

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Widows Home of Dayton		STREET ADDRESS, CITY, STATE, ZIP CODE 50 South Findlay Street Dayton, OH 45403	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure nursing staff communicated with resident physicians regarding significant changes in status. This affected one (Resident #14) of three residents reviewed for notification of change. The facility census was 64 residents.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #14 revealed an admitted [DATE] with diagnoses including periprosthetic fracture around internal prosthetic right hip joint, history of falling, heart failure, chronic obstructive pulmonary disease, and peripheral vascular disease. Resident #14 was discharged to the hospital on 09/11/24.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 08/21/24 revealed the resident was cognitively intact and required extensive assistance of two staff members for bed mobility.</p> <p>Review of the admission assessment for Resident #14 dated 08/21/24 revealed the resident was admitted to the facility following surgical revision of a right total knee replacement and had a surgical incision to the right knee.</p> <p>Review of the wound visit note per wound Certified Nurse Practitioner (CNP) #300 dated 08/29/24 revealed the surgical incision to the right knee was healing and free of signs of infection.</p> <p>Review of the nurse progress note for Resident #14 dated 09/04/24 revealed the facility nurse removed the staples from the resident's right knee incision and left the incision open to air per the surgeon's orders. Resident #14 was scheduled for a follow up with the orthopedic surgeon on 09/11/24. The surgical incision was free of signs of infection.</p> <p>Review of the wound visit note for Resident #14 dated 09/05/24 per wound Certified Nurse Practitioner (CNP) #300 revealed the surgical incision to the resident's right knee showed signs of possible infection. CNP #300 gave orders for an oral antibiotic, Doxycycline 100 milligrams (mg) twice a day for 10 days and also indicated the facility should call the orthopedic surgeon's office as soon as possible with an update on the surgical wound.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse progress note for Resident #14 dated 09/05/24 timed at 1:51 P.M. revealed the orthopedic surgeon left a message indicating a message was left for the doctor to see if the resident could come in for a follow-up appointment sooner than 09/11/24 and someone from the surgeon's office would call the facility back with instructions from the surgeon.</p> <p>Review of the nurse progress notes for Resident #14 dated 09/05/24 through 09/11/24 revealed the notes did not include documentation of further communication with the orthopedic surgeon.</p> <p>Review of the nurse progress note for Resident #14 dated 09/11/24 revealed the resident was admitted to the hospital for complications of right knee surgery.</p> <p>Interview on 09/30/24, at 11:59 A.M. with CNP #300 confirmed on 09/05/24 she instructed the nursing staff to call Resident #14's orthopedic surgeon as soon as possible to notify him of the changes to the resident's surgical wound.</p> <p>Interview on 09/30/24 at 12:30 P.M. the Director of Nursing (DON) confirmed the facility nurses had left a message with the orthopedic surgeon's office staff on 09/05/24 to see if the resident could get a follow up appointment sooner than 09/11/24 and the office never called back. The DON further confirmed when Resident #14 went to the orthopedic surgeon's appointment on 09/11/24 the surgeon transferred the resident to the hospital for evaluation of her right knee. The DON further confirmed that the facility nurses made no attempts at additional communication with the orthopedic surgeon after the call on 09/05/24 requesting an earlier appointment and did not notify him that the resident's surgical wound showed signs of infection.</p> <p>Review of the policy titled Change in Condition and Physician Notification dated 09/25/24 revealed the nursing department was responsible for monitoring residents, conducting assessments, notifying physicians, and documenting all relevant information promptly when significant changes had occurred in a resident's condition.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00157269.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648</p> <p>Based on medical record review, staff interview, review of the facility policy, and review of guidelines per the National Pressure Injury Advisory Panel (NPIAP), the facility failed to thoroughly assess residents' skin and to implement interventions to prevent the development of pressure ulcers and failed to initiate prompt and timely treatment for a resident with pressure ulcers (a pressure ulcer is a localized injury of the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). This resulted in Actual harm when Resident #14 was admitted to the facility without pressure sores but was at risk for the development of pressure ulcers and subsequently developed an avoidable unstageable pressure ulcer to the right heel (full-thickness tissue loss where the depth of the wound bed was completely obscured by eschar in the wound bed) and a stage II pressure ulcer to the left heel. This affected one (Resident #14) of three residents reviewed for pressure ulcers. The facility census was 64 residents.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #14 revealed an admitted [DATE] with diagnoses including periprosthetic fracture around internal prosthetic right hip joint, chronic obstructive pulmonary disease, and peripheral vascular disease. Resident #14 was discharged to the hospital on 09/11/24.</p> <p>Review of the admission assessment for Resident #14 dated 8/21/24 revealed the resident had a surgical incision to her right knee with no pressure ulcers.</p> <p>Review of the pressure ulcer risk assessment for Resident #14 dated 08/21/24 revealed the resident was at risk for the development of pressure ulcers.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 08/28/24 revealed the resident was cognitively intact and required extensive assistance of two staff members for bed mobility. Resident #14 was at risk for the development of pressure ulcers but had no pressure ulcers during the MDS review period.