STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365330	A. BUILDING _____ B. WING _____	**10/24/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF WAUSEON	**303 W LEGGETT ST WAUSEON, OH 43567**

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 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, resident and staff interviews, and review of facility resident council minutes, the facility failed to ensure a resident received showers per his preference and shower schedule. This affected one (#35) of three residents reviewed for showers. This facility census was 38 residents. Findings include: Review of Resident #35's medical record revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 12, indicating mild impairment in cognition. His speech was clear and he was usually understood. He required extensive assistance with two plus staff for bed mobility and transfers. He required extensive assistance with one staff for dressing and personal hygiene. He was totally dependent for bathing. Interview with Resident #35 on 10/24/18 at 8:56 A.M., revealed he would like to receive a shower at least five times per week. He stated he generally only gets a shower about once per week, and sometimes not even that frequently. Review of the resident's care plan dated 11/30/17, revealed an activities of daily living (ADL) self-care deficit as evidenced by need for maximum assistance of two related to general weakness, impaired standing balance, spinal stenosis, chronic back pain, and right foot drop. The goal was for the resident to receive assistance necessary to meet the resident's ADL needs. One of the resident's interventions included assist to bathe/shower as needed. Review of the resident's shower schedule revealed he was scheduled for showers twice weekly on Wednesday and Saturday evenings. Review of the resident's shower sheets for (MONTH) and (MONTH) (YEAR) revealed the resident received five of sixteen scheduled showers. Interview with the Director of Nursing on 10/24/18 at 4:17 P.M., verified the resident only received five of sixteen scheduled showers for (MONTH) and (MONTH) (YEAR). Review of the facility resident council minutes for (MONTH) through (MONTH) (YEAR) revealed complaints about showers not being completed on scheduled days in (MONTH) and August. This deficiency was an incidental finding discovered during the investigation of Master Complaint Number OH 607.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, review of facility policies and staff and resident interviews, the facility failed to provide physician ordered treatments to resident's with non-pressure skin impairments. This resulted in actual harm when the surgical area beneath Resident #45's splint was not checked for three days and the resident developed an open wound with exposed surgical hardware. In addition, the facility failed to monitor wounds and complete wound care as ordered for two (#10 and #20) additional residents of three total residents reviewed with skin impairments. The facility identified five current residents with skin impairments requiring dressing changes. The facility census was 38. Findings include: 1. Review of Resident #45's medical record revealed an admission date of [DATE]. Resident #45 was discharged to the emergency roiagnom on [DATE] and did not return to the facility. Medical [DIAGNOSES REDACTED]. Review of the resident's Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's speech was clear and she was sometimes understood and sometimes understood others. Staff assessment for cognition revealed the resident's cognition was severely impaired. She required extensive assistance with one staff member for bed mobility, transfers, walking, locomotion, dressing, eating, toilet, and personal hygiene. She received scheduled pain medication. Review of the resident's orthopedic discharge instructions dated 08/16/18, revealed the resident had an open reduction, internal fixation (ORIF) surgery of the right olecranon (bony tip of the elbow near the end of the ulna bone). The resident was in a splint which was to be kept clean and dry and she was scheduled for an orthopedic follow up in ten to fourteen days. Review of the orthopedic follow up visit on 08/28/18 revealed the resident's right elbow incision was clean and dry with no drainage. Sutures were removed. Review of the resident's orthopedic physician's orders [REDACTED]. She was to follow up with the orthopedic physician in three weeks. Review of the resident's orthopedic follow up visit on 09/18/18 revealed the right elbow fracture was stable and orders were to continue splint to right elbow, ok to remove to shower or change clothes. No right elbow ROM, right elbow skin checks daily. Follow up with orthopedic physician in three weeks. Review of the resident's shower sheets revealed