STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365206	A. BUILDING _____ B. WING _____	07/26/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF UPTOWN WESTERVILLE	140 OLD COUNTY LINE ROAD WESTERVILLE, OH 43081

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 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to follow up with the family after a family brought a grievance to the facility's attention. This affected one (Resident #200) of two residents reviewed for grievances. Findings include: Review of the medical record revealed Resident #200 was admitted on [DATE]. A progress notes dated 06/09/17 and documented by Licensed Social Worker #52 stated during the care conference, the family expressed concerns over a staff person and the care they provided to Resident #200. The Administrator was immediately notified and an investigation was to occur. Interview with the Administrator on 07/27/17 at 9:00 A.M. revealed the investigation occurred and was reported to the State agency. He stated the results of the investigation and the facility's plan were discussed with the resident but he did not follow up with the family who voiced the concerns. He stated he should have discussed this with the family since they were the ones who expressed concern about the care. This deficiency substantiates Complaint Number OH 381.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide timely care and services to address a resident's change in condition. This affected one (Resident #200) of five residents reviewed. Findings include: Review of the medical record for Resident #200 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of lab work results revealed potassium and blood urea and nitrogen (BUN) levels were drawn on 07/12/17 at 8:12 A.M. Results were faxed to the facility on [DATE] at 1:58 P.M. The potassium level was 5.7 (normal 3.5-5.3 milligrams/deciliter) and the BUN was 84 (normal 7-25 millequivalents/liter). There was no documentation of physician notification of the lab results until 07/13/17 at 3:44 A.M. Review of the change of condition progress note written by Registered Nurse #20 on 07/13/17 at 3:44 A.M. revealed the BUN and potassium abnormal results were received. The on call physician was made aware and gave new orders for [MEDICATION NAME] 15 milligrams once. The resident had jerking movements when attempted to arouse her. The physician was aware. Unable to give her [MEDICATION NAME] as ordered because she could not open her mouth. Vital signs 105/58, pulse 92, respiration 14, temperature 97.3 and oxygen saturation 95% on room air. The note indicated the resident was transferred out via 911 to the emergency department. Interview on 07/26/17 at 2:30 P.M. with the Director of Nursing verified that the lab work was drawn on 07/12/17 at 8:12 A.M. and reported via fax to the facility at 1:58 P.M. that same day. She agreed the physician was not notified timely to address the abnormal results. This deficiency substantiates Complaint Number OH 381.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observation and staff interview, the facility failed to ensure a resident was monitored and received necessary treatment to prevent and treat in a timely manner two unstageable pressure ulcers. Actual Harm occurred when Resident #59 developed two unstageable pressure ulcers on the heels that were not discovered until they had necrotic tissue present. This affected one (Resident #59) of two residents reviewed for pressure ulcers. Findings include: Review of the medical record for Resident #59 revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the admission assessment dated [DATE] revealed the resident did not have any pressure ulcers. The care plan initiated on 06/06/17 identified the resident was at risk for alteration in skin integrity related to impaired mobility, pain and incontinence. The goal was for the skin will remain free of breakdown within the limits of his disease process. Interventions included encourage to reposition as needed, float heels as able, observe skin condition with activities of daily living care daily and report abnormalities, pressure redistributing cushion to wheelchair, mattress on bed, and use pillows as positioning devices as needed. Review of Braden Scale (risk for skin breakdown) assessments dated 06/15/17, 06/22/17, 06/29/17, and 07/03/17 17 determined Resident #59 was at risk for skin breakdown. Review of a progress note dated 07/02/17 at 10:29 A.M., written by Licensed Practical Nurse (LPN) #3, revealed the resident had a deep tissue injury (DTI) on the left heel. It was described as thick, black and necrotic, and measured 7 centimeter (cm) by 10 cm with 1+ [MEDICAL CONDITION] to ankle. Scant amount of serous drainage noted. The resident also had a DTI on the right heel. It was described as a thick, black necrotic area, and measured 6.8 cm by 10 cm with scant amount of serous drainage. 