STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366053	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkeley Square Retirement Cen	100 Berkeley Drive Hamilton, OH 45013

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** 44080 Based on record review, staff interview, observation, and review of the facility policy, the facility failed to follow the physician's order to treat the resident's pressure wounds and failed to routinely assess the resident's pressure wounds. This affected one (Resident #11) of three residents reviewed for pressure wounds. The facility identified eight residents with pressure ulcers. The facility census was 29. Findings include: Review of the medical record revealed Resident #11 had an admitted [DATE]. Diagnoses included chronic systolic heart failure, vertebra osteomyelitis, and Parkinson's disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively impaired. Review of the skin only evaluation dated 07/29/24 revealed Resident #11 had the following skin concerns: left heel, buttocks excoriation, right buttocks medial, back excoriation, right elbow skin tear not painful, right and left lower legs discoloration, and right shin tear. There were no measurements or description of the wounds. Review of the plan of care dated 07/29/24 revealed Resident #11 was at risk for potential for skin breakdown related to bowel incontinence, catheter tubing in use, decreased mobility, previous issues with Moisture Associated Skin Damage (MASD) on right inner buttocks, stage III pressure injury (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed) to the left heel. Deep tissue injury (purple or maroon area of discolored intact skin due to damage or underlying soft tissue) to right buttocks, yeast under right and left arm. Many refusals of care and treatment to be completed. On 08/06/24, a wound consultant assessed Resident #11's wounds and included the following pressure areas: right buttock was a deep tissue injury (DTI) and showed deterioration. Left heel stage III smaller in size. Resident #11 was discharged to the hospital on 08/11/24 and returned to the facility on [DATE]. Review of the skin only evaluation dated 08/15/24 revealed Resident #11 had wounds which included the following: left heel (DTI), right heel (DTI), right buttock (marked as open lesion), and left buttock (marked as open lesion). There were no measurements or descriptions of the wounds. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11 was discharged to the hospital on 08/18/24 and returned to the facility on [DATE]. Review of the skin only evaluation dated 08/27/24 revealed Resident #11 had wounds which included the following: back had excoriation, coccyx (open area), left heel (DTI), and right heel (redness). There were no measurements or descriptions of the wounds. Resident #11 was discharged to the hospital on 09/02/24 and returned to the facility on [DATE]. Review of the skin only evaluation dated 09/03/24 revealed Resident #11 had wounds which included coccyx (open area), left heel (DTI), right heel (redness), and back (excoriation). Review of the Resident #11's wound measurements dated 09/10/24 revealed the right lateral buttocks measured 2.5 centimeter (cm) in length by 2.5 cm in width by 0.1 cm in depth, right inner buttocks measured 3.5 cm by 2.5 cm by 0.1 cm, left lateral buttocks measured 1.0 cm by 1.0 cm by 0.1 cm, and the left inner buttocks measured 1.2 cm by 0.5 cm by 0.1 cm. Review of the physician order dated 09/12/24 revealed Resident #11 had an order to clean with normal saline then apply Remedy Calazime paste 0.4-20.5% to the two open areas on the left buttocks topically daily on day shift. Cover with Optifoam gentle dressing. The order dated 09/12/24 stated to cleanse the two open areas on the right buttocks with normal saline and apply Triad Hydrophillic Wound Dress External Paste. Cover with Optifoam gentle dressing. Interview on 09/12/24 at 3:00 P.M. with the Director of Nursing (DON) verified the facility should have had wound assessments upon admission, and readmission from the hospital for Resident #11 on 07/29/24, 08/15/24, and 08/27/24. The DON verified the facility only completed skin assessments with measurements and description of the wounds for Resident #11 on 09/03/24 and 09/10/24. Observation and interview on 09/16/24 at 2:00 P.M. revealed Licensed Practical Nurse (LPN) #345 and State tested Nurse Aid (STNA) #277 provided wound care to Resident #11. LPN #345 removed Resident #11's ABD dressing to the right and left buttocks and the treatment was Hydrofero Blue (antibacterial, non-cytotoxic wound care product) dressing under the ABD dressing. LPN #345 confirmed Hydrofero Blue was not ordered for Resident #11's right and left buttocks wound treatment. Review of the facility policy titled Skin: Prevention, Detection and Treatment of Pressure Ulcers dated 08/2024 revealed to prevent pressures sores was to have early detection of potential or actual pressure ulcer sites. Assessments of pressure ulcers included type of ulcer pressure or not, the ulcer stage, ulcer's characteristics, progress toward healing or complications, presence of infection, presence and treatment of pain, and presence and type of dressing and treatment. Review of the facility policy titled Wound Treatment Protocol dated 10/2023 revealed the policy was to establish immediate treatment of non-intact skin, protocols in treating different levels of wounds, and to enhance the healing process of non-intact skin. Continue to describe the wound thoroughly included: wound bed, drainage, peri wound in the skin assessment, and document the specific area being treated in the order set upon admission. This deficiency represents non-compliance investigated under Complaint Number OH00156890.