STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366142	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Run Care Center	3399 Mill Run Drive Hilliard, OH 43026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, resident and staff interviews, and facility policy review, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) were provided routine nail care. This affected two (#20 and #40) of three residents reviewed for ADL care. The facility census was 62. Findings include: 1. Review of the medical record for Resident #40 revealed an initial admitted [DATE]. Diagnoses included pulmonary fibrosis, diabetes mellitus, peripheral venous insufficiency, chronic pain syndrome, and gout. Review of the resident's admission evaluation dated 03/20/25 revealed Resident #40 had no cognitive deficit. On 03/26/25 at 9:45 A.M., observation of Resident #40 revealed her fingernails were long jagged and had a black substance on the third and fourth fingernail of the right hand. Interview with Resident #40 at the time of the observation revealed she was unsure what the black substance was and had tried to get the substance out. Resident #40 stated she would like nail care provided. On 03/26/25 at 2:30 P.M., interview with Licensed Practical Nurse (LPN) #163 confirmed Resident #40's nails were long jagged and dirty with a black substance. On 0327/25 at 9:30 A.M., interview with LPN #130 stated Resident #40 prefers to stay in bed. LPN #130 stated Resident #40 was dependent on the staff for personal hygiene due to lack of motivation to complete any tasks herself. 2. Review of the medical record for Resident #20 revealed an initial admitted [DATE] with Parkinson's disease, palliative care, peripheral vascular disease, diabetes mellitus, anxiety disorder, and dementia. Review of the plan of care dated 01/16/24 revealed Resident #20 had an ADL self care deficit as evidence by weakness, confusion, and required assistance with ADL. Interventions included the resident required assist of two staff for bed mobility, assist with bathe/shower as needed, and assist with meals. (continued on next page)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had a moderate cognitive deficit. On 03/26/25 at 9:52 A.M., observation of Resident #20 revealed the resident's nails were long, jagged and had a brown substance under the nail. On 03/26/25 at 11:45 A.M., observation of Resident #20's nails revealed his nails remained long, jagged and had a brown substance und the nail. Interview with Certified Nursing Assistant (CNA) #160 verified Resident #20's nails were long, jagged and had a brown substance under the nail. Review of the facility policy titled Hygiene and Grooming dated 07/20/18 revealed it was the facility's policy to make sure the resident's needs are met regarding hygiene and grooming while addressing the resident's personal preferences and daily routine. This was an incidental finding discovered during the course of this complaint investigation.

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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 - 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** 32654 Based on observation, record review, resident and staff interviews, review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), and facility policy and procedure review, the facility failed to comprehensively assess, provide timely interventions, and implement a treatment to an existing pressure ulcer. This resulted in Actual Harm to Resident #40 on 03/20/25 when the facility failed to assess a resident's wound and obtain physician orders for wound treatments resulting in Resident #40 developing an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed) to the right gluteus. This affected one (#40) of three residents reviewed for pressure ulcers. The facility census was 63. Findings include: Review of the medical record for Resident #40 revealed an initial admitted [DATE]. Diagnoses included pulmonary embolism, diabetes mellitus, severe protein calorie malnutrition, peripheral venous insufficiency, chronic pain syndrome, gout, anemia, gastro-esophageal reflux disease, irritable bowel syndrome, and fatty liver. Review of the resident's admission evaluation dated 03/20/25 revealed Resident #40 was admitted with no skin abnormalities. Review of the skin issues care plan contained within the admission evaluation revealed no interventions were implemented. The assessment indicated Resident #40 required extensive assistance with bed mobility and toileting. Review of the Braden scale assessment dated [DATE] revealed a score of 19 indicating Resident #40 was at risk for skin breakdown. Review of the weekly skin and wound evaluation dated 03/20/25 revealed Resident #40 was admitted to the facility with a Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister.) to the right gluteus. The assessment had no measurements or description of the wound. The assessment indicated the facility implemented to cleanse the wound with normal saline, but indicated the wound had no dressing. The assessment indicated the facility implemented the interventions of nutrition/dietary supplement and turning and repositioning program. There was no baseline care plan-initiated addressing Resident #40's high risk for skin breakdown. Review of Resident #40's physician orders dated 03/20/25 revealed an order to monitor scattered bruising and scabbing to