Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365435	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Logan	300 Arlington Avenue Logan, OH 43138

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review ,staff interview, and facility policy review, the facility failed to ensure the physician was notified after a change in condition of a new wound or the worsening of a current wound. This affected four residents (#3, #74, #89, and #93) of seven reviewed for skin impairments. Facility census was 98. Findings include: 1. Review of the medical record for the Resident #89 revealed an admitted [DATE]. Diagnoses included depression, heart failure, diabetes, end stage renal disease, and absence of left leg below the knee. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 was cognitively intact and required supervision touching assistance for personal hygiene and activities of daily living. Review of the plan of care dated 01/2024 revealed Resident #89 was at risk for skin impairments with interventions to inspect for reddened areas during daily care, weekly skin assessments, charge nurse to notify wound nurse, physician and family of any new areas, and wound care practitioner to eval and treat as indicated. Review of the skin observation assessment dated [DATE] revealed a new red area on the left knee. Facility had no evidence of physician notification of this new skin impairment. Review of the skin grid non-pressure assessment dated [DATE] revealed a new skin impairment was noted of a red area blister to knee. Facility had no evidence of physician notification of this new skin impairment. Review of the skin grid non-pressure assessment dated [DATE] revealed multiple scabs to distal finger joints (date acquired 9/22). Facility documented physician was notified 09/25/23, three days after new skin impairments were identified. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the skin observation assessment dated [DATE] revealed a previously identified area was present. The area included scabs on the right hand and fingers and a scab on the left knee. It did not indicate how many scabs, specific locations or sizes. Several of these scabs were not identified on several previous skin observations or assessments. Facility had no evidence the physician was notified. Review of the skin grid non-pressure assessment dated [DATE] revealed bruising to left knee. Facility had no documentation of physician being notified. Review of the skin observation assessment dated [DATE] identified scabs to right fingers. Facility did not have evidence of the physician being notified to new skin impairment. Review of the skin observation assessment dated [DATE] identified scabbed areas on right hand fingers and a bruise on the abdomen. Facility had no evidence of the physician being notified of skin impairment or bruising. Review of the skin observation assessment dated [DATE] identified a scabbed area on the back of the left hand. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] identified a scabbed area on the left hand. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Facility had no evidence of the physician being notified. Review of the skin observation assessment dated [DATE] identified scabbed areas to right hand. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Facility had no evidence of the physician being notified. Review of the skin observation assessment dated [DATE] identified hand blisters. Facility had no evidence of the physician being notified of the skin impairments. Review of the skin observation assessment dated [DATE] identified scabbed areas to bilateral fingers. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] identified scabbed areas to the right hand fingers. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Facility had no evidence of the physician being notified. Review of the skin observation assessment dated [DATE] identified scabbed areas to right and left hands. Facility had no evidence of the physician being notified of the skin impairment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the skin observation assessment dated [DATE] identified scabbed areas to right hand fingers. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] identified scabbed areas to fingers of right and left hands. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] identified scabbed areas to right hand fingers. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin grid non-pressure assessment dated [DATE] identified a skin tear that occurred at the device check appointment. This assessment was updated to state the tear was healed on 02/28/24. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] identified an area to LFA and scabbed areas to right fingers. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Facility had no evidence of the physician being notified. Review of the skin grid non-pressure assessment dated [DATE] identified a bruise to the top of the scalp. The assessment revealed this wound was identified at 02/13/24. Review of the skin observation assessment dated [DATE] stated skin was intact with no impairments, but also stated left fingers wound treatments were in place. Facility had no evidence of the physician being notified. Review of the skin grid non-pressure assessment dated [DATE] identified a bruise was acquired on 02/13/24. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin grid non-pressure assessment dated [DATE] identified scabs on the right fingers. Facility had no evidence of the physician being notified. Review of the skin grid non-pressure assessment dated [DATE] identified scabs on his right fingers. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Facility had no evidence of the physician being notified. Review of the skin grid non-pressure assessment dated [DATE] identified scabs on his right fingers. Facility had no evidence of the physician being notified of the skin impairment. Interview on 04/03/24 at 2:30 P.M. with Director of Nursing (DON) confirmed facility had an order for the wound practitioner to evaluate and treat as necessary dated 03/2024 and confirmed the wound provider saw resident but had no recommendations and did not document any assessment or findings. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for the Resident #3 revealed an admitted [DATE]. Diagnoses included diabetes type 1, respiratory failure, metabolic encephalopathy, heart failure, vascular disease and kidney failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact and required substantial maximum assistance for lower body dressing, showering and moderate assistance for hygiene and upper body dressing. Review of the plan of care dated 11/16/23 revealed Resident #3 was at risk for alteration in skin integrity with interventions for wound care practitioner to evaluate and treat as indicated. The care pan also stated the resident had an actual area of skin impairment of pressure ulcer to left knee amputation stump with interventions to indicate wound treatment, nursing to observe the wound dressing. Observe and document the character of wound weekly, observe for clinical changes and complete skin observations on bath/shower days. Review of the skin grid non-pressure assessment dated [DATE] identified bruising to the neck. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin grid non-pressure assessment dated [DATE] identified redness to the back of the right hand. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin grid non-pressure assessment dated [DATE] identified redness to the back of left hand. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin grid non-pressure assessment dated [DATE] identified a surgical incision to the left illiac crest. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified. The assessment revealed the left knee had an open area. The assessment did not include any descriptions or measurements. Facility had no evidence of the physician being notified of the skin impairment. (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified. The assessment revealed a skin tear to the left forearm with treatment in place. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed skin was marked as intact, but also marked with previous areas noted. The assessment identified a scabbed area to the left knee and scabbed area to the right foot. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed a toe skin impairment. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed skin was not intact, marked with previous areas noted. The assessment identified a scabbed area to the left knee. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed skin was not intact. The assessment did not include any areas listed or descriptions of wound impairments. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed skin was not intact. The assessment did not include any areas listed or descriptions of wound impairments. Facility had no evidence of the physician being notified of the skin impairment.

