with a clean gauze, removed gloves, completed hand hygiene, donned gloves, and cut the collagen to fit over wound bed, placed three drops of normal saline on the collagen and laid the collagen onto the wound bed, and covered with silicone border foam. Resident #9's pressure ulcer was an odd circular shape with a red wound bed, edges around the wound were intact. Interview with LPN #167 on 04/03/24, after the dressing change, verified staff should be charting with each dressing change the wound appearance. LPN #167 verified the charting with each of the dressing changes completed by LPN #167 for Resident #9 have not been documented. LPN #167 after reviewing the medical record for Resident #9 also verified no weekly skin assessments had been completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated policy titled Wound Treatment Management, stated wound treatments are completed to promote wound healing by providing evidenced based treatments in accordance with current standards of practice and physician orders. Wound dressings will be provided in accordance with physician orders, including cleansing method, type of dressing and frequency of dressing change. Wound treatments will be documented in the treatment administration record or in the electronic health record. The effectiveness of treatments will be monitored thorough ongoing assessment of the wound. Considerations for needed modifications include lack of progression toward healing, changes in characteristics of the wound and changes in the resident's goals and preferences. Review of the undated policy titled Skin Assessment, stated full body assessments are part of the systematic approach to pressure injury prevention and management. Full body assessments, head to toe skin assessment will be conducted by a licensed nurse upon admission, re-admission, daily for three days and then weekly thereafter. The assessment may also be performed after a change in condition or after any newly identified pressure injury. Documentation of the skin assessment includes the date and time of the assessment, documentation of observations, document of wounds, description of wound, including measurement, color, type of tissue in the wound bed, drainage odor, pain, and any other information as indicated and appropriate. This deficiency represents non-compliance investigated under Complaint Number OH00152361.