she received a shower on 09/26/18 from State tested Nursing Assistant (STNA) #64 and on 09/29/18 from STNA #65. Review of the resident's (MONTH) Treatment Administration Record (TAR) revealed the resident's daily skin check was not completed from 10/01/18 through 10/03/18. Review of the resident's nursing notes revealed a skin audit was performed with no new skin issues noted on 09/26/18. There were no further nursing notes until 10/03/18 at 6:24 P.M., when the Director of Nursing (DON) documented the resident complained of increased pain to her right ulna (bone between elbow and wrist). She was medicated with narcotic pain medication at 4:00 P.M., after redirection, distraction, activity, and toileting were ineffective. The right elbow area was assessed at 6:00 P.M. and it was noted a pin was visible and the resident's skin was slightly reddened with a scant amount of yellowish serosanguineous drainage noted. The area was sore to touch. The physician was notified. At 7:35 P.M., the physician gave an order to send the resident to the emergency room . Review of Resident #45's hospital emergency room documentation dated 10/03/18 revealed a complaint of right elbow pain with surgical hardware exposed at the olecranon. No fever and no drainage from the area but apparently quite painful as resident was crying when the elbow was manipulated. It was unknown how long hardware had been exposed. The resident's daughter reported the nursing home facility reported the area was being cleansed daily. The resident was wearing a splint that has apparently worn through. The course of treatment progress comments included skin breakdown was significant. The plan was

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.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) for observation given risk of infection and further complication of significantly exposed hardware. Review of a hospital document titled Report of Operation dated 10/04/18, revealed the preoperative [DIAGNOSES REDACTED]. The operation was metal removal complex closure with Z-plasty (an orthopedic technique in which one or more Z-shaped incisions are made) on right elbow. Indications included the resident underwent [REDACTED]. The resident had basically healed the fracture in a fibrous union but apparently while at the nursing home has basically worn through her skin to metal on the posterior part of her elbow. Originally, the surgeon thought this was wound dehiscence (surgical complication in which a wound rupture along a surgical incision) but on better inspection the wound had actually healed, and the dehiscence was medial to that and right over previously intact skin. Operative summary included standard incision was made over the previous incision but to veer to include the open area. The metal could be seen easily from across the room and through the defect which measured approximately 3.0 centimeters (cm) x 2.0 cm. The metal was removed, and the incision closed. Care will not be provided by the nursing home previously caring for her. Continued review of the hospital documentation revealed the resident was discharged on [DATE] to a different skilled nursing home. Interview with Licensed Practical Nurse (LPN) #53 on 10/23/18 at 4:47 P.M., verified the order to check the resident's elbow daily was not documented on the Treatment Administration Record (TAR) as being completed 10/01/18 through 10/03/18. Telephone interview with STNA #64 on 10/24/18 at 3:20 P.M., verified she gave the resident a shower on 09/26/18. She stated she covered the resident's arm with plastic when she gave her a shower. She stated she did not see the resident's arm without her splint. She did not seem to be in a lot of pain on 09/26/18. Telephone interview with STNA #65 on 10/24/18 at 2:03 P.M., revealed she never took the resident's splint off. She stated she did not actually give her a shower on 09/29/18. She gave her a bed baths because she had a splint on. She stated when she dressed her she put something big on her, so it would not hurt the splint. She stated the last week or two the resident was at the facility she was a little whinier and complaining, holding her right arm. She notified the nurse but could not remember which one. She does not know if the nurse followed up. Interview with STNA #68 on 10/24/18 at 2:48 P.M., revealed she worked full time on Resident #45's hall and never seen anyone remove the splint from the resident's arm. She verified she worked on 10/03/18, when the resident was sent to the hospital. She also worked on 10/02/18 and notified the nurse that Resident #45 seemed to be in more pain as she was so anxious and pointing at her elbow. She stated the nurse gave Resident #45 pain medication, but she did not know if the nurse observed the resident's skin under the splint. She stated the