Review of the skin observation assessment dated [DATE] revealed skin was not intact. The assessment identified a scabbed area to the left knee. Facility had no evidence of the physician being notified of the skin impairment.

3. Review of the medical record for the Resident #74 revealed an admitted [DATE]. Diagnoses included respiratory failure, diabetes, dysphagia, muscle weakness, encephalopathy, and pulmonary embolism.

Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 was cognitively impaired and was rarely if ever understood and was dependent for activities of daily living.

Review of the plan of care dated 03/04/24 revealed Resident #74 was at risk of skin impairments.

Review of the skin grid non-pressure assessment dated [DATE] identified a new skin impairment of scabs to the left toes, also identified on 10/24/23. The assessment marked the wound as improved and marked as declined on 10/24/23. Facility had no evidence of the physician being notified.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the skin observation assessment dated [DATE] revealed skin was intact with no new areas, dressing and treatment were not applicable. The assessment identified a left toe(s) impairment with great toenail ingrown with treatment in place. Facility had no evidence of the physician being notified of the skin impairment. Review of the skin grid non-pressure assessment dated [DATE] identified redness and scab to left toes around the toenail bed. Facility had no evidence of the physician being notified. Interviews on 04/04/24 from 2:30 P.M. to 3:15 P.M. with DON confirmed Residents #3, #74 and #89 had numerous wounds and also confirmed facility had no evidence of the physician being notified of these skin impairments. 41271 4. Review of the medical record for Resident #93 revealed an admitted [DATE]. Diagnoses included delirium, vascular dementia, hemiplegia affecting the left non-dominant side, and a history of falling. Review of Resident #93's significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating a severely impaired cognition for daily decision making abilities. Resident #93 was noted to display disorganized thinking, inattention, rejection of care and delusions. Resident #93 was noted to to experience impairment to one upper and one lower extremity and required substantial to maximal assistance for bed mobility and turning from side to side. Per assessment, Resident #93 was noted to be incontinent of bowel and bladder function and noted to one stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) that was not present upon admission to the facility. Review of the plan of care dated 11/02/23 and revised 02/14/24 revealed Resident #93 had the potential for alteration in skin integrity related to incontinence. Interventions included to report to physician for evaluation and treatment as indicated. Review of the Skin Grid Pressure assessment dated [DATE] revealed Resident #93 was noted to have a area to the coccyx noted to measure 1.2 centimeter(cm) in length by 1.2 cm in width by 0.1 cm in depth described as a stage two pressure. No evidence was noted to indicate the physician was notified of this newly identified pressure wound. Review of progress notes from 01/14/2023 through 01/31/2024 revealed no evidence of the physician being notified of the newly identified pressure wound identified for Resident #93. Interview on 04/04/24 at 10:13 A.M. with Charge Nurse, Licensed Practical Nurse (LPN) #50 verified Resident #93 had a stage two pressure wound that was newly identified per nurses notes on 01/14/24 and per Skin Grid Pressure assessment dated [DATE]. Charge Nurse, LPN #50 also verified there was no evidence noted in the nurses progress notes or skin assessment that the physician had been notified of the newly identified pressure wound. Charge Nurse, LPN #50 claimed the wound physician was notified the following week when the physician was onsite to complete wound treatments for other residents but not notified immediately when the pressure wound was identified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Notification of Change, dated 08/22/22 revealed, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as b. Clinical complications or development of a stage two pressure injury.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on medical record review, staff interview, and policy review the facility failed to ensure all resident Pre-Admission Screening and Resident Review (PASRR) documents were accurate to resident current conditions and diagnoses. This affected one (Resident #6) of one residents reviewed for PASRR documents. The facility census was 98. Findings Include: Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia with agitation/ mood disturbance, anxiety disorder, major depressive disorder (MDD), and delusional disorder. Review of Resident #6's Preadmission Screening and Resident Review (PASRR) Identification Screen dated 11/30/23 revealed under Section (D.) the resident was identified as having a diagnosis of dementia. Under Section (E.) Indications of Serious Mental Illness, the resident was identified as having the diagnosis of a mood disorder and anxiety. Delusional disorder was not marked despite that being a diagnosis the resident was known to have upon admission. Review of a request for a Level of Care Review dated 01/02/24 revealed the facility sent the review request to the Central Ohio Area Agency on Aging for a nursing facility to nursing facility transfer as the resident was admitted to the facility from another nursing facility in Ohio. The Request for a Level of Care Review did not require the facility to include the resident's