1+ [MEDICAL CONDITION] also noted on the right heel. Toe nails of both feet were very long and curved. Nail on right great toe digging into second toe. An open area on the right second toe measured 0.5 cm by 1.2 cm by 0.2 cm with 100% moist yellow tissue. Areas to both heels washed with soap and water, and clean dry dressings applied. The resident denied pain at this time. The on call manager, nurse practitioner and son notified. The record showed that on 07/26/17 a correction was made for 07/03/17 that both heel wounds were actually unstageable pressure ulcers, not DTI's. Review of a complete body audit dated 07/03/17, conducted by wound team member Registered Nurse (RN) #4, revealed the resident had wounds on both heels. The left heel wound was described as a DTI, unstageable, 4.5 cm by 6.5 cm pressure ulcer with 100% eschar, scant serosangiuneous drainage, pink and blanching around the wound. The right heel wound was described as a DTI, unstageable, 5.9 cm by 8 cm pressure ulcer with 80% eschar, 20% non blanching, scant serous drainage. It has been determined that the pressure ulcers to both right and left heels were the result of the resident propelling himself in his wheelchair down the hallway to visit with his wife and while sitting in his wheelchair constantly resting his heels on the floor. The note indicated the resident had appointment with the wound clinic on 07/12/17 and podiatry on 07/13/17. Prevalon boots (pressure relieving boots) placed on resident while in bed. treatment for [REDACTED]. Change daily and as needed. Care plan and Kardex were updated. The resident, significant other and certified nurse practitioner aware of findings and plan of care. Resident will be encouraged to use foot rests when in wheelchair and will be assisted to visit his wife. Review of the Treatment Administration Record (TAR) for July 2017 revealed the treatment was not signed off as completed on 07/09/17, 07/21/17 and 07/24/17.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365206	A. BUILDING _____ B. WING _____	07/26/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF UPTOWN WESTERVILLE	140 OLD COUNTY LINE ROAD WESTERVILLE, OH 43081

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 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) Wound clinic note dated 07/12/17 revealed a first visit for evaluation and treatment of [REDACTED]. Both wound treatments included to change dressing every day, cleanse with antibacterial soap and water, okay to shower and clean wounds. Saturate heels with [MEDICATION NAME] to help the eschar to dry out so it can be removed in the future and wrap in dry gauze. Prevalon boots to both feet to be worn at all times when in bed or up in chair. They have to be on 24 hours. Laboratory blood work for [MEDICATION NAME] and [MEDICATION NAME] were ordered and results were to be faxed to the wound clinic nurse. Follow up in one week on 07/19/17. Review of Resident #59's record revealed the wound clinic note dated 07/19/17 and the [MEDICATION NAME] and [MEDICATION NAME] laboratory results were not in the record. Interview with the Director of Nursing (DON) on 07/26/17 at 3:20 P.M. stated they had determined the resident used his heels to propel his wheelchair causing the pressure ulcers to the heels. She was unable to explain how they became so large and had advanced to necrotic tissue before anyone reported this. She stated they should have been found when the nurses completed the weekly body audits. Interview with the DON on 07/26/17 at 4:06 P.M. confirmed the wounds were staged wrong initially. She confirmed the laboratory testing ordered by the wound clinic was never completed. She confirmed the Prevalon boots were documented in the record to be worn when in bed and not 24 hours/day as ordered by the wound clinic physician. She stated they started the use of the Prevalon boots before he went to the wound clinic and the order was not updated when the wound clinic ordered them to be worn 24 hours. She confirmed the wound clinic notes from 07/19/17 were not in the record but stated he did go to the appointment. She called the wound clinic and had the 07/19/17 wound clinic notes faxed to the facility. The DON confirmed there were new orders to change the wound treatment to the left heel orders but this did not occur. The new order included to apply Santyl ointment ([MEDICATION NAME] agent) nickel thick, only to the wound bed on the left heel, apply around wound edges, between good skin and eschar, use the [MEDICATION NAME] on the eschar, cover with dry dressing; the resident will continue use of offloading to prevent further irritation to the heels; follow up in roughly three weeks for further evaluation and treatment. She confirmed the above treatments and orders were delayed from 07/19/17 to 07/26/17. Observation on 07/27/17 at 8:55 A.M. revealed Resident #59 was in bed. The resident was sitting in the bed with the head of the bed at about 45 degrees. The resident was not wearing the Prevalon boots on either heel and there were no other positioning devices, such as pillows to offload his heels. Interview on 07/27/17 at 8:55 A.M. with State tested Nurse Aide (STNA) #20 confirmed the resident was not wearing the Prevalon boots. This deficiency substantiates Complaint Number OH 381.