

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Monroe County Operating Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 47045 Moore Ridge Road Woodsfield, OH 43793	
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 0686</p> <p>Level of Harm - Minimal harm or potential for 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** 47985</p> <p>Based on observation, record review, facility policy review and interview the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers for Resident #13 and Resident #22. This affected two residents (#13 and #22) of five residents reviewed. The facility census was 32.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #13 admitted to the facility on [DATE] with diagnoses including hyperlipidemia, hypertension, and altered mental status.</p> <p>Review of a care plan revised on 06/26/24 revealed Resident #13 required (staff) assistance with activities of daily living (ADLs) related to dementia, heart disease and fatigue. Interventions included requiring extensive assist to total dependence from one to two staff to complete bed mobility and toileting, check incontinence garments every two to three hours, change per product recommendations and provide peri-care as needed.</p> <p>Review of Resident #13's assessment dashboard revealed the most current Braden Assessment was completed on 07/05/24, which reflected the resident was at moderate risk for developing pressure ulcers.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment completed on 09/24/24 revealed Resident #13 had severely impaired cognition, no behaviors, was dependent on staff for toileting hygiene and bed mobility, was always incontinent of bowel and bladder, and had no pressure injuries.</p> <p>Review of Weekly Skin Assessments dated 11/11/24, 11/18/24, and 11/26/24 revealed Resident #13 had no new areas of concern.</p> <p>Review of a care plan revised on 11/27/24 revealed Resident #13 was at risk for alteration in skin integrity related to dry, thin skin and decreased dermal vascularity secondary to aging and impaired mobility as well as incontinence episodes. Interventions included turning and repositioning, and providing incontinence care as needed.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a care plan dated 12/01/24 revealed Resident #13 had a Stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer to her coccyx. Interventions included administer treatments as ordered and observe for effectiveness, assess/record/monitor wound healing weekly and as needed, measure length, width and depth when possible, assess and document the status of wound bed and healing progress and report to physician, alternating air mattress to bed, encourage resident to turn ever two hours side to side and only have laying on back for meals and when up in chair, and follow facility policies/protocol for the prevention/treatment of skin breakdown.</p> <p>A physician order, dated 12/01/24 revealed to encourage resident to turn side to side every two hours, encourage to be on back only for meals and when in chair.</p> <p>Review of a nursing note dated 12/01/24 at 1:39 P.M. by Registered Nurse (RN) #146 revealed while assisting an aide change Resident #13, an open area was observed to the resident's coccyx. The area was noted to be a Stage II pressure area and measured at 0.4 centimeters (cm) in length by 0.2 cm width with less than 0.1 cm depth The area was red with a small amount of serous sanguineous drainage, surrounding tissue was pink in color. The area was cleansed with wound cleanser, dried and a dime size amount of hydrogel was applied, then covered with a dry dressing. An order was written to change dressing daily. No pain was noted.</p> <p>Review of the physician order, dated 12/02/24 revealed a treatment order for Resident #13's coccyx including to mix hydrogel and collagen sprinkles, apply to wound bed and cover with a bordered gauze dressing every day shift for pressure injury to coccyx.</p> <p>Review of a Weekly Skin Assessment completed on 12/02/24 revealed Resident #13 had previously identified skin areas/abnormalities, but did not indicate location or measurements.</p> <p>An additional order dated 12/04/24 revealed Resident #13 required a pressure reducing cushion to her wheelchair. An order dated 12/04/24 revealed Resident #13 required an alternating pressure air mattress as of 12/01/24 for pressure injury to her coccyx.</p> <p>Review of nursing assistant documentation related to toileting assistance for Resident #13 revealed the resident was provided incontinence care only twice on 11/24/24, twice on 11/25/24, twice on 11/26/24, twice on 11/27/24, once on 11/28/24, once on 11/29/24, twice on 11/30/24, three times on 12/01/24, no documentation on 12/02/24, three times on 12/03/24, once on 12/04/24, and once on 12/05/24.</p> <p>Interview on 12/06/24 at 1:02 P.M. with Certified Nursing Assistant (CNA) #161 revealed she was concerned residents were not receiving the care they deserved, and her main concern was toileting. CNA #161 stated two residents, Resident #13 and Resident #22 had skin breakdown (pressure ulcers) and she believed this was due to incontinence care (check and changes) not being completed every two hours. The CNA stated this was because the facility was short staffed and there were only two aides most days with multiple residents requiring an assist of two staff. CNA #161 stated sometimes the nurse would help, but it depended on who was working. CNA #161 stated having 16 residents requiring incontinence care every two hours and residents who required two staff to assist meant there was not sufficient staff to provide the care.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/06/24 at 2:26 P.M. revealed Resident #13 was not in her bed which had a regular mattress with a waffle overlay on top of it. There was not an alternating air mattress as noted in the physician orders.