mental illness diagnoses only an instrumental activities of daily living to show how much assistance the resident needed in areas such as shopping, meal preparation, and laundry/ housekeeping activities. Review of a Pre-Admission Screen Determination dated 01/03/24 revealed it was not applicable. An in-person assessment was indicated not to be required. The comment section indicated it was for a delayed exempt and the resident was approved for transfer. On 04/03/24 at 3:26 P.M., an interview with Social Worker #216 revealed she had been the facility's social worker since just after their last annual survey. She reviewed PASRR's upon a resident's admission for accuracy and to ensure the appropriate diagnoses were added to the PASRR. She acknowledged Resident #6 had the diagnosis of delusional disorder that was not included on her PASRR they received from the transferring facility. She confirmed she received the PASRR from the transferring facility and assumed it had been completed accurately. She further confirmed she did not review it for accuracy. She acknowledged there could have been the possibility of the resident triggering for a Level II review if the prior PASRR had been completed accurately. She further acknowledged any such services that could have been required through a Level II review would not have been provided to the resident timely, if the resident required them. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Resident Assessment- Coordination with PASARR Program revised 01/01/24 revealed the facility coordinated assessments with the preadmission screening and resident review (PASARR) program under Medicaid (MCD) to ensure that individuals with a mental disorder, intellectual disability, or a related condition received care and services in the most integrated setting appropriate to their needs. All applicants to the facility would be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's MCD rules for screening. The social services director would be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on medical record review, staff interview, and policy review, the facility failed to ensure all significant mental health changes were communicated to the state mental health agency. This affected one (Resident #6) of one residents reviewed for PASRR documents. The facility census was 98. Findings Include: Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia with agitation/ mood disturbance, anxiety disorder, major depressive disorder (MDD), and delusional disorder. Review of Resident #6's Preadmission Screening and Resident Review (PASRR) Identification Screen dated 11/30/23 revealed under Section (D.) the resident was identified as having a diagnosis of dementia. Under Section (E.) Indications of Serious Mental Illness, the resident was identified as having the diagnosis of a mood disorder and anxiety. Delusional disorder was not marked despite that being a diagnosis the resident was known to have upon admission. Review of a request for a Level of Care Review dated 01/02/24 revealed the facility sent the review request to the Central Ohio Area Agency on Aging for a nursing facility to nursing facility transfer as the resident was admitted to the facility from another nursing facility in Ohio. The Request for a Level of Care Review did not required the facility to include the resident's mental illness diagnoses only an instrumental activities of daily living to show how much assistance the resident needed in areas such as shopping, meal preparation, and laundry/ housekeeping activities. Review of a Pre-Admission Screen Determination dated 01/03/24 revealed it was not applicable. An in-person assessment was indicated not to be required. The comment section indicated it was for a delayed exempt and the resident was approved for transfer. On 04/03/24 at 3:26 P.M., an interview with Social Worker #216 revealed she had been the facility's social worker since just after their last annual survey. She reviewed PASRR's upon a resident's admission for accuracy and to ensure the appropriate diagnoses were added to the PASRR. She acknowledged Resident #6 had the diagnosis of delusional disorder that was not included on her PASRR they received from the transferring facility. She confirmed she received the PASRR from the transferring facility and assumed it had been completed accurately. She further confirmed she did not review it for accuracy. She acknowledged there could have been the possibility of the resident triggering for a Level II review if the prior PASRR had been completed accurately. She further acknowledged any such services that could have been required through a Level II review would not have been provided to the resident timely, if the resident required them. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Resident Assessment- Coordination with PASARR Program revised 01/01/24 revealed the facility coordinated assessments with the preadmission screening and resident review (PASARR) program under Medicaid (MCD) to ensure that individuals with a mental disorder, intellectual disability, or a related condition received care and services in the most integrated setting appropriate to their needs. All applicants to the facility would be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's MCD rules for screening. The social services director would be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Any resident who exhibited a newly evidence or possible serious mental disorder, intellectual disability, or a related condition would be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include a resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.

