Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366380	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indianspring of Oakley	4900 Babson Place Cincinnati, OH 45227

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, observation, staff interview, review of facility policy, and review of guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to adequately assess and monitor a resident's skin which resulted in Actual Harm for Resident #20 who was admitted to the facility without pressure ulcers and developed a stage three pressure ulcer (a full thickness skin break into the subcutaneous tissue which did not go into muscle or bone) to the right ischium which was not identified until it had reached an advanced stage. This affected one (Resident #20) of three residents reviewed for pressure ulcers. The facility census was 113. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, anemia, atherosclerotic heart disease of coronary artery, and hypertension. Review of the weekly skin round assessments for Resident #20 dated 01/29/24, 02/26/24, 03/07/24 and 03/14/24 revealed they did not include documentation regarding the resident's right ischium. Review of the care plan for Resident #20 dated 02/12/24 revealed the resident had potential for skin impairment related to impaired mobility, fragile skin, and incontinence. Interventions included the following: assist as needed with toileting and hygiene, staff to apply barrier cream as needed after incontinent episodes, staff to check skin daily while doing routine care and report changes to the nurse, staff to apply pressure reducing mattress to bed. Review of the pressure ulcer risk assessment for Resident #25 dated 02/25/24 revealed the resident was at moderate risk for the development of pressure ulcers. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #20 dated 02/27/24 revealed the resident was cognitively impaired and dependent with eating, toileting, bathing, dressing, and transfers. Resident #20 was at risk for the development of pressure ulcers but did not have pressure ulcers. (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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the wound progress note for Resident #20 dated 03/20/24 per Wound Nurse Practitioner (WNP) #70 revealed the resident had developed an in-house acquired stage three pressure ulcer to the right ischium first observed by the staff on 03/19/24 which measured 2.0 centimeters (cm) in length by 2.0 cm in width by 0.8 cm in depth. The wound bed was yellow, pink and red with granulation tissue present and moderate amounts of serous and serosanguineous drainage noted. Treatment recommended was to apply alginate to the wound bed. Review of the physician's orders for Resident #20 revealed an order dated 03/20/24 to cleanse the pressure ulcer to the right ischium with normal saline, pat dry, apply calcium alginate and cover with abdominal pad and retention tape. Observation on 04/17/24 at 11:25 A.M. of wound care for Resident #20 per Licensed Practical Nurse (LPN) #200 revealed the resident had a quarter-sized pressure ulcer to right ischium with a moderate amount of serous drainage. Interview on 04/17/24 at 3:46 P.M. with Wound Nurse Practitioner (WNP) #70 confirmed she examined Resident #20 on 03/20/24 and determined the resident had a facility-acquired stage III pressure ulcer to the right ischium which was first identified by the staff on 03/19/24. Interview on 04/18/24 at 11:05 A.M. with the Assistant Director of Nursing (ADON) confirmed Resident #20 developed an open area to her right ischium which was first identified by the facility staff on 03/19/24. The wound was first measured and assessed by WNP #70 on 03/20/24 who determined the wound was a stage III pressure ulcer. The ADON confirmed the facility did not complete assessments of the skin to Resident #20's right ischium prior to 03/20/24. Review of the facility policy titled Skin Integrity Team (SIT) - Skin Monitoring Process dated June 2023 revealed the facility team would improve, maintain, and monitor residents' skin integrity with the goal for residents not to develop pressure ulcers unless clinically unavoidable. The nursing assistant should report any new and/or abnormal skin conditions to the nurse. Review of the NPUAP guidelines dated 2014 pages at https://npiap.com/general/custom.asp?page=2014Guidelines revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that included the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order 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. This deficiency represents noncompliance investigated under Complaint Number OH00152496.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to implement nutritional interventions for a resident with significant weight loss in a timely manner. This affected one (Resident #20) of three residents reviewed for weight loss. The facility census was 113. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, anemia, atherosclerotic heart disease of coronary artery, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #20 dated 02/27/24 revealed the resident was cognitively impaired and was dependent on staff assistance for eating, toileting, bathing, dressing, and transfers. Review of the care plan for Resident #20 dated 02/27/24 revealed the resident had a nutritional problem and was at risk for malnutrition related to unintentional weight changes, altered diets, and dysphagia. Interventions included the following: administer medications as ordered staff to monitor weight and make recommendations as needed, staff to obtain and monitor lab/diagnostic work as ordered, staff to provide extra high calorie, high protein food items as needed, staff to provide diet as ordered and monitor intake. staff to obtain weights per clinician orders. Review of the weights records for Resident #20 revealed the following dates and weights: 02/01/24-125.2 pounds (lbs.), 03/01/24- 116.2 lbs., 03/05/24-110 lbs., 03/20/24-108.9 lbs. Review of the nutritional progress note for Resident #20 dated 03/07/24 revealed resident had a significant weight loss of 12.1 percent (%) in thirty days. Resident #20 had impaired skin and increased metabolic demands for healing. The resident's meal intakes varied from zero to 100% of meals. Resident #20 remained dependent on staff for intake of meals. The dietitian recommending adding fortified pudding at lunch and dinner daily for additional nutrition support and for staff to monitor the resident's weight weekly. Review of the physician's orders for Resident #20 revealed an order dated 03/18/24 for the resident to be weighed weekly. Observations of meal service on 04/17/24 and 04/18/24 revealed Resident #20 was dependent on staff for feeding. Interview on 04/18/24 at 10:04 A.M. with Registered Dietician (RD) #60 confirmed weekly weights were not ordered for Resident #20 until 03/18/24. Interview on 04/18/24 at 2:47 P.M. with RD #60 confirmed the recommendation for fortified pudding at lunch and dinner was not implemented as a physician's order. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Weight Monitoring dated June 2020 revealed nursing staff and dietician would evaluate, implement nutritional interventions, and monitor residents' weight status in order to provide appropriate nutritional and clinical care. The dietician reviewed weight differences and determined the next course of action. To appropriately confirm significant weight changes, a re-weight might be indicated. The dietician would ask nursing to complete necessary reweights. This deficiency represents noncompliance investigated under Complaint Number OH00152496.