</p> <p>Interview on 12/06/24 at 3:10 P.M. with the Administrator confirmed Resident #13 had a waffle overlay instead of an alternating air mattress as ordered, the lack of documentation of adequate toileting and check and changes every two hours, and the lack of documentation in the medical record regarding the type, size, and location of the Stage II pressure ulcer following the development of the area.</p> <p>2. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis, muscle weakness, and altered mental status.</p> <p>Review of Resident #22's assessment dashboard revealed the most current Braden Assessment was completed for the resident on 05/31/24.</p> <p>Review of a care plan revised on 06/10/24 revealed Resident #22 had an ADL self care performance deficit related to dementia, heart disease, fatigue, impaired balance, impaired strength and endurance. Interventions included providing a total dependence to extensive assist of one to two staff for bed mobility and providing total dependence to extensive assist of one to two staff for toileting. A care plan revised on 06/10/24 revealed Resident #22 was at risk for an alteration to skin integrity related to impaired independence in mobility and incontinence as well as having thin/frail skin. Interventions included encouraging Resident #22 to turn and reposition at least regularly.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #22 had impaired cognition, no behaviors, was dependent on staff for toileting hygiene and bed mobility, was always incontinent of bowel and bladder, and had no pressure injuries</p> <p>Review of Weekly Skin Assessments dated 11/08/24, 11/15/24, 11/22/24, and 11/29/24 revealed Resident #22 did not have any new or existing skin breakdown.</p> <p>Review of nursing assistant documentation for toileting assistance revealed Resident #22 was provided incontinence care only twice on 11/24/24, once on 11/25/24, three times on 11/26/24, once on 11/27/24, once on 11/18/24, once on 11/29/24, twice on 11/30/24, twice on 12/01/24, once on 12/02/24, three times on 12/03/24, and once on 12/04/24. There was no documentation for 12/05/24.</p> <p>Review of a nursing progress note dated 12/01/24 at 2:39 P.M. revealed staff should encourage Resident #22 to lay down after meals to be checked and changed and apply A&D ointment every shift and as needed to bilateral coccyx moisture associated skin dermatitis (MASD).</p> <p>There were no additional nursing notes addressing the resident's skin impairment.</p> <p>Review of the physician's orders revealed Resident #22 had an order to apply A&D ointment to bilateral buttocks every shift and as needed for MASD dated 12/01/24, Prostat twice daily for nutritional supplement dated 12/02/24, and an alternating pressure air mattress to bed as of 12/01/24 dated 12/04/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a care plan dated 12/04/24 revealed Resident #22 had a Stage II pressure ulcer to right buttock. Interventions included an alternating air mattress to the bed, encourage resident to shift weight frequently, and provide wound care per orders.</p> <p>Review of a physician order dated 12/05/24 revealed an order for the right buttocks pressure injury which included to mix hydrogel and collagen sprinkles, apply to wound bed and cover with a bordered gauze dressing daily.</p> <p>Interview on 12/06/24 at 1:02 P.M. with Certified Nursing Assistant (CNA) #161 revealed she was concerned residents were not receiving the care they deserved, and her main concern was toileting. CNA #161 stated two residents, Resident #13 and Resident #22 had skin breakdown (pressure ulcers) and she believed this was due to incontinence care (check and changes) not being completed every two hours. The CNA stated this was because the facility was short staffed and there were only two aides most days with multiple residents requiring an assist of two staff. CNA #161 stated sometimes the nurse would help, but it depended on who was working. CNA #161 stated having 16 residents requiring incontinence care every two hours and residents who required two staff to assist meant there was not sufficient staff to provide the care.</p> <p>Observation on 12/06/24 at 2:25 P.M. revealed Resident #22 was not in her room which had a bed with a regular mattress and a waffle overlay. There was no alternating air mattress in place.</p> <p>Interview on 12/06/24 at 3:10 P.M. with the Administrator confirmed Resident #22 had a waffle overlay instead of an alternating air mattress as ordered, the lack of documentation for toileting and check and changes every two hours, and the lack of documentation in the medical record regarding the type, size, and location of the Stage II pressure ulcer.</p> <p>Review of the facility undated policy titled Incontinence Management Standard of Care revealed routine rounding with turning and repositioning should be completed, assist with toileting needs, timely response to the needs of the resident, provision of personal hygiene and skin care after each incontinent episode and barrier cream applied after each incontinent episode.</p> <p>Review of the facility policy (reviewed 08/2023) titled Pressure Injury Risk Assessment revealed the standard risk assessment should be completed upon admission and throughout the resident's stay including quarterly and significant change of condition.</p> <p>Review of the facility undated policy titled Pressure Injury Treatment revealed residents with pressure injuries would be treated with consisted treatment protocols to aid in the healing process and would have an individualized treatment program which provided the appropriate treatment to facilitate healing and assesses and addresses comorbid conditions in a systemic manner.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159233. This violation is also an example of continued non-compliance from the survey dated 11/07/24.</p>		