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F 0684 Level of Harm - Minimal harm or potential for 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** 44070 Based on record review, staff interview, and facility policy review, the facility failed to ensure skin and wound assessments were completed thoroughly, accurately, and timely for three residents (#3, #74 and #89) of four reviewed for non-pressure wounds. The facility census was 98. Findings include: 1. Review of the medical record for the Resident #89 revealed an admitted [DATE]. Diagnoses included depression, heart failure, diabetes, end stage renal disease, and absence of left leg below the knee. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 was cognitively intact and required supervision touching assistance for personal hygiene and activities of daily living Review of the plan of care dated 01/2024 revealed Resident #89 was at risk for skin impairments with interventions to inspect for reddened areas during daily care, weekly skin assessments, charge nurse to notify wound nurse, Physician and family of any new areas, and wound care practitioner to eval and treat as indicated. Review of the skin observation assessment dated [DATE] revealed a new red area on the left knee. Review of the skin grid non-pressure assessment dated [DATE] revealed a new skin impairment was noted of a red area blister to knee. Review of the skin observation assessment dated [DATE] revealed no areas identified. It did not indicate if prior redness and blistering had healed. Review of the skin grid non-pressure assessment dated [DATE] revealed multiple scabs to distal finger joints (date acquired 9/22). The assessment marked the wounds as unchanged but identified skin impairments had not been previously assessed or identified. Review of the skin observation assessment dated [DATE] revealed a previously identified area was present. The area included scabs on the right hand and fingers and a scab on the left knee. It did not indicate how many scabs, specific locations or sizes. Several of these scabs were not identified on several previous skin observations or assessments. Review of the skin grid non-pressure assessment dated [DATE] revealed resident had bruising to the left iliac crest. This bruising was marked as unchanged, but skin impairment had not been previously identified or assessed. Review of the skin observation assessment dated [DATE] revealed bruising to left illiac crest. Review of the skin grid non-pressure assessment dated [DATE] revealed bruising to left knee. None of the recent previous skin assessments mentioned concerns of bruising to the left knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin observation assessment dated [DATE] identified scabs to right fingers. Assessment did not provide details of the scabs including amount and sizes. Review of the skin observation assessment dated [DATE] identified scabbed areas on right hand fingers and a bruise on the abdomen. Review of the skin observation assessment dated [DATE] identified a scabbed area on the back of the left hand. Review of the skin observation assessment dated [DATE] identified a scabbed area on the left hand. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Review of the skin observation assessment dated [DATE] identified scabbed areas to right hand. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Review of the skin observation assessment dated [DATE] identified hand blisters. The assessment did not specify which hand, how many, or the size of the blisters. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] identified scabbed areas to bilateral fingers. Review of the skin observation assessment dated [DATE] identified scabbed areas to the right hand fingers. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Review of the skin observation assessment dated [DATE] identified scabbed areas to right and left hands. Review of the skin observation assessment dated [DATE] identified scabbed areas to right hand fingers. Review of the skin observation assessment dated [DATE] identified scabbed areas to fingers of right and left hands. Review of the skin observation assessment dated [DATE] identified scabbed areas to right hand fingers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin grid non-pressure assessment dated [DATE] identified a skin tear that occurred at the device check appointment. This assessment was updated to state the tear was healed on 02/28/24. Review of the skin observation assessment dated [DATE] identified an area to LFA and scabbed areas to right fingers. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Review of the skin grid non-pressure assessment dated [DATE] identified a bruise to the top of the scalp. The assessment revealed this wound was identified at 02/13/24. Review of the skin observation assessment dated [DATE] stated skin was intact with no impairments, but also stated left fingers wound treatments were in place. Review of the skin grid non-pressure assessment dated [DATE] identified a bruise was acquired on 02/13/24. The assessment included no information on description location or size of the bruise. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin grid non-pressure assessment dated [DATE] identified scabs on the right fingers that were marked as unchanged, gave no date of when they were acquired and no description or size. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin grid non-pressure assessment dated [DATE] identified scabs on his right fingers. The assessment was marked as unchanged and provided no date the wound was acquired. Review of the skin observation assessment dated [DATE] stated a previous area had been identified and provided no information on which site or description of the skin impairment it was referring to. Review of the skin grid non-pressure assessment dated [DATE] identified scabs on his right fingers. The assessment was marked as unchanged and provided no date the wound was acquired or any size or description of the wound. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/02/24 at 8:56 A.M. with Resident #89 revealed he had several visible wounds on his bilateral hands with a grayish scab on the right middle finger and several additional red colored blisters on his bilateral fingers. Resident stated he had blisters on his hands for several months and also revealed the large grey scab like wound had been there for several months. He revealed it started as a blister and believed it to be caused by his dialysis port causing issues with blood flow to his hand. Interview on 04/03/24 at 2:20 P.M. with Director of Nursing (DON) confirmed facility had an order for the wound practitioner to evaluate and treat as necessary dated 03/2024 and confirmed the wound provider saw resident but had no recommendations and did not document any assessment or findings. 