STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366410	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Commons	12469 Five Point Road Perrysburg, OH 43551

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure timely orders were in implemented to address the care and needs of a stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) affecting Resident #5, failed to ensure accurate and ongoing skin monitoring for Resident #39, and failed to ensure wound care recommendations were implemented for Residents #5 and #39. This affected two (#5 and #39) of three residents reviewed for pressure ulcers. The facility census was 52. Findings include: 1. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, type II diabetes mellitus, and a urinary tract infection. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact, independent for toilet and personal hygiene, was occasionally incontinent of urine, and had one stage III unhealed pressure ulcer to the left buttock. Review of the admission skin assessment completed on 06/28/24 revealed Resident #5 had impaired skin to the sacrum, the physician was notified, and orders were obtained. The physician orders to treat the pressure ulcer on the sacrum were not initiated until 07/01/24, three days after the physician provided the orders. Review of the stage III pressure ulcer care plan for Resident #5 dated 07/01/24 included interventions to complete a nutritional assessment, turn and reposition frequently, pressure reducing mattress, evaluate skin for blanching or redness, treatments as ordered, and to ensure enhanced barrier precautions. Review of the wound care note dated 07/01/24 revealed Resident #5 had a full thickness stage III pressure wound to the left buttock, measurements 0.5 centimeters (cm) long by 0.2 cm wide and 0.1 cm deep with a light amount of serous drainage. The wound care provider wrote a recommendation for Vitamin C 500 milligrams (mg) twice a day. The wound care note did not state a treatment was applied to Resident #5's pressure wound. (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	Review of Resident #5's physician order dated 07/01/24 (Monday) revealed to cleanse the stage III pressure ulcer of the coccyx with wound cleanser, pat dry, apply collagen and secure with foam dressing every Monday, Thursday and Saturday on night shift. Review of the treatment administration record (TAR) for June 2024 and July 2024 revealed Resident #5's stage III pressure ulcer did not receive a treatment on 06/28/24, 06/29/24, 06/30/24, and 07/01/24. Treatment was completed on 07/04/24 and 07/06/24. Review of the medication administration record from 07/01/24 to 07/07/24 revealed Resident #5 had no physician order for vitamin C 500 mg twice a day written as recommended by the wound care provider. Interview on 07/08/24 at 2:30 P.M. with the Assistant Director of Nursing (ADON) #500 verified the treatment order obtained from the physician on 06/28/24 for Resident #5's stage III pressure ulcer was not entered into the medical record until 07/01/24. The treatment entered 07/01/24 was not completed on 07/01/24. The first treatment to Resident #5's stage III pressure ulcer was completed on 07/04/24. ADON #500 verified the wound care provider's recommendation to start Vitamin C 500 mg twice a day on 07/01/24 had not been written or implemented. 2. Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact, was dependent on staff for toilet hygiene, and was incontinent of both bowel and bladder. Review of the care plan dated 12/07/22 revealed Resident #39 was identified at risk for skin breakdown. Interventions included to monitor for skin breakdown, administer medications and treatments as ordered, and monitor nutritional status. Review of a skin assessment completed on 06/01/24 revealed Resident #39 had small open areas to the left and right buttock due to Resident #39 scratching. The next skin assessment was completed on 06/24/24 with no wounds identified (however wound care provider noted Resident #39 had a stage III pressure ulcer on left buttock on 06/24/24), and on 06/29/24, a new wound was noted to the left buttock. Review of the Wound Care Provider evaluation dated 06/24/24 revealed Resident #39 was noted to have a full thickness stage III pressure ulcer to the left buttock, measurements were 2.0 centimeter (cm) long by 3.0 cm wide by 0.2 cm deep. An order was written to cleanse the wound with wound cleanser, pat dry, apply collagen with silver, cover with border foam three times a week for thirty days with an additional recommendation for a dietician consult for nutritional needs to promote wound healing. Review of the shower sheet dated 06/30/24 revealed Resident #39 had no skin issues. The shower sheets did not identify a pressure ulcer noted on the left buttock which was noted by the wound care provider on 06/24/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's medical record from 06/24/24 to 07/07/24 revealed there was no evidence a dietician consult for nutritional needs to promote wound healing was completed. Interview on 07/08/24 at 2:30 P.M. with the Assistant Director of Nursing (ADON) #500 verified the skin assessment completed by the nurse dated 06/24/24 was inaccurate