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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365343 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Embassy of Willard | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E Howard St Willard, OH 44890 | |

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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on medical record review, observations, resident and staff interviews, and review of the facility policy, the facility failed to ensure the resident's sheets were maintained in a clean condition. This affected one (Resident #39) of 50 residents reviewed for clean linens. The facility census was 50.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #39 revealed an admitted [DATE] with a diagnosis of psoriasis.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had intact cognition and was independent for bed mobility, lying to sitting, sitting to standing, and transferring from the bed to the chair.</p> <p>Review of the current physician orders for April 2024 revealed Resident #39 was scheduled for showers on Fridays and Tuesdays.</p> <p>Interview and observation on 04/22/24 at 12:08 P.M. with Resident #39 revealed his sheets were stained along the edge of the mattress near the head of his bed, and his pillow case had several spots that appeared to be dried blood. Resident #39 stated he had asked for his sheets to be changed since his previous shower (04/19/24).</p> <p>Interview and observation on 04/23/24 at 3:57 P.M. with Resident #39 revealed he was in bed relaxing. His sheets and pillow remained stained. Resident #39 stated he was scheduled for a shower that night and he would insist staff change his bedding.</p> <p>Interview and observation on 04/24/24 at 10:23 A.M. with State tested Nurse Aide (STNA) #370 confirmed Resident #39's sheet was stained near the head of the bed and his pillowcase was stained with dark drops. STNA #370 stated Resident #39 refused his shower the previous evening. STNA #370 confirmed bedding was normally changed on shower days, and also confirmed bedding should be changed when obviously soiled.</p> <p>Interview on 04/24/24 at approximately 10:26 A.M. with Resident #39 confirmed he refused his shower the previous evening and expected to have a shower on night shift 04/24/24.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the facility policy titled Safe and Homelike Environment, revised 10/01/22, revealed the facility would provide and maintain bed and bath linens that are clean and in good condition.</p> |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</p> <p>Based on observation, medical record review, staff interview, and review of the facility incontinence policy, the facility failed to ensure timely incontinence care was provided to a resident who was incontinent and dependent on staff for toileting This affected one (Resident #30) of two residents reviewed for incontinence care. The facility census was 50.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #30 admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, mood disorder, seizure disorder, chronic obstructive pulmonary disease, dementia, anxiety disorder, and major depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #30 had severely impaired cognition, dependent on staff for the completion of activities of daily living, always incontinent of bowel and bladder, and at risk for pressure ulcer development.</p> <p>Review of the nursing plans of care dated 01/09/24 revealed Resident #30's plan addressed an actual area of skin impairment related to moisture associated skin damage (MASD) to bilateral buttocks with interventions including: lay resident down and offload after every meal. Reposition every two hours when in bed. Pressure relieving cushion to wheelchair. On 05/24/23, a nursing plan of care was revised to address the resident has bowel incontinence related to rule out decreased mobility and memory impairment. Interventions included to assist the resident to the bathroom as needed. Provide peri care after each incontinence episode. Check the resident for incontinence as needed.</p> <p>Review of the bowel and bladder evaluation dated 02/08/24 revealed Resident #30 was noted to have the diagnosis of Alzheimer's disease of dementia, completely immobile, unable to ambulate, and incontinent of bowel and bladder.</p> <p>Review of the skin risk assessment dated [DATE] revealed Resident #30 was at moderate risk of developing skin breakdown.