2. Review of the medical record for the Resident #3 revealed an admitted [DATE]. Diagnoses included diabetes type 1, respiratory failure, metabolic encephalopathy, heart failure, vascular disease and kidney failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact and required substantial maximum assistance for lower body dressing, showering and moderate assistance for hygiene and upper body dressing. Review of the plan of care dated 11/16/23 revealed Resident #3 was at risk for alteration in skin integrity with interventions for wound care practitioner to evaluate and treat as indicated. The care pan also stated the resident had an actual area of skin impairment of pressure ulcer to left knee amputation stump with interventions to indicate wound treatment, nursing to observe the wound dressing. Observe and document the character of wound weekly, observe for clinical changes and complete skin observations on bath/shower days. Review of the skin grid non-pressure assessment dated [DATE] identified bruising to the neck. The assessment had marked this finding as new but did not include the date acquired or description. Review of the skin grid non-pressure assessment dated [DATE] identified redness to the back of the right hand. The assessment did not include description or measurements. Review of the skin grid non-pressure assessment dated [DATE] identified redness to the back of left hand. The assessment did not include description or measurements. Review of the skin grid non-pressure assessment dated [DATE] identified a surgical incision to the left illiac crest. The assessment had marked this healed on 11/29/23 and it was included in any other assessments. Review of Physician orders dated 11/16/23 to 11/30/23 to monitor incision cite to left groin each shift for signs of infection. The wound to the left groin was never marked or included in any skin observation assessments or skin grid non-pressure assessment. Another order dated 11/16/23 to 04/01/24 revealed an order for right second toe to cleanse wound with wound cleanser or normal saline, apply betadine, and leave open to air daily. The wound on the second right toe was not documented in the skin assessments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin grid non-pressure assessment dated [DATE] identified bruising to the neck. The assessment had marked this finding as new again but did not include the date acquired or description. The assessment also stated the impairment was improved but also that Physician was notified of the decline in skin a few days prior. Review of the skin grid non-pressure assessment dated [DATE] identified redness to the back of the right hand. The assessment had marked this finding as new again but did not include description or measurements. The assessment also stated the impairment was improved. Review of the skin grid non-pressure assessment dated [DATE] identified redness to the back of the left hand. The assessment had marked this finding as new again but did not include description or measurements. The assessment also stated the impairment was unchanged but also that it was healed. Review of the skin grid non-pressure assessment dated [DATE] identified a surgical incision to the left illiac crest. The assessment had marked this finding as new again but did not include description or measurements. The assessment also stated the impairment was unchanged but also that it was healed. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment revealed a left knee wound of amputation stump wound. The assessment did not include any descriptions or measurements. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment revealed a left knee wound of amputation stump wound had an open area. The assessment did not include any descriptions or measurements. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified. The assessment revealed a left knee had an open area. The assessment did not include any descriptions or measurements. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified. The assessment revealed a skin tear to the left forearm with treatment in place. The assessment did not include any measurements. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was marked as intact, but also marked with previous areas noted. The assessment identified a scabbed area to the left knee and scabbed area to the right foot. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment identified a toe skin impairment but did not include any description or details including if it was the right or left, which toe and what the injury actually was (cut, bruise, scab ect). Review of the skin observation assessment dated [DATE] revealed skin was not intact, marked with previous areas noted. The assessment identified a scabbed area to the left knee. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was not intact, previous areas identified, dressing and treatment in place. The assessment did not include any areas listed or descriptions of wound impairments. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Physician order dated 03/13/23 revealed wound care practitioner to evaluate and treat as indicated. The order did not specify any specific wounds and assessments before and after the order stated no skin impairments. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was not intact, and marked with previous areas noted. The assessment identified a scabbed area to the left knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin grid non-pressure assessment dated [DATE] identified a an other wound measuring 0.5 by 0.5 and a scab on the second right toe. The assessment had marked this finding as healed but did not specify if both wounds were healed (one had measurements). Review of wound practitioner notes dated 01/15/24, 01/22/24, 01/29/24, 02/05/24, 02/19/24, 02/26/24, 03/04/24, 03/11/24, 03/18/24, 03/25/24, and 04/01/24 revealed the wound practitioner observed and made recommendations regarding the stump pressure wound but had no documentation of assessing any other skin impairments. Review of the Skin grid assessment listing found Resident #3 had not had a skin grid assessment from 11/01/23 to 03/13/24 and then none after 03/13/23. Interview and observation on 04/01/24 at 11:38 A.M. with Resident #3 revealed resident had several visible wounds and scabs on his bilateral lower extremity as well as dried blood on his pillow and a bloody bandage on the floor. Resident revealed he had consistently had various wounds on his legs and feet with scabs and skin tears. 