STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365084	A. Building B. Wing	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasantview Care Center	7377 Ridge Rd Parma, OH 44129

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 - 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** 34297 Based on closed medical record review, hospital record review, policy and procedure review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent and timely identify bilateral heel pressure ulcers for Resident #165. Actual harm occurred on 01/31/23 when Resident #165, who was cognitively impaired required extensive/dependence on staff for bed mobility and activities of daily living (ADL) care, was found to have an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer to the right heel and a suspected deep tissue injury (SDTI) (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear) pressure ulcer to the left heel. The ulcers deteriorated and on 05/23/23 the resident's daughter requested the resident be sent to the emergency room related to the condition of the heel ulcers, the ulcers had moderate amounts of copious drainage with a foul odor noted. The resident was subsequently admitted to the hospital and diagnosed and treated for heel ulcer wound infection. This affected one resident (#165) of three residents reviewed for pressure ulcers. Findings include: Review of Resident #165's closed medical record revealed the resident was admitted to the facility on [DATE], discharged to the hospital on 12/21/22, readmitted on [DATE] and discharged to the hospital on 05/31/23. Resident #165 had diagnoses including essential hypertension, muscle weakness and adult failure to thrive. A plan of care dated 12/20/22 revealed the resident had the potential for altercation in skin integrity due to a diagnosis of failure to thrive (FTT), easily bruising, history of a skin tear due to fragile skin condition, abnormal labs, decreased circulation/oxygenation, vitamin deficiency, mood/behavior status and being at risk for malnutrition and incontinence. Interventions included to administer medications as ordered, administer treatments as ordered, Braden score quarterly and as needed, diet per recommendations, monitor for bruising, monitor labs, offload heels as tolerated, pressure redistribution cushion to chair. An intervention dated 01/04/23 indicated to implement a low air loss mattress to the bed. (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 - Actual harm Residents Affected - Few	Review of Resident #165's admission assessment and baseline care plans form dated 12/30/22 revealed Resident #165 was at high risk for skin breakdown and no skin concerns or pressure areas were identified on the document. Review of Resident #165's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderate cognitive impairment and required extensive two person assist for bed mobility and toilet use. The assessment also revealed the resident required total dependence with two-person assist for transfers and toilet use as well as total dependence one person assist for dressing, personal hygiene, and bathing. Review of Resident #165's medication administration records (MAR) and treatment administration records (TAR) from 01/01/23 to 01/31/23 revealed the low air loss mattress was implemented on 01/03/23. Review of Resident #165's Shower Sheet Forms dated 01/16/23, 01/19/23 and 01/23/23 did not reveal skin concerns or evidence of pressure ulcers. Review of Resident #165's progress note dated 01/25/23 at 2:26 P.M. revealed no new skin issues identified. Review of Resident #165's Shower Sheet Form dated 01/26/23 revealed her right and left heels were dry, and her shower sheet form dated 01/30/23 revealed nothing new was documented on the form. Review of Resident #165's progress note authored by Registered Nurse (RN) Wound Nurse #817 dated 01/30/23 at 11:15 A.M. revealed the resident was alert and responsive. Resident #165 required extensive assistance from one person for bed mobility and extensive assist from one person for transfers and toilet use. The note documented the resident's skin was within normal limits (WNL) and a treatment was in place. However, the progress note did not identify the type of treatment or the location of the treatment. Review of Resident #165's shower sheet form dated 01/31/23 revealed no skin issues were noted on the form. Review of Resident #165's progress note dated 01/31/23 at 7:39 A.M. revealed the resident had a SDTI (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear) to the left heel and the wound bed was not visible with no drainage noted. The note also reflected the resident had a right heel pressure ulcer with the wound bed partially visible, 50% granulation tissue and scant drainage. (The right heel pressure ulcer was not staged by the facility per this note and the facility did not document wound measurements at this time). Review of Resident #165's Skin Alteration Incident Report Dated 01/31/23 at 11:02 A.M. indicated the son was notified on 02/01/23 at 1:05 P.M. and Certified Nurse Practitioner (CNP) #601 was notified on 01/31/23 at 1:05 P.M. of the new pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #165's facility Weekly Ulcer/Wound Documentation form dated 02/01/23 revealed a left heel SDTI measuring 5.1 centimeters (cm) length by 7.1 cm width with no cm depth which was a dark colored, non-blanching area. Resident #165 also had a right heel unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) which measured 2.3 cm by 6.1 cm by 0.1 cm depth. Resident #165 was noted to have 50% granulation tissue and 50% dark discolored area with a treatment in place. Review of the treatment administration records for February 2023 revealed no evidence the treatments were provided as ordered for the left heel on 02/06/23 or for the