</p> <p>Continuous observations and interview on 04/23/24 starting at 9:37 A.M. revealed Resident #30 was placed in a reclining geriatric chair (Geri-chair) in the dining room. Resident #30 was positioned on his back with feet elevated. At 10:37 A.M., State tested Nurse Aide (STNA) #341 approached Resident #30 and wheeled the resident in the chair to his room. Interview with STNA #341 at 10:37 A.M. revealed she last checked the resident for incontinence and repositioning at 7:15 A.M. Continued observation noted STNA #341 and STNA #531 transferred Resident #30 to his bed utilizing a mechanical lift. Resident #30 was soiled with urine soaking through an adult incontinence brief, shorts, lift sling and onto the seat cushion. Urine was also observed on the back of the resident's shirt. STNA #341 removed the soiled clothing and brief and discovered Resident #30 was incontinent of a medium amount of stool, which was contained in the brief. STNA #341 and #531 cleansed the resident, placed a clean adult brief with clean clothing on the resident.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 04/23/24 at 11:12 A.M., an interview with STNA #341 verified Resident #30 was incontinent of bowel and bladder, was dependent on staff for all care, and required frequent checks with repositioning.</p> <p>On 04/23/24 at 11:13 A.M., an interview with Registered Nurse (RN) #502 verified Resident #30 required incontinence checks and repositioning every two hours due to the resident being unable to inform staff of need to utilize restroom or reposition self.</p> <p>On 04/23/24 at 1:20 P.M., an interview with the Director of Nursing (DON) verified Resident #30 was assessed as incontinent. The DON confirmed no interventions were implemented to determine Resident #30's bowel or bladder habits including frequency of incontinence checks to prevent heavy soiling.</p> <p>Review of the facility's incontinence policy dated 10/01/22 revealed residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure medications were administered and were not left at the resident bedside. This affected one (#40) of one resident reviewed for pharmaceutical services. The facility census was 50.</p> <p>Findings include:</p> <p>Review of Resident #40's medical record revealed an admitted [DATE]. Diagnoses included chronic gout, type II diabetes mellitus, malignant melanoma of skin, hypokalemia, hydronephrosis, hypertension, hyperlipidemia, lymphedema, muscle weakness, and supraventricular tachycardia.</p> <p>Observation on 04/22/24 at 10:21 A.M. revealed Resident #40 had a medication cup containing eight unidentified pills located on a table in the resident's room.</p> <p>During an interview on 04/22/24 at 10:25 A.M., Resident #40 reported the medications were their morning medications. Resident #40 reported staff were not supposed to leave medications in the room but they always did because they trusted Resident #40 and because Resident #40 took approximately 15 minutes to consume all of their morning medications.</p> <p>During an interview on 04/22/24 at 10:45 A.M., Licensed Practical Nurse (LPN) #807 verified they had taken Resident #40's morning medications into Resident #40's room and left them there without observing the resident consume them. LPN #807 reported Resident #40 always administered their own medications.</p> <p>During an interview on 04/24/24 at 7:09 A.M., LPN #801 reported there were no residents in the building who administered their own medications and the nurses were required to observe all residents swallow their medications.</p> <p>During an interview on 04/24/24 at 9:06 A.M., the Director of Nursing (DON) verified Resident #40 should have been observed while taking their medications.</p> <p>Review of the facility policy titled Medication Administration, dated 08/22/22, revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy explanation and compliance guidelines contained in the policy stated to observe resident consumption of medication.</p> |

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| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>49742</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure the menu was followed for residents receiving pureed diets. This affected six residents (#3, #27, #30, #37, #45, and #50) who were prescribed a pureed diet. The facility census was 50.</p> <p>Findings include:</p> <p>Review of the lunch meal spreadsheet for 04/23/24 revealed residents on a pureed diet should include pureed dinner rolls using one #20 scoop (equivalent to 3.5 tablespoons).</p> <p>Observation of tray line on 04/23/24 from approximately 12:15 P.M. to 12:45 P.M. revealed the facility did not include the pureed dinner rolls and/or an appropriate substitution to residents receiving pureed food items.</p> <p>Interview on 04/23/24 at 12:45 P.M. with Cook #405 verified pureed dinner rolls were available on the tray service line but were not served to residents receiving pureed meals at the time of observation.</p> <p>Review of the facility's list of residents on a pureed diet revealed Residents #3, #27, #30, #37, #45, and #50 were on a pureed diet.</p> <p>Review of the facility policy titled Accuracy and Quality of Tray Line Service, dated 2019, revealed tray line positions and set up procedures will be planned for efficient and orderly delivery. All meals will be checked for accuracy by the food and nutrition services staff, and by the service staff prior to serving the meal to the individual.