3. Review of the medical record for the Resident #74 revealed an admitted [DATE]. Diagnoses included respiratory failure, diabetes, dysphagia, muscle weakness, encephalopathy, and pulmonary embolism. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 was cognitively impaired and was rarely if ever understood and was dependent for activities of daily living. Review of the plan of care dated 03/04/24 revealed Resident #74 was at risk of skin impairments. Review of the skin grid non-pressure assessment dated [DATE] identified a new scab on the left toes also noted to be an abscess. The assessment marked this finding as unchanged while also marked as worsened with physician notification on 10/24/23 and also marked as healed but gives measurements of 0.5 by 0.5. Review of the skin grid non-pressure assessment dated [DATE] identified a new skin impairment of scabs to the left toes, also identified on 10/24/23. The assessment marked the wound as improved and marked as declined on 10/24/23. Review of the skin observation assessment dated [DATE] revealed skin was intact with no new areas, dressing and treatment were not applicable. The assessment identified a left toe(s) impairment with great toenail ingrown with treatment in place. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin grid non-pressure assessment dated [DATE] identified redness and scab to left toes around the toenail bed. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin observation assessment dated [DATE] revealed skin was intact and no areas of skin impairment were identified. Review of the skin grid assessments revealed resident was missing several skin grid non-pressure assessments. Observations and interview dated 04/01/24 at 10:52 A.M. with Resident #74's representative and Resident #74 revealed resident had wounds to his toes and had a dressing in place. Resident Representative revealed resident had an ingrown toe that was causing issues to his skin around the nailbed. Resident Representative revealed resident had a wound on his toe for the last several weeks and they had not fully healed. Interviews on 04/04/24 from 2:30 P.M. to 3:15 P.M. with DON confirmed wound assessments did not contain thorough information of what wounds were present and when. The assessments also did not contain descriptions of the wounds and document when they were discovered and when they were healed. DON revealed facility had previously identified an issue with nursing assessment documentation not being accurate and detailed and revealed they had completed education on 02/2024 and 03/2024. DON confirmed issues were still present in documentation after the trainings had been completed. DON revealed skin grid assessments non pressure assessments should be completed when a new wound was identified and then weekly thereafter until the wound was healed and confirmed several skin grid assessments were not completed and also skin observation assessments should be completed weekly regardless of wounds being present or healing status. Review of the facility policy titled Licensed Nurse Skin Condition Documentation, dated 03/01/22 revealed it was the practice of the facility to complete weekly wound observations and provide weekly documentation of any wound area in order to identify progress or lack of progress in a wound area. The assessments would include identification of the type of wound and description including color, size/measurements, location and exudate if present. The nurse shall document on forms and place in medical record and will notify physician of any changes.

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F 0686 Level of Harm - Minimal harm or potential for 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** 41271 Based on medical record, skin assessment review, staff interview, and facility policy review, the facility failed to properly document a newly identified pressure wound. This affected one (Resident #93) of the seven residents reviewed for skin assessment accuracy. The facility census was 98. Findings include: Review of the medical record for Resident #93 revealed an admitted [DATE]. Diagnoses included delirium, vascular dementia, hemiplegia affecting the left non-dominant side, and a history of falling. Review of Resident #93's significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating a severely impaired cognition for daily decision making abilities. Resident #93 was noted to display disorganized thinking, inattention, rejection of care and delusions. Resident #92 was noted to to experience impairment to one upper and one lower extremity and required substantial to maximal assistance for bed mobility and turning from side to side. Per assessment, Resident #93 was noted to be incontinent of bowel and bladder function and noted to one stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) that was not present upon admission to the facility. Review of the plan of care dated 11/02/23 and revised 04/01/24 revealed Resident #93 has an actual area of skin impairment related to pressure area to coccyx. Interventions included to observe the area for clinical changes and document findings and notify the physician. Review of the completed Weekly Skin Observation dated 01/12/24 revealed Resident #93 had no skin issues and skin was intact. Review of the progress note dated 01/14/24 at 11:41 A.M. created by Licensed Practical Nurse (LPN) #220 revealed, Treatment applied to open area to crack of buttocks resident tolerated well. Encouraged turning and repositioning while in bed. Turns back on his back, non-compliant with recommendations. Review of a completed Skin Grid Non-Pressure assessment dated [DATE] revealed Resident #93 was noted to have a new skin problem, abrasion, acquired 01/22/24 to the coccyx measuring 0.5 centimeters (cm) in length, by 1 cm in width, by 0 cm in depth, no staging noted. Review of the progress note dated 01/27/24 at 6:56 P.M. created by LPN #220 revealed, Encouraged turning and repositioning while in