right/left hand every shift and monitor scattered bruising to bilateral lower extremities and bilateral upper extremities. There was no treatment ordered on 03/20/25 to treat the Stage II pressure ulcer identified on the weekly skin and wound evaluation. From 03/20/25 to 03/26/25, there was no evidence a nutrition/dietary supplement was ordered for Resident #40 for wound healing, no evidence of Resident #40 being on a turning and repositioning schedule, and no treatment was ordered to the Stage II pressure ulcer to the right gluteus. There was no baseline care plan in place after Resident #40 was identified to be at risk for skin breakdown and had a Stage II pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/24/25, there was a new physician order to encourage Resident #40 to float heels while in bed. On 03/27/25, Resident #40's weekly skin and wound evaluation revealed the Stage II pressure ulcer had deteriorated to an unstageable pressure ulcer. The wound measured 2.2 centimeters (cm) in length by 1.8 cm wide and described as 100% slough. The wound had no exudate. The facility implemented the new treatment of cleansing with normal saline, apply Medi-honey to the wound bed and cover with clean dry dressing daily. The facility determined the wound had deteriorated. On 03/27/25, there were physician orders to place a low air loss mattress on the bed for pressure reduction, monitor low air loss mattress functioning and check that the settings are appropriate for the resident. Cleanse wound to right gluteus with normal saline, pat dry with gauze, apply Medi-honey to wound bed and cover with clean dry dressing daily and as needed. Enhanced barrier precautions for unstageable wound to the right gluteus and consult wound care. On 03/26/25 at 9:45 A.M., an interview with Resident #40 stated she had a wound on her right buttocks that developed while she was in the hospital. Resident #40 stated the facility was not providing any treatment to the area or turning/repositioning her. Resident #40 was positioned on her back at the time of the interview. Resident #40 stated she was applying Vaseline to the wound and off-loading with her hand to help alleviate pain. The resident rated her current pain level as a six (zero being no pain and 10 being the worst pain). On 03/27/25 at 11:27 A.M., an observation of Licensed Practical Nurse (LPN) #193 and Certified Nursing Assistant (CNA) #145 revealed they were going to observe Resident #40's pressure ulcer. LPN #193 and CNA #145 washed their hands and donned gloves and did not don a gown for enhanced barrier precautions. LPN #193 and CNA #145 pulled the resident's incontinence brief down and assisted the resident to turn back on her left side from her back. The wound bed was covered with 100% yellow slough and the surrounding tissue was dark red. LPN #193 verified the stage II pressure ulcer had deteriorated into an unstageable pressure ulcer and stated she would notify the physician for an appropriate treatment. LPN #193 stated she would obtain an order for a low air-loss mattress also. On 03/27/25 at 2:40 P.M., an interview with the Regional Nurse (RN) #153 confirmed Resident #40's stage II pressure ulcer was not comprehensively assessed and no treatment was initiated on admission 03/20/25. RN #153 verified there was no treatment to Resident #40's stage II pressure ulcer seven days later 03/27/25. RN #153 verified Resident #40's stage II pressure ulcer was now an unstageable pressure ulcer. Review of the NPUAP guidelines dated 2014 revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled Skin and Wound Guidelines dated 03/05/24 revealed the policy describes the process steps required for identification of residents at risk for the development of pressure injuries, identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations. This deficiency represents non-compliance investigated under Complaint Number OH00163575.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, and staff interview, the facility failed to ensure one resident (#20) received routine podiatry care. This affected one (#20) of one resident reviewed for podiatry. The facility census was 62. Findings include: Review of the medical record for Resident #20 revealed an initial admitted [DATE] with Parkinson's disease, palliative care, peripheral vascular disease, diabetes mellitus, anxiety disorder, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had a moderate cognitive deficit. Review of the plan of care revealed ancillary services for the resident's needs such as dental, podiatry, optometry, audiology, psychological as needed. Interventions included to coordinate with Social Services for scheduling of resident need to see in house specialty physicians. On 03/26/25 at 9:52 A.M., observation of Resident #20 revealed the resident was laying in bed with his sheet on his chest exposing his incontinence brief. The resident was observed to have long toenails curled over the ends of his toes. On 03/26/25 at 11:45 A.M., observation of Resident #20 during incontinence care being provided by Certified Nursing Assistants (CNA) #126 and #160 revealed the resident's toenails were long and curled over the ends of his toes. Interview with CNA #160 at the time of the observation verified the resident needed both fingernail and toenail care. This was an incidental finding discovered during the course of this complaint investigation.