</p> <p>Individuals will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44815</p> <p>Based on observations, staff interview, and review of the facility policy, the facility failed to ensure staff used appropriate hand hygiene during meal services. This affected three (#17, #21, and #22) of four residents observed during meal service on the 400-hall. The facility census was 50.</p> <p>Findings include:</p> <p>Observation on 04/22/24 at 7:57 A.M. revealed State tested Nurse Aide (STNA) #301 passing breakfast trays to residents eating in their rooms. STNA #301 entered Resident #13's room and provided her breakfast tray and removed the lids from the food items. Resident #13 requested some assistance and STNA #310 adjusted the socks on Resident #13's feet. STNA #301 exited Resident #13's room, did not perform hand hygiene, and picked up the tray for Resident #22. STNA entered Resident #22's room, picked up her computer tablet and placed the breakfast tray on the overbed table. STNA #301 then removed the lids from Resident #22's meal items and exited her room without performing hand hygiene.</p> <p>Interview on 04/22/24 at 8:00 A.M. with STNA #301 confirmed she touched Resident #13's socks and did not perform hand hygiene before providing Resident #22 her breakfast tray. STNA #301 stated she performed hand hygiene before passing the first tray on the hall, then performed hand hygiene after she finished passing all trays for the hall.</p> <p>Observation on 04/22/24 at approximately 8:01 A.M. revealed STNA #301 did not perform hand hygiene and picked up the breakfast tray for Resident #21 and placed it on her overbed table, then returned to the tray cart, without performing hand hygiene, and picked up the tray for Resident #17 and delivered it to her room. Continued observation revealed STNA #301 was called by staff to assist with care in another resident's room and STNA #301 stopped passing meal trays to assist with care.</p> <p>Review of the policy titled Hand Hygiene, copyright 2023, revealed hand hygiene is indicated and will be performed under the conditions listed in the attached hand hygiene table. Review of the undated Hand Hygiene Table revealed hand hygiene should occur between resident contacts.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on record review, observations, staff interviews, review of the facility policy and review of staff in-service, the facility failed to ensure staff wore personal protective equipment (PPE) when providing care to residents in enhanced barrier precautions (EBP). This affected one resident (#26) of two residents observed in EBP. The facility census was 50.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #26 revealed an admitted [DATE] with a diagnosis of acquired absence of right toe.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had intact cognition and required limited assistance of one person for transfers.</p> <p>Review of the current physician order dated 04/05/24 revealed Resident #26 was in EBP precautions for a chronic wound. The order stated gloves and gown should be worn when transferring the resident.</p> <p>Review of the current care plan for Resident #26 revealed he had an area of skin impairment related to a right foot stump wound. Interventions included EBP as ordered.</p> <p>Observations on 04/22/24 at 7:47 A.M. revealed a sign posted on Resident #26's door indicating he was in EBP and PPE was required while providing care. There was a plastic cart outside Resident #26's room with gowns and gloves. State tested Nurse Aide (STNA) #408 opened Resident #26's door from inside the room and asked STNA #404 to come into the room to assist with a transfer for Resident #26. STNA #408 was not wearing PPE inside the room. STNA #404 donned PPE before entering Resident #26's room. During this observation, interview with STNA #404 confirmed STNA #408 was not wearing PPE inside Resident #26's room.</p> <p>Interview on 04/22/24 at 7:52 A.M. with STNA #301, who came out of Resident #26's room after providing care with a transfer alongside STNA #404 and STNA #408 confirmed she also did not wear PPE while providing care to Resident #26.</p> <p>Interview on 04/22/24 at 7:53 A.M. with STNA #404 confirmed staff were required to wear PPE (gown and gloves) while transferring residents who were in EBP.</p> <p>Interview on 04/25/24 at 10:21 A.M. with Regional Director of Clinical Services #802 revealed all staff were educated in March 2024 regarding EBP and donning and doffing PPE when providing care for residents in EBP.</p> <p>Review of the undated staff in-service sign-in sheet revealed the topics of EBP and donning and doffing PPE were provided. STNA #301 and STNA #408 signed the sign-in sheet for the education.</p> <p>Review of the policy Enhanced Barrier Precautions, revised 03/20/24, revealed EBP referred to the use of gown and gloves during high-contact resident care activities. It defined high-contact resident care activities included transfers.</p> |