STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365704	A. Building B. Wing	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Healthcare Center	955 Garden Lake Pkwy Toledo, OH 43614

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 observation, medical record review, staff interview, and review of policy, the facility failed to ensure recommended interventions were implemented to prevent skin breakdown. This affected one (#35) of five residents reviewed for skin breakdown. The facility census was 57. Findings include: Review of Resident #35's medical record revealed an admitted [DATE]. Diagnoses for Resident #35 included: chronic respiratory failure, obstructive sleep apnea, atrial fibrillation, hypertension, cerebral infarct due to occlusion or stenosis of the left cerebellar artery, anxiety disorder, chronic peripheral venous insufficiency, morbid obesity, major depressive disorder, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had moderate cognitive impairment. Resident #35 required extensive assistance of two staff for bed mobility and was dependent upon staff for the completion of activities of daily living. The resident was incontinent of bowel and had a catheter in place for bladder and was at risk for pressure ulcer development, with deep tissue injury to the left heel present on admission. Further review of the medical record revealed on 04/21/22, the resident was assessed to be at high risk for skin breakdown. On 04/21/22, the physician ordered weekly skin assessments to be completed on the resident and on 05/06/22, the physician ordered the resident to be placed on a pressure reducing/relieving mattress. Review of the care plan dated 04/22/22, revealed Resident #35 was at risk for skin breakdown down due to peripheral vascular disease, morbid obesity, limited mobility with physical impairments of both sides of body and being non-ambulatory. Resident #35 had a deep tissue injury to the left heel and a vascular wound to the right lower leg. The goal indicated Resident #35 would have no further skin breakdown. Interventions included, administer medications as ordered, monitor for side effects and effectiveness, administer treatments as ordered by medical provider, apply barrier creams, complete skin at risk assessment upon admission/readmission, quarterly, and as needed, evaluate existing wounds daily, complete weekly skin checks, elevate heels and ensure resident is frequently repositioned. (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	Further review of the medical record revealed weekly skin assessments completed by nursing on 07/28/22 and 08/04/22 with no new skin breakdown noted. The resident was evaluated by Wound Certified Nurse Practitioner (NP) #100 on 08/10/22. Current wounds were described as follows: venous ulcer to the right post superior leg measured 1.1 centimeters (cm) long by (x) 0.95 cm wide x 0.20 cm deep, venous ulcer to the posterior right middle lower leg 1.7 cm long x 4.92 cm wide x 0.0 cm deep, venous ulcer to the anterior lateral right leg measured 1.6 cm long x 1.2 cm wide x 0.1 cm deep, and a deep tissue injury to the left heel measured 2.1 cm long x 1.5 cm wide x 0.0 cm. A new wound, a deep tissue injury to the right heel with a discovery date of 08/10/22 measured 1.9 cm long x 2.4 cm wide x 0.0 cm deep. Wound Certified NP #100 recommended the following interventions: pressure reduction/offloading to include ensure compliance with turning, elevate legs regularly, wedge/foam cushion for offloading, and mattress overlay. Resident #35 was reassessed by nursing on 08/10/22 and 08/17/22 and by Wound Certified NP #100 on 08/17/22, the resident remained at high risk for skin breakdown. No additional pressure relieving interventions were implemented. Review of Wound Certified NP #100 documentation dated 08/17/22 revealed the deep tissue injury to the right heel measured 2.4 cm long x 1.9 cm wide x 0.0 deep. Wound Certified NP #100 continued to recommend pressure reduction/offloading and compliance with repositioning. Observation on 08/23/22 at 9:50 A.M., revealed Resident #35 was positioned on his back, in bed with the left and right heel resting on the surface of the mattress, two pillows were in place under the residents' knees and upper calves with the bottom of the left and right foot was resting against the foot board of the bed. At 2:50 P.M., the resident remained positioned on his back with the left and right heel resting on the mattress. Observation on 08/24/22 at 10:44 A.M., revealed the heels of Resident #35 were resting on the mattress and his feet were touching the end of the bed. Resident #35 required repositioning in bed prior to wound care. Observation of the wound care for Resident #35 completed by Wound Certified NP #100 verified a deep tissue injury wound to the right heel. Interview