right heel on 02/06/23, 02/10/23, 02/14/23 or 02/28/23. Prior to the development of the pressure ulcers, there was no documented evidence of offloading for the resident's bilateral heels or turning and repositioning. Following the development of the bilateral heel pressure ulcers, the facility implemented the use of heel lift suspension boots to be used at all times. The use of the heel boots was reflected on the administration records. Record review revealed the facility completed weekly wound measurements from 02/01/23 through 05/23/23. Review of Resident #165's wound Certified Nurse Practitioner (CNP) #601's Wound Note form dated 02/14/23 revealed a left heel SDTI and a right heel unstageable pressure ulcer. The Weekly Wound Note, dated 03/28/23 at 11:27 A.M. revealed the resident had a left heel unstageable pressure ulcer which measured 5.0 cm length by 5.5 cm width with no depth and a right heel unstageable pressure ulcer which measured 2.6 cm length by 3.8 cm width with no depth which had 90% slough/necrosis present and a scant amount of thin, straw-colored drainage. Review of Resident #165's facility Weekly Ulcer/Wound Documentation form dated 05/23/23 revealed the CNP was in to assess and treat. The left heel was noted to have an unstageable pressure ulcer which measured 2.5 cm by 4.4 cm by 0.3 cm depth. Resident #165 also had a right heel unstageable pressure ulcer which measured 2.2 cm by 2.8 cm by 0.4 cm. Both heels were debrided at that time. Review of Resident #165's CNP #601's Weekly Wound Note dated 05/23/23 at 2:49 P.M. indicated the resident had an unstageable pressure ulcer to the left heel which measured 2.5 cm by 4.4 cm by 0.3 cm with a wound base of 50% granulation tissue and 50% slough/necrotic tissue with a scant amount of thin, straw-colored drainage and a debridement (a procedure to remove debris or infected/dead tissue from a wound) was completed. Resident #165 also had an unstageable right heel pressure ulcer which measured 2. 0 cm by 2.8 cm by 0.4 cm with a wound base which was 100% slough/necrosis with a moderate amount of thin, straw-colored drainage and a debridement was completed. Review of Resident #165's progress note dated 05/23/23 at 10:08 P.M. indicated the resident's daughter requested the resident to be sent to the emergency room due to the ulcers to her heels. Wound care was provided, and moderate amounts of copious drainage was noted with a foul odor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #165's progress note dated 05/24/23 at 7:19 A.M. indicated the resident was admitted to the hospital for an infection. Review of Resident #165's emergency room visit note dated 05/24/23 at 1:46 A.M. indicated during an exam, Resident #165 was noted to have approximately grade three ulcerations of her bilateral heels, with the left worse than the right. There was foul smelling, purulent discharge with antibiotics initiated. No systemic symptoms or evidence of sepsis and radiographs showed no evidence of osteomyelitis or other deep space infection. Interview on 06/16/23 at 10:07 A.M. with CNP #601 indicated Resident #165's bilateral heels did have an odor but she did not feel it was an infectious odor but rather the odor of necrotic tissue. There was no evidence the resident's heel ulcers had ever been cultured while the wounds were being treated in the facility. Interview on 06/28/23 at 1:29 P.M. with the Director of Nursing (DON) revealed she believed Resident #165's bilateral heels were offloaded and the resident was being turned and repositioned prior to the development of the left heel SDTI heel pressure ulcer as well as the right heel unstageable pressure ulcer, although staff were not required to document the offloading or turning and repositioning in the resident's medical record. The DON confirmed Resident #165's hospital paperwork reflected the resident, upon admission to the hospital had purulent, foul-smelling drainage to her bilateral heels and she was hospitalized with a diagnosis of infection. Interview on 06/29/23 at 9:54 A.M. with Registered Nurse (RN) Wound Nurse #817 revealed the treatment in place that she documented in the progress note on 01/30/23 was barrier cream used to the resident's buttocks associated with incontinence. Interview on 06/29/23 at 11:46 A.M. with Resident #165's power of attorney (POA) for care revealed wound care concerns. The POA revealed there were multiple times the family would visit the resident and her heels would be directly on the bed and multiple times the dressings were not changed as ordered. He stated Emergency Contact #2 had visited Resident #165 prior to her discharge from the facility (on 05/24/23), and the resident's bilateral feet had a foul odor. The POA indicated the facility neglect was the reason why the resident did not return following her most recent hospitalization . Interview on 06/29/23 at 12:31 P.M. with the DON confirmed the facility did not obtain a culture of Resident #165's bilateral heel pressure wounds at any point following the development of the ulcers. Review of the facility policy titled Pressure Ulcer Prevention Protocols/Risk Assessment, dated 06/08/22, revealed a resident's level of risk for pressure ulcer development would initially be determined at the time of admission or readmission taking into consideration the nature of risk to include underlying causes. Residents were considered HIGH risk when admitted with any pressure ulcers, any history of pressure ulcers, any pressure ulcer wounds which the resident has physician order(s) addressing treatment(s), or a Braden Scale score less than or equal to 12. Pressure ulcer preventative/supportive precautions would be implemented including to offloading the resident's heels. This deficiency represents non-compliance investigated under Complaint Numbers OH00144100 and OH00143241.