and the shower sheet dated 06/30/24 was inaccurate and did not reflect Resident #39 did have a stage III pressure ulcer on her left buttocks. ADON #500 verified lack of ongoing monitoring of the scratches noted on 06/01/24 to the left and right buttock of Resident #39 and further verified the dietician had not been consulted to evaluate Resident #39's nutritional status as recommended by the wound care provider. Review of the facility policy titled Pressure Injury Prevention and Management dated 10/24/22 revealed after completing a thorough assessment /evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment and may include but are not limited to the redistribution of pressure, minimizing pressure and maintaining or improving nutritional and hydration status. Additionally, the Unit Manager will review all relevant documentation regarding skin assessments, pressure risks progression toward healing and compliance at least weekly. Review of the facility policy titled Wound Treatment Management dated 11/23/22 revealed to promote wound healing, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing and frequency of dressing change with the effectiveness of treatments will be monitored through ongoing assessment of the wound. This deficiency represents non-compliance investigated under Master Complaint Number OH00154788 and Complaint Number OH00154178.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to ensure the appropriate care and treatment of a resident's urinary catheter. This affected one (#13) resident of three residents reviewed for urinary catheters. The facility census was 52. Finding include: Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included acute cystitis with hematuria, neuromuscular dysfunction of the bladder, and paraplegia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact, required maximal assistance from staff for toilet hygiene. Review of a nurse progress note dated 06/18/24 revealed Resident #13 was sent to the Emergency Department for evaluation of blood in urine. On 06/21/24 at 9:13 A.M., Resident #13 returned from hospital with an indwelling urinary catheter in place to gravity with yellow colored urine with sediment. The nurse progress note dated 06/26/24 at 2:19 P.M. revealed a new catheter holder was applied to the right thigh. Review of the physician orders revealed an order dated 07/05/24 for a urinalysis for culture and sensitivity due to hematuria (blood in urine) and an order dated 07/09//24 for levofloxacin 500 mg once daily for cystitis hematuria. There were no physician orders for Resident #13's catheter care and maintenance from 06/21/24 to 07/03/24. Review of Resident #13's care plan revealed there was no care plan in place for Resident #13's catheter care and maintenance from 06/21/24 to 07/03/24. Observation on 07/03/24 at 10:00 A.M. revealed Resident #13 was sitting upright in bed with uncovered quarter full urinary drainage bag hanging off the right side of the bed with a dependent loop with cloudy yellow urine in the catheter hanging off the mattress. Additional observation on 07/03/24 at 10:55 A.M. of urinary catheter care completed for Resident #13 by State tested Nursing Assistant (STNA) #146 revealed a kink in the urinary catheter between the leg strap on the right leg and the catheter insertion site at the meatus (urethral opening) preventing urine from draining. The urinary catheter was straight up at the meatus with cloudy white colored urine sitting in the drainage tube. STNA #146 verified this catheter was kinked and urine was not draining with Resident #13 at which time the urinary catheter was removed from the leg strap and readjusted to ensure the catheter tubing was laying flat on the thigh of Resident #13. STNA #146 then picked up the drainage tubing and the catheter drainage bag to make sure urine was flowing freely before hanging the urinary drainage back on the bed and positioning the catheter drainage tubing on the bed along side the resident. Following the observation on 07/03/24 at 11:05 A.M., an interview with STNA #146 verified the urine in Resident #13's catheter was not draining due to a dependent loop and a kink in the urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/08/24 at 2:30 P.M. with the Assistant Director of Nursing (ADON) #500 verified Resident #13 had an indwelling urinary catheter in place since 06/21/24 when Resident #13 returned from the hospital. ADON #500 verified Resident #13 had no physician orders in place for the care or maintenance of the indwelling urinary catheter nor was Resident #13's plan of care updated to reflect an indwelling urinary catheter. Review of the facility policy titled Catheter Care, dated 05/10/23 revealed residents with indwelling catheters will receive appropriate catheter care, catheter care will be performed every shift and as needed by nursing personnel. Privacy bags are available and catheter bags should be covered at all times while in use. Catheter drainage bags are emptied when bag is half-full or every three to six hours, and drainage bags are to be below the level of the bladder to discourage the backflow of urine. This deficiency represents non-compliance investigated under Complaint Number OH00154178.