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of closed medical records and staff interview, the facility failed to provide adequate supervision and fall interventions to prevent resident falls. This affected two (Residents #201, 200) of three residents reviewed for fall. Findings include: 1. Review of the closed medical record revealed Resident #201 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan revised on 05/22/17 revealed the resident was at risk for falls related to cerebrovascular accident (CVA) with hemiparesis (one sided weakness), potential medication side effects, osteoporosis, [DIAGNOSES REDACTED] with [DIAGNOSES REDACTED], insomnia and incontinence. Goal was to minimize risk for injury related to falls. Interventions included encourage resident to transfer and change positions slowly, evaluate medications if has change in mental status, activities of daily living (ADL) function, provide assistance with transfers and ambulation as needed, reinforce need to call for assistance. Review of the progress notes revealed Resident #201 had falls on 05/28/17 at 12:15 A.M., on 05/29/17 at 8:30 P.m., on 05/29/17 at 9:30 P.M. A care plan revision dated 05/31/17 revealed Resident #201 would have 1:1 supervision at all times. Review of progress notes revealed Resident #201 fell on [DATE] at 11:30 P.M., on 06/03/17 at 12:45 A.M., on 06/03/17 at 5:30 A.M., and on 06/04/17 at 8:00 P.M. The notes contained no information about 1:1 supervision at the time of the falls. On 06/04/17 a care plan revision added a medication review for insomnia. There was no evidence in the resident's record of a medication review by the physician on 06/04/17 or later. Review of progress notes revealed Resident #201 fell on [DATE] at 5:50 A. M., on 06/09/17 at 6:30 P.M., on 06/10/17 at 8:30 A.M., and on 06/13/17 at 6:15 P.M. The notes contained no information about 1:1 supervision at the time of the falls. Review of the incident reports for the above falls did not reveal what fall interventions were in place at the time of the falls. Interview on 07/26/17 at 1:53 P.M. with the Director of Nursing (DON) revealed the resident was put on 1:1 supervision after the fall on 05/29/17 at 10:00 P.M. She provided a schedule with a staff member's name beside 1:1 from 05/29/17 day shift through 06/06/17 night shift. The schedules were the only evidence that Resident #201 was provided 1:1 supervision. There were no statements in the incident reports by staff who were doing the 1:1 supervision at the time of the falls. The DON confirmed there were only a couple of progress notes stating 1:1 supervision was provided to Resident #201. The DON also confirmed the incident reports did not include if the fall interventions on the care plan were in place at the time of each fall. Interview on 07/26/17 at 2:30 P.M. with the DON confirmed the progress note dated 06/05/17 revealed the physician was notified of the need for a medication review regarding insomnia. She verified there was no documented evidence by the physician that a medication review was completed. 2. Review of Resident #200's closed medical record revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. The record indicated Resident #200 had a fall on 06/05/17 at 7:30 P.M. without injury. The intervention put in place to prevent further falls was an anti-rollback device to the wheelchair because the resident slid out of her wheelchair while in the television lounge. The resident was wearing anti-slip socks at the time of the fall. Family was notified. Resident #200 had a second fall two days later on 06/07/17 at 1:50 P.M. when she was found again in the lounge area by an STNA. Resident stated she slipped out of her wheelchair. No injuries were noted. The fall investigation did not indicate whether the resident had the anti-rollback device in place on her wheelchair at the time of the second fall. Interview of the DON on 07/26/17 at 2:30 P.M. verified there was no evidence that Resident #200 had the anti-rollback device on her wheelchair at the time of the second fall. This deficiency substantiates Complaint Number OH 381.
F 0505 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Quickly tell the resident's doctor the results of lab tests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and staff interview, the facility failed to promptly notify the physician of abnormal laboratory results. This affected one (Resident #200) of three residents reviewed for laboratory results. Findings include: Review of the medical record for Resident #200 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of lab work results revealed potassium and blood urea and nitrogen (BUN) levels were drawn on 07/12/17 at 8:12 A.M. Results were faxed to the facility on [DATE] at 1:58 P.M. The potassium level was 5.7 (normal 3.5-5.3 milligrams/deciliter) and the BUN was 84 (normal 7-25 millequivalents/liter). There was no documentation of physician notification of the lab results until 07/13/17 at 3:44 A.M. Review of the change of condition progress note written by Registered Nurse #20 on 07/13/17 at 3:44 A.M. revealed the BUN and potassium abnormal results were received. The on call physician was made aware and gave new orders for [MEDICATION NAME] 15 milligrams once. The resident had jerking movements when attempted to arouse her. The physician was aware. Unable to give her [MEDICATION NAME] as ordered because she could not open her mouth. The note indicated the resident was transferred out via 911 to the emergency department. Interview on 07/26/17 at 2:30 P.M. with the Director of Nursing verified that the lab work was drawn on 07/12/17 at 8:12 A.M. and reported via fax to the facility at 1:58 P.M. that same day. She agreed the physician was not notified timely to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365206	A. BUILDING _____ B. WING _____	**07/26/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF UPTOWN WESTERVILLE	**140 OLD COUNTY LINE ROAD WESTERVILLE, OH 43081**

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 0505 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) address the abnormal results. This deficiency substantiates Complaint Number OH 381.