| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366486 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rockland Ridge Nursing & Rehabilitation Center | 2511 Washington Blvd<br>Belpre, OH 45714 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, physician assistant interview, review of the National Pressure Injury Advisory Panel (NPIAP) guidelines, and facility policy review, the facility failed to identify potential risks for skin breakdown and implement preventative measures and failed to timely identify the resident's pressure injury until it reached an advanced stage. This resulted in Actual Harm on 03/11/26 when the facility found an unstageable pressure ulcer (slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar) on Resident #32's mid back caused by mechanical lift pad straps bunched up behind the resident's back while seated in the wheelchair. This affected one (Resident #32) of four residents reviewed for wound care. The facility census was 59. Findings include:Review of the medical record for Resident #32 revealed a re-entry date of 11/20/25 and a discharge date of 03/30/26. Diagnoses included dementia, displaced fracture of the left femur, moderate protein calorie malnutrition and adult failure to thrive. Review of the plan of care (POC) dated 07/28/25 revealed Resident #32 was at risk for alteration in skin integrity related to impaired independence in mobility, stage two chronic kidney disease, vision impairment, incontinence, impaired cognition, malnutrition, pain, and fragile skin. Interventions include applying Aquaphor to bilateral upper and lower extremities, complete skin assessments per facility policy, turn and reposition, and provide skin care as needed. Review of the Braden Scale for Predicting Pressure Ulcers/Injuries dated 01/16/26 revealed Resident #32 was at risk for skin breakdown.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had severe cognitive impairment, required substantial to maximum assistance from staff with upper body dressing and was dependent on staff with bathing.Review of a shower/bath skin sheet dated 02/28/26 revealed Resident #32 was free of any pressure wounds or injuries. Review of the wound assessment dated [DATE] revealed Resident #32 had a new unstageable pressure injury on mid-back measuring 8.4 centimeter (cm) in length by 7.8 cm in width and unable to determine depth. The wound had a small amount of serous exudate, and there was no odor or pain. The wound had 70 percent slough (moist, dead tissue that is pale yellow, cream, or tan and appears stringy or sticky) and 30 percent eschar (a layer of dead, necrotic tissue that forms over severe wounds, such as burns, pressure injuries, or diabetic ulcers which appear as dry, firm, and black or brown leathery crust).The progress note dated 03/02/26 at 5:30 P.M. and written by the Director of Nursing (DON) revealed she was called into Resident #32's room by Certified Nursing Assistant (CNA) #110 to look at an area on the resident's back. While transferring Resident #32 back to bed via mechanical lift, CNA #110 noticed that the mechanical lift pad handles were bunched up behind Resident #32. The new intervention was to place a pillow between Resident #20 and the lift pad when up in a wheelchair.Review of the interdisciplinary team (IDT) note dated 03/03/26 at 8:15 A.M. revealed the IDT met to discuss the area found to Resident #32's back on 03/02/26 at 5:30 P.M. The area was caused by the mechanical lift pad handles rubbing against the resident's back while she was up in her wheelchair. The doctor and family were notified. New orders were received and implemented. The IDT agrees with the intervention to place a pillow between Resident #20 and the lift pad when up in a wheelchair and there were no further recommendations at the time. The POC dated 03/03/26 revealed Resident #32 had an<br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | alteration in skin integrity as evidenced by a pressure ulcer to the mid back. Interventions included body check weekly and as needed, notify the physician and family of changes as needed, provide resident and family education on skin impairment and potential complications as needed, provide skin care as needed, treatments per physician orders, and request therapy screening and evaluations as needed. This new focus area did not include the new intervention to place a pillow between the resident and lift pad when up in wheelchair. The wound physician note dated 03/11/26 revealed Wound Nurse #320 documented that Resident #32 had a new pressure injury to midline back caused from a medical device (lift pad) that was initially staged as unstageable pressure injury. The physician classified the pressure injury to the midline line as a stage IV pressure injury (Full thickness tissue lost with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.) The wound has undermining and exposed tendon and measured 3.1 cm in length by 6.5 cm. in width and 0.7 cm in depth.During an interview on 06/02/26 at 1:10 A.M., Physician Assistant (PA) #350 revealed Resident #32 was suspectable to developing pressure injuries due to multiple issues including her age, weight, lack of or poor nutritional intake, and a diagnosis of Kyphosis (an excessive, forward rounding of the upper back). During an interview on 06/02/26 at 1:20 P.M., the DON revealed she was the one who completed the initial wound assessment on Resident #32 for the midline back wound observed on 03/02/26. The DON stated the area to Resident #32's back was dark in color like to have a bruise appearance and the skin appeared like a yellowish color where the mechanical lift pad straps appeared to rub. The DON verified the unstageable pressure injury was caused by the mechanical lift pad straps. The DON revealed after the pressure injury was noted on Resident #32's mid back, the new intervention was to complete wound care and treatments as ordered along with ensuring a pillow was placed between the resident and the mechanical lift pad when up. During an interview on 06/02/26 at 1:54 P.M., Registered Nurse (RN) #250 revealed she has worked with Resident #32, and her daily routine was to get up after breakfast and lay back down when she wanted to or at least after lunch. Most of the time when the CNAs would provide incontinent care for her between breakfast and lunch, Resident #32 would choose to stay in bed. When Resident #32 would be up in her wheelchair, she could very easily and would often move around in the chair and fidget. She liked to be placed in front of the windows and would lean forward and side to side often to see things or follow objects. There were a few times she was found swinging her legs over the side of the arm rest and had to be repositions. Resident #32 was able to tell them when she was having pain or discomfort and when she wanted to go back to bed. RN #250 confirmed Resident #32 had an abnormal outer curvature of the back and verified there was no protection in this area to prevent skin injuries or issues when the resident was noted to be moving and fidgeting in her chair.Review of the NPIAP Current 2026 PI (Pressure Injury) Guideline dated 09/16/25 revealed it is good practice to consider the following factors when selecting a chair or wheelchair that meets the individual's needs for pressure redistribution and shear reduction: the individual's overall risk of pressure injuries, independence, mobility, and activity needs, body size, shape and weight distribution, posture deformity and asymmetry and its affect on pressure distribution, need for enhanced features, and the individual's preferences and care goals.Review of the facility policy titled Skin Assessment dated 03/15/24 revealed it is the intent of the facility to provide necessary care to prevent the development of pressure injuries unless the resident's clinical condition demonstrates that the development is unavoidable. Licensed nurses should ensure skin assessments are completed timely by evaluating residents as scheduled and per the resident's need. Risk factors impacting the development, treatment and/or healing of pressure injuries, including underlying medical conditions, intrinsic/extrinsic risk factors and casual factors are evaluated and provide the basis for defining approaches for the prevention and management of pressure injuries in accordance with the resident's needs, goals and professional standards or practice.This deficiency represents non-compliance investigated under Complaint Number 2999890. |