</p> <p>Review of a visit note per wound Certified Nurse Practitioner (CNP) #300 dated 08/29/24 revealed the CNP was treating the resident's surgical incision and did not include documentation regarding the presence or absence of pressure ulcers.</p> <p>Review of the care plan for Resident #14 initiated 08/30/24 revealed the resident was at risk for skin integrity/breakdown related to impaired mobility and incontinence of bowel and bladder. Interventions included the following: assess skin condition with activities of daily living (ADL) care daily and report abnormalities, encourage/assist the resident to turn/reposition at least every two hours or more often as needed or requested, position with pillows daily as needed, pressure relieving mattress to bed, preventative skin treatments as ordered, and weekly skin checks by a licensed nurse.</p> <p>Review of the Treatment Administration Record (TAR) for Resident #14 dated August 2024 revealed there were no orders for heel protection or offloading of heels.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the weekly skin check for Resident #14 dated 09/03/24 revealed resident had no pressure ulcers.</p> <p>Review of the occupational therapy note for Resident #14 dated 09/03/24 revealed the resident was in bed and was noted to have reddened areas to both heels.</p> <p>Review of the nurse progress note for Resident #14 dated 09/05/24 revealed new pressure ulcers to the right and left heel were observed during a wound assessment with wound CNP #300.</p> <p>Review of the wound visit note for Resident #14 dated 09/05/24 per wound CNP #300 revealed the resident had an unstageable pressure ulcer to the right heel which measured 5.0 centimeters (cm) in length by 6.0 cm in width with the depth unable to be determined as the wound bed was covered 100 percent (%) with eschar (dead tissue.) and a stage II pressure ulcer to the left heel which measured 2.0 cm in length by 2.0 cm in width. CNP #300 gave orders for treatment of the wound and recommended offloading of the resident's heels.</p> <p>Review of the TAR for Resident #14 dated September 2024 revealed there were no orders for heel protection or offloading of heels. There was a treatment order dated 09/05/24 to cleanse the pressure ulcer to the left heel with wound cleanser, apply skin prep, cover with an ABD pad, and wrap with Kerlix gauze on Tuesday, Thursday, and Saturday which was signed off as completed. There was a treatment order dated 09/05/24 to cleanse the pressure ulcer to the right heel with wound cleanser, apply Betadine, cover with an ABD pad, and wrap with Kerlix gauze on Tuesday, Thursday, and Saturday which was signed off as completed.</p> <p>Interview on 09/30/24 at 11:59 A.M. with CNP #300 confirmed on 09/05/24 she evaluated Resident #14's surgical incision to the right knee and discovered the resident had developed an avoidable unstageable pressure ulcer to the right heel and a stage II pressure ulcer to the left heel. CNP #300 confirmed she identified the pressure ulcers and reported them to the Director of Nursing (DON) and gave orders for wound care for the pressure ulcers and recommended the resident's heels be offloaded.</p> <p>Interview on 10/15/24 at 1:40 P.M. with Occupational Therapist (OT) #305 confirmed she noticed Resident #14's heels were reddened on 09/03/24 but she did not report this to the nursing staff.</p> <p>Interview on 10/15/24 at 2:00 P.M. with the DON confirmed the facility nursing staff did not identify Resident #14's pressure ulcers to the heels. The DON confirmed wound CNP #300 identified the pressure ulcers to Resident #14's heels on 09/05/24. The DON further confirmed the facility did a skin assessment upon admission which revealed Resident #14 had no pressure ulcers. The DON confirmed residents should have a skin assessment completed weekly per a licensed nurse. The DON confirmed the only weekly skin assessment completed for Resident #14 per the facility nursing staff form was completed on 09/03/24 and indicated the resident had no pressure ulcers. Further interview with the DON confirmed Resident #14's care plan did not include interventions to protect the heels from skin breakdown such as floating or offloading heels or applying heel protectors. The DON confirmed Resident #14 had no physician orders for heel protection, and the pressure ulcer to resident's right heel was not identified until it had reached an advanced stage (unstageable with 100% eschar to the wound bed.)</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>Review of the facility policy titled Pressure Injury Prevention and Management dated 10/17/24 revealed the facility was committed to the prevention of avoidable pressure injuries and to providing treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.</p> <p>Review of the policy titled Change in Condition and Physician Notification dated 09/25/24 revealed the nursing department was responsible for monitoring residents, conducting assessments, notifying physicians, and documenting all relevant information promptly when significant changes have occurred in a resident's condition.</p> <p>Review of the guidance from the National Pressure Injury Advisory Panel (NPIAP) dated 2014 revealed staff should assess the pressure ulcer upon discovery and at least weekly thereafter and should implement appropriate wound care. Further review revealed with each dressing change, staff should observe the pressure ulcer for signs that indicate if a change in treatment is required (e.g., wound improvement, wound deterioration, signs of infection, or other complications). Wound status could change rapidly. Wound improvement or deterioration indicated by change in wound dimensions, change in tissue quality, an increase or decrease in wound exudate, signs of infection or other complications all provided indications of the effectiveness of the current management plan. The person responsible for dressing changes should be educated regarding signs and symptoms of complications that should be reported to the health professional.</p>		