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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366399	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Village of Green Township	3210 West Fork Road Cincinnati, OH 45211

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50007 Based on closed medical record review, staff interviews, interview with Wound Nurse Practitioner (WNP) #175, review of facility policy, and review of guidelines from the National Pressure Injury Advisory Panel (NPIAP), the facility failed to adequately assess and monitor residents' skin and failed to timely identify 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 #104 who was admitted without pressure ulcers but was at risk for the development of pressure ulcers, subsequently developed an avoidable facility acquired pressure ulcer which was not identified until it had reached an advanced stage. Resident #104 developed a pressure ulcer which was first identified on 11/05/24 as a stage III (full-thickness skin loss in which adipose [fat] is visible) pressure ulcer on the resident's left gluteus with eschar (dead tissue). This affected one (#104) of three residents reviewed for pressure ulcers. The facility identified eight residents with pressure ulcers. The census was 103. Findings include: Review of the closed medical record for Resident #104 revealed an admitted [DATE] and discharged on [DATE]. Diagnoses included unspecified fracture of first lumbar vertebra, chronic diastolic (congestive) heart failure, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Admission Skin assessment dated [DATE], for Resident #104, revealed the resident was assessed to have intact skin and no identified pressure areas. Review of the daily nurse's assessments completed twice daily from 10/24/24 through 11/04/24 for Resident #104, revealed no documented evidence of any skin impairments. Review of the care plan dated 10/24/24 for Resident #104, revealed the resident was at risk for impaired skin integrity related to fragile skin and the resident was incontinent. Interventions included the following: Apply moisture barrier after each incontinent episode, float heels while in bed as the resident will allow, monitor Braden Scale assessment quarterly, monitor use of skin protective devices, assess condition of skin especially over bony prominences for breakdown, educate the resident on need to reposition, pressure reducing mattress to bed, resident to wear a TLSO (a brace used to limit motion in the thoracic, lumbar and sacral regions of the spine) brace when out of bed and skin checks under the TLSO brace every shift. (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: 366399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Covenant Village of Green Township		STREET ADDRESS, CITY, STATE, ZIP CODE 3210 West Fork Road Cincinnati, OH 45211	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a physician order dated 10/25/24 for Resident #104, revealed an order to cleanse buttock with soap and water, pat dry and apply a barrier cream to buttocks twice daily and as needed. Review of a Braden Scale for Predicting Pressure Sore Risk dated 10/31/24 for Resident #104, revealed the resident was at low risk for developing pressures ulcers. Review of a physician order dated 11/04/24, revealed Resident #104 was ordered to have her buttocks cleansed with house wound cleanser, dried, Xeroform (a gauze impregnated with medication to aid in healing by controlling bacteria and keeping a wound moist) applied to open areas one in the middle of the buttocks and one on the left buttock, and covered with silicone (adhesive boarder) dressing. Place house barrier cream on remainder of the buttocks twice daily until healed. Review of the October 2024 and November 2024 treatment administration records (TAR) for Resident #104, revealed from 10/25/24 to 11/05/24, the nursing staff marked the treatment of cleansing the resident's buttock with soap and water, patted dry and applied a barrier cream twice daily as being completed. Review of an incident note dated 11/04/24 at 1:30 P.M. for Resident #104 and authored by Unit Manager/Licensed Practical Nurse (LPN) #69, revealed the nurse was informed by Certified Nursing Assistant (CNA) #124 who identified two new open wounds located on the resident's buttocks. LPN #69 assessed the resident and discovered two open areas on the resident's buttocks. One wound was in the middle of the resident's buttocks and measured approximately 1.5 centimeters (cm) in length by 0.5 cm in width by less than 0.1 cm in depth. The other wound was located on the resident's left buttocks and measured approximately 2.0 cm in length by 1.5 cm in width by less than 0.1 cm in depth. The nurse cleaned and dressed the resident's wounds. LPN #69 notified the physician. Review of a wound visit note for Resident #104, dated 11/05/24 at 1:09 P.M. and authored by WNP #175, revealed the resident had a new, facility acquired stage III pressure ulcer to the resident's left gluteus and the wound was first observed by the staff on 11/04/24. The pressure ulcer measured 7 cm in length by 4 cm in width by 0.3 cm in depth, the fat layer (subcutaneous tissue) was exposed and there was a medium amount of serosanguineous exudate (drainage) noted. The wound margin was distinct with the outline attached to the wound base and there was eschar tissue within the wound bed including adherent slough (peeling) and ecchymosis. WNP #175 recommended for the resident to have a low air loss(LAL) mattress, a ROHO cushion (specialized pressure reduction cushion) to the wheelchair, and offloading heels with pressure reducing boots. A treatment order to cleanse the resident's wound with house cleanser, pack the wound with Xeroform gauze (a moistened gauze that contains debriding agents and antibiotics) and cover the wound with a foam bordered dressing daily and as needed and weekly visits. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #104 had moderately impaired cognition and did not reject care. Resident did not have a pressure ulcer/injury but was at risk of developing pressure ulcers/injuries and needed pressure reducing devices for the bed. Resident #104 was dependent on staff for activities of daily living (ADLs). Interview with Director of Nursing (DON) on 12/02/24 at 1:19 P.M., verified Resident #104 developed a facility acquired pressure ulcer that was not identified until it had reached a stage III. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with WNP #175 on 12/02/24 at 4:35 P.M., revealed he evaluated Resident #104 on 11/05/24 and determined the resident had a stage III pressure ulcer to the resident's left gluteus. WNP #175 stated he measured the wound as one open area since the two wounds were close together and their margins were indistinct. Interview with LPN #68 on 12/02/24 at 4:40 P.M., revealed she was notified on 11/04/24 by CNA #125 that Resident #104 had open areas to his bottom. LPN #68 stated she observed two open areas to Resident #104's buttocks. LPN #68 stated she contacted WNP #175 and notified him of the open areas and the need to be evaluated. LPN #68 verified Resident #104 was at risk for developing pressure ulcers and the resident developed a facility acquired pressure ulcer which was first identified as a stage III by WNP #175. Review of the facility policy titled Pressure Ulcer Risk Assessment, not dated, revealed all residents should be assessed for pressure ulcer risk by utilizing a risk assessment tool on admission and then weekly times three weeks, and with each additional quarterly, annual, and with significant change assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Staff will perform routine skin observations during daily care. Review of the NPIAP guidelines, dated 2014, pages 70-71 at (https://npiap.com/general/custom.asp?page=2014Guidelines), 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. 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. The NPIAP Pressure Injury Stages, revealed if necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). This deficiency represents non-compliance investigated under Complaint Number OH00159654.