bed. Patient non-compliant, moves body even with his left sided weakness (status post stroke with left upper and lower weakness) off his side/ either side he is place on and turns back onto back/ buttocks. Treatment in place and continues to coccyx. Encouraged turning and repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin Grid Pressure assessment dated [DATE] revealed Resident #93 was noted to have a newly identified area to the coccyx noted to measure 1.2 centimeter(cm) in length by 1.2 cm in width by 0.1 cm in depth described as a stage two pressure. No evidence was noted to indicate the physician was notified of this newly identified pressure wound. Interview on 04/04/24 at 10:13 A.M. with Charge Nurse, Licensed Practical Nurse (LPN) #50 verified Resident #93 had a stage two pressure wound that was newly identified per nurses notes on 01/14/24 and per Skin Grid Pressure assessment dated [DATE]. Charge Nurse, LPN #50 also verified there was no evidence noted in the nurses progress notes or skin assessment that the physician had been notified of the newly identified pressure wound. Charge Nurse, LPN #50 claimed the wound physician was notified the following week when the physician was onsite to complete wound treatments for other residents but not notified immediately when the pressure wound was identified. Interview on 04/04/2024 10:52 A.M. with Charge Nurse LPN #220 revealed skin assessment could not be located related to the progress note entered 01/14/23 indicating that a treatment to the coccyx was in place. No skin assessment was noted to have been completed until 01/24/24 and should have been completed when the area was first identified. Review of the facility policy titled Notification of Change, dated 08/22/22 revealed, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as b. Clinical complications or development of a stage two pressure injury. Review of the facility policy titled Licensed Nurse Skin Condition Documentation, dated 03/01/2022 revealed, It is the practice of the facility to complete weekly wound observation and provide weekly documentation of any pressure area(s) and wound area(s) in order to identify progress or lack of progress to any wound area.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure a resident receiving a narcotic pain medication ordered on an as needed basis (prn) had parameters ordered from the physician on when to administer the medication. This affected one (Resident #6) of five residents reviewed for unnecessary medications. The facility census was 98. Findings include: Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, opioid use, and a history of a displaced fracture of the upper end of the left humerus with routine healing. A review of Resident #6's physician's orders revealed she had an order to received Norco (Acetaminophen and Hydrocodone) 5-325 milligrams (mg) one half tablet by mouth (po) twice a day on a scheduled basis beginning on 02/21/24. Her orders also included the use of Norco 5-325 mg one half tablet po every six hours as needed for pain. There was no direction for the nurses to know when to administer the prn Norco such as for moderate to severe pain or for pain levels of 4 to 10 on a 1-10 scale. The resident also had an order to receive Acetaminophen (Tylenol) 650 mg po with instructions to administer every six hours as needed for general discomfort. Her pain was to be monitored every shift for medication monitoring. Review of Resident #6's medication administration record (MAR) for January 2024 revealed the resident was given Norco 5-325 mg one half tablet 18 times that month. She received it less than daily but somedays was given two doses. The nurses administering the prn Norco did not specify what the resident's pain level was when she received it, but did indicate the medication was effective when administered. In addition to the prn Norco, the resident received Acetaminophen 650 mg po as ordered every six hours prn for general discomfort twice that month. The nurses administering the Acetaminophen did include a pain level and recorded the resident's pain level as a 1 and 3 when the Acetaminophen was given. Both doses were indicated to be effective when given. The MAR also documented the resident's pain level each shift when assessed. She denied any pain 50 of the 55 shifts her pain was assessed. She complained of a pain level of 1 out of 10 twice, a 2 out of 10 once, and a 3 out of 10 only two times. Review of Resident #6's MAR for February 2024 revealed the resident began receiving a scheduled dose of Norco 5-325 mg one half tablet po twice a day on 02/21/24, after it had been ordered. She received four doses of the Norco 5-325 mg one half tablet on a prn basis for pain. The nurses administering those prn doses of Norco did not specify what the resident's pain level was at the time the prn medication was given. All four doses were indicated to have been effective. She was not given any of the Acetaminophen 650 mg tablets on a prn basis despite that medication being recorded as having been effective in managing the resident's pain the previous month. Her pain level continued to be monitored every shift as ordered and she was not indicated to have had any pain when assessed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Logan	300 Arlington Avenue Logan, OH 43138

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/04/24 at 10:50 A.M., an interview with the Director of Nursing (DON) confirmed Resident #6's physician's orders for the use of prn Norco did not include parameters to direct the nurses on when it should be given. She acknowledged the resident had an order for Acetaminophen 650 mg to be given every six hours prn for general discomfort and the medication was documented as being effective in managing the resident's pain when it was given. She further acknowledged the resident had been given four doses of the prn Norco in February 2024, without the Acetaminophen being used at all on a prn basis for pain. She also confirmed the pain assessment that was being completed every shift as ordered in February 2024 revealed the resident had no complaints of pain when assessed each shift the entire month. She stated she would contact the physician to obtain further orders for parameters on when to use the prn Norco.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

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Embassy of Logan	300 Arlington Avenue Logan, OH 43138