resident's daughter was at the facility on 10/03/18 and was helping her get ready for bed. The resident's daughter noticed the resident was acting different, so her daughter took her sling off and looked at it. The resident's daughter told the DON, who was working the floor, the resident's hardware was sticking out of her arm. Interview with the DON on 10/23/18 at 4:30 P.M., verified she was working Resident #45's hall on 10/03/18 when she was sent to the emergency room . She stated Resident #45 seemed to be holding her elbow more and she had administered her pain medication and checked her vital signs earlier. She verified Resident #45 had an open area to the right elbow and hardware was visible. She stated there was no bleeding, but there was some yellow drainage on the ace wrap. She thought it was being checked daily but verified the order for the daily wound check right elbow was not on the (MONTH) TAR. Interview with LPN #53 on 10/24/18 at 3:55 P.M., verified she worked on Resident #45's hall on 10/02/18 and did not visualize Resident #45's skin under her splint. She stated Resident #45 did not seem to want her to touch her and she did not want to put her through more trauma. Review of a facility policy titled Medication and Treatment Administration Guidelines updated on 03/18 revealed treatment orders were to be transcribed or electronically entered then noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders. 2. Review of Resident #20's medical record revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's MDS assessment dated [DATE] revealed she had a brief interview for mental status (BIMS) score of 13, indicating minimal impairment in cognition. The resident had one venous/arterial ulcer, a [MEDICAL CONDITION], infection of the foot, and a surgical wound. She was receiving surgical wound care and application of dressings to the feet. Review of the resident's physician's orders [REDACTED]. On 10/10/18, the order was changed to start [MEDICATION NAME], abdominal (ABD) pad, kerlix, then coban daily, cleanse with normal saline. Review of the resident's TAR revealed the resident's wound care was documented as being completed on 10/05/18, 10/09/18 or 10/14/18. Review of the resident's nursing notes revealed no documentation of refusals of dressing changes on the dates. Continued review of the medical record revealed no weekly wound assessment or measurements of the resident's left heel wound except for a wound care physician note on 10/10/18. Review of the resident's wound care physician notes revealed she was seen by the wound nurse on 10/10/18 with wound measurements of 8.0 cm x 7.2 cm x 0.1 cm. The wound was described as a diabetic wound ulcer with pressure components. The wound showed improvement with no signs of infection. Exposed bone was noted. A small amount of serous drainage was noted. Peri-wound skin was intact. Interview with Resident #20 on 10/23/18 at 2:19 P.M., revealed she does not receive daily dressing change to her left heel. She stated the only nurse that completed her dressing change was LPN #51. She stated she does not say anything to the other nursing staff because she figured they should know what they were supposed to do. Interview with LPN #51 on 10/23/18 at 12:34 P.M., revealed she has had residents tell her dressings were not always completed as ordered. She stated Resident #20 had told her dressings were not being completed daily. She stated there were times she noticed the resident's dressing change was not signed off on the TAR as being completed. Interview with the DON on 10/24/18 at 9:46 A.M., verified Resident #20's dressing changes were not documented as completed on 10/05/18, 10/09/18 or 10/14/18. She provided wound measurements from 10/24/18 which showed a decrease in size of the wound from the 10/10/18 assessment. Interview with Quality Assurance Consultant #55 on 10/24/18 at 1:45 P.M., verified there were no weekly wound assessments completed for Resident #20. She stated the facility nursing staff should have completed weekly wound grids, but did not. 3. Review of Resident #10's medical record revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's MDS assessment dated [DATE] revealed the resident was independent for decision making and her memory was ok. Review of the resident's physician's orders [REDACTED]. Review of the resident's TAR revealed the wound care was not signed off on 10/21/18 as being completed. Review of the resident's nursing notes revealed no entry regarding a refusal on 10/21/18. Continued review of the resident's medical record revealed [REDACTED]. Interview and observation with Resident #10 on 10/23/18 at 11:22 A.M., revealed she gets a dressing change to her right outer foot. She stated she was thought she was supposed to have the dressing changed once daily. She