

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2024
NAME OF PROVIDER OR SUPPLIER  Liberty Retirement Community of Lima Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  2440 Baton Rouge Avenue Lima, OH 45805	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076</b></p> <p>Based on review of records, facility policy and staff interviews, the facility failed to accurately document and treat wounds. This affected one (#10) of three residents reviewed. The facility census was 46.</p> <p>Findings include:</p> <p>Review of medical record for Resident #10 revealed admitted [DATE]. The resident was admitted with diagnoses including end stage renal disease, dialysis dependent, anemia, dementia without behaviors, and early onset Alzheimer's Disease. The resident was discharged on [DATE] to the hospital and did not return.</p> <p>The discharge return anticipated Minimum Data Set (MDS) dated [DATE] revealed severely impaired cognition. She required set up assistance for eating and was dependent on bed mobility, transfers and toileting hygiene. No pressure ulcer was documented.</p> <p>A care plan for potential for wounds or pressure development was initiated on 01/29/24 with interventions which included weekly treatment documentation to include measurement of each area of skins breakdown in width, length, depth and exudate.</p> <p>Record review of the 06/06/24 skin assessment revealed documentation of three separate rash areas to her right trochanter (hip) with measurements of 4.5 centimeters (cm) by (x) 3.0 cm, 7.0 cm x 5.0 cm and 2.5 cm. There were no depth measurements for any of the three areas.</p> <p>Review of subsequent skin assessments and progress notes revealed no further description or measurement of the rash on her right trochanter.</p> <p>Review of the physician orders revealed on order for skin prep to red areas every shift with a start date of 06/07/24.</p> <p>Interview on 07/23/24 at 11:03 A.M. with Licensed Practical Nurse (LPN) revealed she had cared for Resident #10 prior to her discharge and she recalled an area on her right hip that looked like scratches she was unsure of the diagnoses of the area, but stated she did have treatment order for it.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 07/23/24 at 4:14 P.M. with the Assistant Director of Nursing (ADON) #100 acknowledged there were no subsequent measurements or description of the rash documented on 06/06/24. ADON #100 stated she had not seen the area and verified Resident #10 had not been seen by the wound nurse practitioner for an official diagnosis and was unable to provide an answer why a referral/ notification had not been made.</p> <p>Review of the 01/10/24 facility policy, Wound Management revealed accurate and timely wound documentation of wound assessment, and communication with healthcare providers.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155214.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076</b></p> <p>Based on review of records, facility policy and staff interviews, the facility failed to accurately document and treat pressure wounds. This affected one (#10) of three residents reviewed. The facility census was 46.</p> <p>Findings include:</p> <p>Review of medical record for Resident #10 revealed admitted [DATE]. The resident was admitted with diagnoses including end stage renal disease, dialysis dependent, anemia, dementia without behaviors, and early onset Alzheimer's Disease. The resident was discharged on [DATE] to the hospital and did not return.</p> <p>The discharge return anticipated Minimum Data Set (MDS) dated [DATE] revealed severely impaired cognition. She required set up assistance for eating and was dependent on bed mobility, transfers and toileting hygiene. No pressure ulcer was documented.</p> <p>A care plan for potential for wounds or pressure development was initiated on 01/29/24 with interventions which included weekly treatment documentation to include measurement of each area of skins breakdown in width, length, depth and exudate.</p> <p>Record review of the facility skin observation tool used for skin assessments revealed Part One contained a front and back diagram of a person with a section to document the site, type length, width and stage of a wound. There was also a key with descriptions of a suspected deep pressure injury (purple or maroon localized area of discolored intact skin due to damage of the underlying soft tissue) , stage one pressure area (intact skin with non-blanchable redness of a localized area usually over a bony prominence), stage two pressure area (partial thickness if dermis presenting as a shallow open ulcer with a pink or red wound bed without slough), stage three pressure area (full tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle was not exposed), stage four pressure area (full tissue loss with exposure of bone, tendon or muscle), unstageable pressure area (full tissue loss in which the base of the ulcer is covered with slough (yellow, tan, gray, or green) or eschar (tan, black, brown) as well as an option of Not Available (NA). Part Two had an area for notes.</p> <p>Review of the 06/11/24 skin assessment revealed documentation of a pressure area to her right heel which measured 4.0 cm x 3.5 cm x 0.0 cm. the stage section was blank.</p> <p>Review of subsequent skin assessments and progress notes revealed no further staging or measurement of the right heel.</p> <p>Review of the physician orders revealed on order for skin prep to right heel every day and night shift with a start date of 06/12/24.</p> <p>Review of the 06/14/24 skin assessment revealed there was no documentation in part one. In part two the note documented reddened area on right heel and buttocks, not of new concern, resident refused to stay repositioned in a way to relieve pressure.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 07/23/24 at 4:14 P.M. with the Assistant Director of Nursing (ADON) #100 acknowledged there were no subsequent measurements or description of the pressure area to her right heel documented on the 06/11/24. ADON #100 also agreed the documentation on her 06/14/24 skin assessment regarding the right heel and buttock was incomplete with no description or measurements documented. ADON #100 verified Resident #10 had not been seen by the wound nurse practitioner and was unable to provide an answer why a referral/ notification had not been made.</p> <p>Review of the 01/10/24 facility policy, Wound Management revealed accurate and timely wound documentation of wound assessment, and communication with healthcare providers.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155214.</p>		