with the Wound Certified NP#100 at the time of the observation verified the heels of Resident #35 were resting on the mattress and his feet were touching the end of the bed. Review of the policy tilted Skin Care and Wound Management, dated 07/01/16, revealed the interdisciplinary team is to implement interventions to prevent and treat skin integrity issues and staff are to implement and verify appropriate interventions to decrease the potential for developing pressure ulcers. In addition, staff were to monitor residents' skin daily, and staff were to monitor residents' skin in contact with adaptive equipment for areas of pressure. This deficiency substantiates Complaint Number OH00135037 and is an example of the continued noncompliance from the survey dated 07/19/22.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review, staff interview, and policy review, the facility failed to ensure residents' weekly weights were consistently and accurately obtained for adequate monitoring of resident nutritional status. This affected one (#57) of five residents reviewed for nutrition. The facility census was 57. Findings include: Record review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses for Resident #57 included: non traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), chronic respiratory failure, communication deficit, anemia, hypertension, atrial fibrillation, schizophrenia, and acute respiratory failure. Resident #57 had a gastrostomy (feeding) tube. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had moderate cognitive impairment. Resident #57 required extensive assistance of one assist for bed mobility, dressing and personal hygiene and was dependent upon staff for the completion of activities of daily living, including toileting and eating. Further review of the medical record revealed on 08/02/22, the resident was assessed to be at significant risk for weight loss due to increased nutrient requirements for wound healing. Resident #57 had a moisture associated skin damage on his buttocks. Review of the care plan dated 04/22/22 revealed Resident #57 was at high risk for skin breakdown, muscle atrophy (wasting) and dehydration due to limited mobility and being bedridden. The goal indicated Resident #57 would have stability or gradual weight loss, adequate nutrition and adequate fluid intake, as well the resident would have wound healing and have no further skin breakdown. Interventions included, tube feeding as ordered, water flushes as ordered, monitoring of tube feed tolerance, and weekly weights for four weeks. Review of physician orders for Resident #57 revealed orders dated 07/28/22 for enteral feeding at 60 milliliters (ml) per hour (ml/hr) for twenty hours, 180 ml of water every four hours and weekly weights for four weeks and orders. Review of the dietician assessment dated [DATE] revealed the nutrient requirements needed for Resident #57 was not being met. The dietician recommended the enteral feeding be increased to 70 ml/hr for twenty hours and water flushes be changed to 35 ml/hr for twenty hours for a total of 700 ml of water in twenty-four hours. Further review of the medical record revealed weights were obtained on 07/28/22 and 08/03/22, both were recorded as 232 pounds. The medical record was silent for weights on 08/10/22 and 08/18/22. A weight was completed on 08/24/22 revealing the resident weighed 200.3 pounds. Additional review of the hospital discharge papers prior to Resident #57's admission to the facility revealed a weight of 189.6 pounds on 07/18/22. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/24/22 at 12:50 P.M., with Dietician #120 revealed the recommended changes on 08/02/22 were based on the facility weights on 07/28/22 and 08/03/22. Dietician #120 verified the medical record was silent for weights on 08/10/22 and 08/18/22 and further verified Resident #57 was to be weighted weekly. Interview with the Director of Nursing on 08/25/22 at 4:10 P.M., revealed the weights on 07/28/22 and 08/03/22 were not accurate. Review of policy titled Resident Height and Weight, dated 07/16/21 revealed a resident's weight will be accurately obtained within twenty-four hours of admission. The admission weight will be obtained at the facility and not recorded from previous hospital paperwork. