| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365295 | A. Building<br>B. Wing | 12/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Logan Elm Health Care Center | 370 Tarlton Road<br>Circleville, OH 43113 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on record review, observation, staff interview and facility policy review, the facility failed to maintain infection control practices during dressing changes. This affected one (#21) of three residents reviewed for pressure ulcers. The facility census was 85.<br><br>Findings include:<br><br>Review of the medical record for Resident #21 revealed an initial admitted [DATE] with the latest readmission of 07/14/23 with diagnoses including sepsis due to methicillin resistant staphylococcus aureus, acute and chronic respiratory failure with hypoxia, diabetes mellitus, chronic obstructive pulmonary disease (COPD), neuromuscular dysfunction of bladder, congestive heart failure, polyneuropathy, hypertension, encounter for palliative care, osteoarthritis, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, necrotizing fasciitis, anemia and cardiomyopathy.<br><br>Review of the resident's admit/readmit assessment dated [DATE] revealed the resident was admitted to the facility with a Stage III (Full thickness tissue loss). Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) pressure ulcer to left buttocks measuring 3.0 centimeters (cm) by 1.8 cm by 0.1 cm, a vascular wound to the left groin measuring 2.0 cm by 2.0 cm by 0.1 cm. The assessment also indicated the resident has an indwelling urinary catheter.<br><br>Review of the resident's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident has not cognitive deficit. The resident had an indwelling urinary catheter and was always incontinent of bowel. The assessment indicated the resident was at risk for skin breakdown and had one Stage III pressure ulcer present on admission. The facility implemented pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, surgical wound care, application of nonsurgical dressings and applications of ointments/medications other than to feet.<br><br>Review of the weekly skin observation dated 12/26/23 revealed the Stage III pressure ulcer to the left ischium measured 2.9 centimeters (cm) by 1.3 cm by 2.5 cm with undermining (the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface) present at 12 o'clock at the depth of 2.7 cm. The wound was describes as being beefy red with a large amount of serosanguinous drainage. The facility determined the wound had improved.<br><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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365295 | A. Building<br>B. Wing | 12/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Logan Elm Health Care Center | 370 Tarlton Road<br>Circleville, OH 43113 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the weekly observation dated 12.26.23 revealed incision and drainage of abscess wound to the resident's right groin revealed the wound measured 1.5 cm by 0.8 cm by 1.5 cm. The wound was described as granulation tissue with a moderate amount of serosanguinous drainage.<br><br>Review of the monthly physician orders for December 2023 identified orders dated 07/18/23 cleanse suprapubic catheter with normal saline (NS) and apply slit gauze twice daily and as needed, 12/04/23 lightly pack right groin wound with VASHE soaked packing strip and cover with foam dressing daily and as needed and 12/11/23 cleanse wound to left ischium with NS, apply mesalt (ensure undermining is packed) cover with absorbent pad then foam daily and as needed.<br><br>Observation on 12/28/23 at 9:18 A.M. of Registered Nurse (RN) #154 provide physician ordered dressing changes for Resident #21 revealed the RN placed all supplies on the resident's bedside table without being cleansed or a barrier being placed. RN #154 then washed her hands and exited the room for a large pair of gloves. RN #154 entered the room and donned the gloves. Resident #21 was positioned, RN #154 removed the split drainage sponge from the resident's suprapubic catheter. RN #154 cleansed the stoma site with normal saline (NS) and placed a clean split drainage sponge on the stoma. RN #154 then removed the visibly soiled dressing to the right groin with the same gloves used to complete the treatment to the suprapubic stoma. RN #154 then cleansed the wound with NS and four by four (4X4), packed the wound with lightly packed VASHE soaked packing using a sterile Q-tip. RN #154 then covered the wound with a foam dressing. Resident #21 was then positioned on his right side. Resident #21 has no dressing on the stage III pressure ulcer. RN #154 cleansed the Stage III pressure ulcer with NS and 4X4 using the same gloves. RN #154 then packed the wound with Mesalt and covered with a foam dressing. RN #154 then removed the gloves and washed her hands. The observations revealed RN #154 wore the same gloves for treatment to the Resident #21's suprapubic catheter, right groin abscess and stage III pressure ulcer.<br><br>Interview on 12/28/23 at 9:25 A.M., interview with RN #154 verified the same soiled gloves where used to provide the physician ordered treatment to Resident #21's suprapubic catheter, right groin abscess and stage III pressure ulcer.<br><br>Review of the facility policy titled, Hand Hygiene, dated 06/23 revealed staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. Hand hygiene is indicated and will be performed under the condition listed in, but not limited to, after handling contaminated objects and before and after handling clean or soiled dressings.<br><br>This deficiency is based on incidental findings discovered during the course of this complaint investigation. |