stated it was last changed on Sunday, 10/20/18. Observation of the dressing at the time of the interview revealed it was very small and undated. Interview with the DON on 10/24/18 at 9:46 A.M., verified Resident #10's dressing change was not documented as completed on 10/21/18. Interview with Quality Assurance Consultant #55 on 10/24/18 at 1:45 P.M., verified there was no wound assessment completed for Resident #10's [MEDICAL CONDITION]. Review of a facility policy titled Medication and Treatment Administration Guidelines updated on 03/18, revealed documentation requirements included treatments administered were documented immediately following administration. Review of the facility Skin Practice Guide Process Flowchart dated 2013, revealed the facility should initiate a skin alteration record for a skin alteration. This deficiency substantiates Complaint Number OH 529.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, staff and resident interviews, and review of a facility policy, the facility failed to ensure a resident was provided a safe transfer by a staff member to prevent a fall in accordance with facility policy. This affected one (#30) of three residents reviewed for falls. The facility identified all 38 residents at risk for falls. Findings include: Review of Resident #30's medical record revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the resident's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 15, on the brief interview for mental status (BIMS) assessment, indicating no impairment in cognition. The resident required extensive assistance with one staff member for transfers, walking, toilet use, and personal hygiene. Her balance was not steady and she was only able to stabilize with staff assistance. She had impairment on one side of both her upper and lower extremity. Review of the resident's nursing notes revealed an entry from Licensed Practical Nurse (LPN) #50 on 09/03/18 at 7:45 A.M. She documented an State Testing Nurse Assistant (STNA) reported assisting resident onto the toilet. The resident was standing holding onto the bathroom bar as STNA was pulling down the resident's pants when the resident's right leg gave out. The STNA attempted to prevent the fall and lowered her to the floor. LPN #50 assessed the resident. She complained of pain in her right ankle. A raised, bruised area was noted to her right ankle. The physician was notified and the resident was sent to the emergency room . Review of the resident's fall investigation revealed a witness statement from STNA #62. She stated she had taken care of the resident previously and she was able to stand with assistance. On 09/03/18, she pushed the resident in the bathroom in her wheelchair and the resident grabbed the handrail bar. She attempted to take the resident's brief off, when the resident let go of the bar and went down with her leg behind her. Review of the resident's care plan dated 05/02/17 and last updated on 09/17/18 revealed an activities of daily living (ADL) self-care deficit as evidenced by maximum/total assist of two assist for ADLs and mobility due to impaired mobility related to [MEDICAL CONDITION] with [MEDICAL CONDITION], cognitive and communication deficits, and impaired balance. Interventions included may ambulate with one assist using walker and gait belt. This intervention was initiated on 06/07/18 and was not discontinued until 09/17/18. Interview with Resident #30 on 10/24/18 at 9:53 A.M., revealed she had a fall on 09/03/18. She stated she broke her foot while she was going to the bathroom. She stated a State tested Nursing Assistant (STNA) took her to the bathroom. She stated the STNA was trying to get her pants down when she lost her balance. She stated she did not have a gait belt on. She stated some STNAs use the gait belt and some do not. Interview with STNA #62 via telephone on 10/24/18 at 10:42 A.M., revealed she took the resident to the bathroom. She stated the resident was holding onto the assist bar and let go of it while she was trying to pull her brief down. She stated she did not know the resident required a gait belt. She stated she thought the resident required a stand by one assist. She stated she was an agency STNA and obtained this information through verbal report. She stated a gait belt would not have prevented the fall as she was pulling the resident's pants down. Interview with Director of Nursing on 10/24/18 at 11:39 A.M., verified Resident #30 did not have her gait belt on at the time of her fall on 09/03/18. Review of a facility policy titled Transfer: Bed-Chair/Wheelchair dated 01/11 revealed the purpose was to move the resident safely from the bed to chair or wheelchair. One person assists included applying a gait belt to the resident. This deficiency substantiates Complaint Number OH 607 and OH 529.