STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365295	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Elm Health Care Center	370 Tarlton Road 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview, observation, and record review, the facility failed to ensure residents attended activities that meets their needs. This affected one (Resident #13) of one resident reviewed for activities. The facility census was 80. Findings include: Record review of Resident #13 revealed an admitted [DATE] with pertinent diagnoses of: hereditary ataxia, personal history of pulmonary embolism, dietary counseling and surveillance, acute pulmonary edema, vascular dementia, abnormal posture, muscle wasting and atrophy, muscle weakness, major depressive disorder, frequency of micturition, dry eye syndrome, presence of functional implant, osteoarthritis, restlessness and agitation, hypothyroidism, hypertension, insomnia, hyperlipidemia, osteopetrosis, dysphagia, anxiety disorder, gastrostomy status, and vascular dementia. Review of the 12/09/24 quarterly Minimum Data Set (MDS) assessment revealed the resident was severely cognitively impaired and was dependent for activities of daily living. Review of the 03/04/24 activity plan of care revealed Resident #13 needs one-on-one intervention to promote sensory and social stimuli, resident non verbal. The goal was is will respond with range of eye contact, holding sensory items, verbal response, facial expression (smile, frown), eye contact, move with the music. Observations on 02/04/25, 02/05/25 and 02/06/25 revealed Resident #13 was not seen in group activities or one on one activities. Review of Resident #13 activity log from 12/01/24 to 1/31/25 revealed Resident #13 was documented as attending one activity during the two month time frame. Interview with Activity Personnel #9 on 02/06/25 at 8:37 A.M. verified Resident #13 was documented as only having one activity completed from 12/01/24 to 1/31/25.

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
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51068 Based on observation, staff interview, and policy review, the facility failed to store their food in a manner that protects against contamination and spoilage. This had the potential to affect 78 out of 81 resident residing in the facility with three residents on nothing by mouth (NPO) diets. The facility census was 81. Findings include: During the initial kitchen observation on 02/03/25, from 9:30 A.M. to 9:55 A.M., conducted with Dietary Supervisor #39, the following unlabeled and undated food items were observed in the freezer: 16 frozen pizzas (unlabeled and undated) 2 unidentified logs of meat (unlabeled and undated) 3 bags of chicken strips (unlabeled and undated) 3 bags of vegetables (unlabeled and undated) Further observation of the dry storage area revealed: 13 open pie crusts (unlabeled and undated) 3 bags of granola (unlabeled and undated) 1 bag of marshmallows with a manufacturer's use-by date of 12/01/24 Interview with Dietary Supervisor #39 confirmed that all observed food items should have been labeled and dated according to facility policy. Review of the facility ' s Date Marking for Food Safety policy states the following: All food shall be clearly marked to indicate the date or day by which it must be consumed or discarded. The individual opening or preparing a food item shall be responsible for date marking it at the time of opening or preparation. The marking system shall include a color-coded label, the date of opening, and the discard date. The discard date must not exceed the manufacturer ' s use-by date or four days, whichever is earliest. The date of opening or preparation counts as day one.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on record review, staff interview, and resident observation, the facility failed to maintain accurate medical records for Resident #21. This affected one (Resident #21) out of 24 residents whose medical records were reviewed. The facility census was 81. Findings include: Review of Resident #21 ' s medical record revealed an admitted [DATE] with diagnoses including unspecified dementia, anxiety disorder, cognitive communication deficit, essential tremor, cerebral infarction (unspecified), history of transient ischemic attack (TIA), history of other diseases of the nervous system, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, and need for assistance with personal care. Review of the annual Minimum Data Set (MDS) 3.0 assessment, completed on 01/01/25, documented a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. Review of physician orders for Resident #21 revealed an order for honey zinc cream to the buttocks every four hours and with incontinence episodes, with a start date of 09/14/24. Review of progress notes revealed a skin note dated 09/12/24 at 4:09 P.M., documenting that a restorative certified nursing aide (CNA) called a nurse into Resident #21 ' s room to assess a newly identified area on the left buttock. The note described a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister) pressure ulcer on the left buttock measuring 3.8 cm x 2.2 cm x 0.1 cm, with blanchable redness to the surrounding area and right buttock. Review of skin assessments showed that weekly skin assessments were completed on 09/23/24, 09/30/24, 10/07/24, 10/14/24, 10/21/24, 10/28/24, 11/04/24, 11/11/24, 11/18/24, 11/25/24, 12/02/24, 12/09/24, 12/16/24, 12/26/24, 12/30/24, 01/09/25, 01/13/25, 01/20/25, and 01/27/25. Each of these assessments documented the Stage II pressure ulcer with the same measurements (3.8 cm x 2.2 cm x 0.1 cm) and described it as a partial-thickness skin loss with exposed dermis. Interview on 02/05/25 at 2:28 P.M. with Registered Nurse (RN) #169 revealed that Resident #21 ' s pressure ulcer had healed within a few days of its identification in September and was reclassified as Moisture-Associated Skin Damage (MASD) by the week of 09/16/24. RN #169 stated she was unsure why the weekly skin assessments continued to document an active Stage II pressure ulcer. She confirmed that the continued documentation of an unhealed Stage II pressure ulcer in the medical record was inaccurate. Observation on 02/05/25 at 3:00 P.M. by a surveyor confirmed that Resident #21 did not have an active pressure ulcer. The surveyor observed redness on the buttocks, and a nurse applied honey zinc cream per physician orders.