STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366284	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amherst Meadows Skilled Nursing and Rehab	1610 First Street NE Massillon, OH 44646

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. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to assess and implement treatment for pressure ulcers for Resident #11. This affected one resident (Resident #11) of three residents reviewed for wound care. The facility census was 81.Findings include: Review of the medical record revealed Resident #11 was admitted on [DATE] with diagnosis including diabetes, congestive heart failure, coronary artery disease and an unstageable sacral pressure area. Resident #11 was admitted to the hospital on [DATE] and returned to the facility on [DATE].Review of Resident #11's minimum data set admission assessment dated [DATE] revealed Resident #11 was moderately cognitively impaired and required maximum assistance for all activities of daily living except for eating.Review of Resident #11's care plan revealed impaired skin integrity and required assistance with bed mobilityReview of a progress note dated 09/10/25, authored by licensed practical nurse (LPN) #666, revealed Resident #11 returned from a hospital stay. Further the note stated that a skin assessment was completed by the wound care nurse #563 . The only skin impairment noted was the pre-existing sacral wound.Review of a progress noted dated 09/10/25, authored by the wound care nurse #563, revealed documentation an unstageable pressure area to Resident #11's sacrum. No other areas were noted. This note was struck out by wound nurse #563 as an error on 09/17/25.Review of a late entry progress note dated for 09/10/25 but entered on 09/17/25 and authored by wound nurse #563, revealed documentation of an unstageable pressure area on Resident #11's right heel. Further review revealed wound nurse #563 notified the family, physician, and obtained new orders on 09/10/25.Review of the physician ' s orders revealed a treatment order for a pressure area on Resident #11's right heel was entered on 09/17/25. The order stated to cleanse the right heel with normal saline, apply skin prep, then cover with an abdominal pad, wrap with Kerlix two times a week and as needed. There was no documentation of a treatment order for Resident #11's right heel prior to this date.Review of the September treatment administration record (TAR) for Resident #11 revealed an order for a treatment to Resident #11's right heel was initiated on 09/17/25 and documented as being completed on assigned days.An interview with LPN #666 on 09/24/25 at 5:00 P.M. revealed she did the readmission assessment for Resident #11. Wound nurse #563 told LPN #666 she had completed the skin assessment and there were no new skin issues, only the pressure ulcer on Resident #11's sacrum that he originally admitted with. LPN #666 stated she specifically documented who did the wound assessment because she was documenting another nurse ' s assessment.An interview on 09/25/25 at 10:45 A.M. with wound care nurse #563 revealed upon admission, the floor nurse does a skin evaluation as part of the admission assessment. The next day the wound nurse does a second skin assessment as a double check. The wound nurse back dates her second assessment back to the date of admission because she was trained that way. Further interview revealed the unstageable pressure area to Resident #11's right heel was present upon their return from the hospital. Wound nurse #563 was aware of the pressure area but waited until the Nurse Practitioner. from an outside company came in to assess Resident #11 to get wound orders. Wound Nurse #563 was unable to explain why she documented she had obtained new orders on 09/10/25.An interview on 09/25/25 at 11:00 A.M. with the Director of Nursing (DON) revealed the skin was assessed at the time of admission or return from the hospital. The expectation was that notifications are completed, and orders are obtained at time of discovery of any abnormal findings. The DON also stated documentation was not to be back dated.Review of facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 09/21 revealed the nurse would examine the skin of a new admission for alterations in skin and that they would document and report the findings to the physician.This deficiency substantiates allegations contained in Complaint Number 2617894.