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure laboratory tests were completed as ordered by the physician. This affected one (Resident #62) of five residents reviewed for unnecessary medications. The facility census was 98. Findings include: Review of Resident #62's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included mood disorder, bipolar disorder, and major depressive disorder. Review of Resident #62's physician's orders revealed the resident had an order to receive Depakote (an anti-convulsant also used in the treatment of bipolar disorder) Delayed Release (DR) 500 milligrams by mouth (po) twice a day for mood disorder. The order had been in place since 10/29/20. Her physician's orders also included the need to obtain a Depakote level every six months and as needed. That order had been in place since 01/20/22. Further review of Resident #62's electronic medical record (EMR) revealed it was absent for evidence a Depakote level had been drawn every six months as ordered. Findings were verified with the Licensed Practical Nurse (LPN) #50. On 04/04/24 at 3:00 P.M., an interview with LPN #50 revealed the last Depakote level they could find for Resident #62 was collected on 08/18/22. She confirmed the resident's physician's orders indicated a Depakote level was to be done every six months. She reported their laboratory system they used for entering a lab test did not allow them to enter it outside the current year they were in. The need to obtain a Depakote level on the resident every six months fell through the cracks, after it was last obtained in August 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Logan		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Arlington Avenue Logan, OH 43138	

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 28923 Based on observation and staff interview, the facility failed to ensure residents' rooms were maintained in a safe, functional, and sanitary manner. This affected six residents (Resident #6, #21, #53, #62, #63, and #152) of 32 that were observed for room conditions. The facility census was 98. Findings include: 1. Review of Resident #6's room on 04/01/24 at 11:39 A.M. revealed the overbed light had a bulb that was burning out in the front of the overbed light. The light would turn on, but shined a pinkish-red color and was not fully lit. The resident's wall next to her bed had chipped paint and was in need of being painted. The entry door on the inside was noted to have chipped paint and was in need of being painted. On 04/04/24 at 8:23 A.M., a follow up observation was made of Resident #6's room and her room remained in disrepair. In addition to the above findings, the vent and surrounding ceiling area was noted to be covered in dust. Findings were verified by Maintenance Director #22. 2. Review of Resident #21's room on 04/01/24 at 10:02 A.M. revealed the floor tile next to her bed had a long crack in it. The inside door frame to the room had chipped paint. The vent in the ceiling and the surrounding ceiling was noted to have dust build up on it. On 04/04/24 at 8:25 A.M., a follow up observation was made of Resident #21's room and her room remained in disrepair. In addition to the above findings, the tile floor between bed A and B was noted to have black marred areas and gouges in it in front of resident in bed B's recliner. Findings were verified by Maintenance Director #22. 3. Review of Resident #53's room on 04/01/24 at 10:02 A.M. revealed the floor had cracked tile. Her inside door frame and door was noted to have chipped paint and was in need of being painted. The vent in the ceiling and the surrounding ceiling area had dust build up on it and was in need of being cleaned. On 04/04/24 at 8:26 A.M., a follow up observation of Resident #53's room revealed it remained in disrepair. The vent and the surrounding ceiling still had dust build up present. Findings were verified by Maintenance Director #22. 4. A review of Resident #62's room on 04/01/24 at 1:43 P.M. revealed the residents's wall around the recessed area where her wardrobe was placed was damaged. The dry wall compound had fallen off exposing the metal strip that was used to make a straight edge. The sink in her bathroom had constant running water and could not be shut off. On 04/04/24 at 8:28 A.M., a follow up visit to Resident #62's room revealed it remained in disrepair. The sink was noted to still have water running from it. Findings were verified by Maintenance Director #22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of Resident #63's room on 04/01/24 at 2:15 P.M. revealed the recessed wall where her wardrobe was placed had damage to it where the door knob to the entry door had hit it. The metal strip was exposed from where the dry wall compound had come off and there was metal edge strips exposed in other areas across the top of that recessed wall. On 04/04/24 at 8:29 A.M., a follow up observation of Resident #63's room noted it remained in disrepair. Findings were verified by Maintenance Director #22. 6. A review of Resident #152's room on 04/01/24 at 10:53 A.M. revealed there had been two separate areas in which the wall had been patched over wallpaper. The patched areas was on each side of a bulletin board that was hanging on the wall above the resident's bed. There was also an area on the ceiling in which a leak had occurred above the window that had flaking ceiling paint. The recessed wall where the wardrobe was placed had damage to the corner where the door knob had hit it. On 04/04/24 at 8:30 A.M., a follow up observation of Resident #152's room revealed it remained in disrepair. Findings were verified by Maintenance Director #22. On 04/04/24 at 8:24 A.M., an interview with State tested Nursing Assistant (STNA) #130 revealed they were to report any issues they noted with the facility's environment to the maintenance department. They were able to enter those issues into the computer when repairs were needed. She denied she had reported any environmental issues. On 04/04/24 at 8:31 A.M., an interview with Maintenance Director #22 confirmed any environmental concerns identified by the staff were to be put into the computer. He denied he had any work orders that had been placed for the environmental issues noted above. He claimed he also made daily rounds throughout the building to check in with the staff to see if anything needed fixed. He denied he had been made aware of any of the environmental concerns identified on the 400 hall.