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on observations, medical record review, family and staff interviews, and review of facility policies, the facility failed to provide pain management to a resident experiencing pain. Actual Harm occurred when Resident #35, with a history of chronic pain, experienced pain as evident by moaning, grunting, and thrashing head on pillow throughout wound care every time one of his lower extremities was moved and grimacing and gritting teeth as range of motion was completed on lower legs. No pharmacological or non pharmacological interventions were offered to alleviate the pain. This affected one (#35) of five residents reviewed for pain. The facility census was 57. Findings include: Review of Resident #35's medical record revealed an admitted [DATE]. Diagnoses for Resident #35 included: chronic respiratory failure, obstructive sleep apnea, atrial fibrillation, hypertension, cerebral infarct due to occlusion or stenosis of the left cerebellar artery, anxiety disorder, chronic peripheral venous insufficiency, morbid obesity, major depressive disorder, and diabetes mellitus. Resident #35 did have a tracheostomy and gastrostomy (feeding) tube. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had moderate cognitive impairment with unclear speech with resident usually understood. Resident #35 required extensive assistance of two staff for bed mobility and was dependent upon staff for the completion of activities of daily living. The resident was incontinent of bowel and had a catheter in place for bladder and was at risk for pressure ulcer development, with deep tissue injury to the left heel present on admission. Resident #35 experienced constant pain, with a score of seven out of ten, with ten being the highest severity level of pain. Review of the care plan dated 04/22/22 revealed Resident #35 had complaints of chronic pain related to osteoarthritis and wounds. Goals included Resident #35's ability to communicate pain relief with interventions that included non-medication interventions, medications as ordered, monitoring of pain every shift, and physician notification of ineffective interventions. Review of current physician orders revealed orders dated 04/21/22 for Resident #35 to be monitored for pain each shift and an order for acetaminophen solution 650 milligrams (mg) per feeding tube every six hours as needed for mild pain, defined as a pain score of one, two or three out of ten. Two additional orders dated 07/08/22, were for hydrocodone-acetaminophen 10-325 mg, half a tablet per feeding tube every six hours as needed for moderate pain (not defined) and an order for hydrocodone-acetaminophen 10-325 mg, one tablet to be administered per feeding tube for severe pain (not defined). Review of the pain scores for the month of August 2022 for Resident #35 revealed a zero level of pain on day shift and the following pain scores on the night shift of five out ten on 08/03/22, seven out of ten on 08/04/22, five out of ten on 08/05/22, eight out of ten on 08/08/22, seven out of ten on 08/09/22, seven out of ten on 08/13/22, one out of ten on 08/18/22 and two out of ten on 08/22/22. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of medication administration record for August 2022 revealed hydrocodone-acetaminophen 10-325 mg, one tablet was administered to Resident #53 at 1:26 A.M. on 08/03/22, at 11:32 P.M. on 08/05/22 and at 9:00 P.M. on 08/09/22. There was no other pain medications documented as being provided. Review of treatment record for Resident #35 for the month of August 2022 was silent for non-medication interventions being attempted for pain management. Interview on 08/23/22 at 9:31 A.M., with Resident #35's Family Member revealed concerns related to the constant pain experienced by Resident #35 and the inability of Resident #35 to participate in therapy and activities of daily living due to pain. Observation on 08/23/22 at 10:44 A.M., revealed Resident #35 moaning, grunting, and thrashing head on pillow throughout wound care every time one of his lower extremities was moved. Observation on 08/23/22 at 3:00 P.M., revealed Resident #35 grimacing and gritting teeth as range of motion was completed on lower legs. Interview on 08/23/22 at 4:45 P.M., with the Director of Nursing verified the pain medication had not been administered to Resident #35 when pain was experienced and further verified there is no documentation of other interventions and or resident refusals of pain medication. The Director of Nursing stated care is often not provided to Resident #35 due to the refusal of care related to pain. Interview on 08/24/22 at 9:07 A.M.,with Registered Nurse (RN) #130 revealed RN #130 was unable to define mild, moderate, or severe pain. Interview on 08/24/22 at 12:13 P.M., with the Director of Therapy Services #140 revealed Resident #35 had plateau with therapy and often refused and did not actively participate due to pain. Review of the policy titled Pain Management and Assessments updated 07/25/18, indicated based on the comprehensive assessment of the resident, the facility must ensure that residents receive treatment and care related to pain. This deficiency is based on incidental findings discovered during the course of this complaint investigation and is an example of the continued non compliance from the survey dated 07/19/22.