

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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 03/19/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Logan		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy and procedure, the facility failed to prepare and serve food under sanitary conditions. This had the potential to affect the 92 of 92 residents who receive trays from the kitchen. The census was 92. Findings include: On 03/17/2026 at 10:33 A.M. Observation of the kitchen revealed the confection oven with food splatter and food crumbs. A container under the steam table with food debris, the wall behind the plate warmer with dust and dirt build up. The wall behind the table with the toaster with dried food splatter. 03/18/2026 at 2:20 P.M. observation of the kitchen with Dietary Manager #109 revealed the hanging electrical outlet over the serving line had a built up of dust hanging on it, and on the air conditioning unit. The trash can be beside the confection oven and in the dish washing area with no lid on them. The stove with dried food debris and splatter on it. The shelf under the tray line with crumbs and food debris on it. This was verified at the time of the observation with Dietary Manager #109. Review of Sanitary Conditions policy and procedure not dated revealed all equipment will be maintained in a clean and sanitary fashion. This deficiency represents non-compliance investigated under Complaint Number 2696142.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews, observation, policy and audit reviews, the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit (F) in the shower rooms on hallways 200 and 400. This had the potential to affect 42 residents (200 Hallway-Resident #51, Resident #27, Resident #64, Resident #39, Resident #15, Resident #33, Resident #89, Resident #41, Resident #45, Resident #85, Resident #34, Resident #79, Resident #08, Resident #54, Resident #01, Resident #40, Resident #23, Resident #36, Resident #12, and Resident #72. 400 Hallway-Resident #65, Resident #29, Resident #20, Resident #77, Resident #71, Resident #92, Resident #58, Resident #26, Resident #81, Resident #07, Resident #67, Resident #18, Resident # 74, Resident #93, Resident #101, Resident #75, Resident #48, Resident #80, Resident # 52, Resident #82, Resident #04, and Resident #69). The census was 92. Review of facilities audit conducted of water temperature log from January 2026-March 2026 revealed documented water temperatures were above 120 degrees F on 03/09/26, 03/02/26, 02/23/26, 02/19/26, 02/09/26, 02/02/26, 01/26/26, 01/19/26, 01/12/26 and 01/05/26 on multiple hallways. On 03/18/26 at 11:27 A.M. interview with Associate #178 confirmed documented water temperatures were above 120 degrees F. On 03/18/26 at 11:45 A.M. observation of shower room water temperatures taken by Associate #125 revealed that Hallway 100 temperature was 113.4 degrees F, hallway 200 was 131.0 degrees F, hallway 300 was 112.7 degrees F, hallway 400 was 122.8 degrees F, hallway 600 was 109.2 degrees F and hallway 700 was 115.0 degrees F. On 03/19/26 at 10:00 A.M. review of Safe Water Temperatures Policy dated 03/01/25 revealed water temperatures will be set to a temperature of no more than 120 degrees F.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review the facility failed to show documented evidence of resident and family participation in the care planning process. This affected one resident (#50) of one sampled for care planning. The facility census was 92. Findings include: Review of Resident #50's medical record revealed an admission date of 09/26/24 and diagnoses including dementia with behaviors, morbid obesity, diabetes, cirrhosis of the liver, hypertension, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of two out of 15 indicating the resident was severely cognitatively impaired. Further review of the MDS revealed Resident #50 used a wheelchair for mobility, required set up for eating, and was dependent on facility staff for all other activities of daily living. Further review of Resident #50's medical record revealed an undated invitation to a care conference on 12/16/25 at 10:00 A.M. However, no evidence of the care conference being held was present in the medical record. In an interview on 03/16/2026 at 10:37 A.M. Resident #50's husband revealed he did not remember having a care conference meeting with the facility at least once a quarter. In an interview on 03/17/2026 at 2:10 P.M. the Administrator revealed the care conference summary in the electronic health care record was not opened for the scheduled 12/16/25 care conference, so the facility had no evidence of care conference being held. Review of the policy titled Care Planning - Resident Participation undated revealed the facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. Further review of the policy revealed the facility will obtain a signature from the resident and/or the resident's representative after discussion or viewing of the care plan.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interviews, and record review, the facility failed to follow up on appropriate and timely completion regarding correct eyeglass prescription. This affected one resident (Resident #11) of two residents reviewed for activities of daily living. The census was 92. Review of the medical record for Resident #11 revealed an admission date of 04/30/25. Diagnoses include schizoaffective disorder and chronic obstructive pulmonary disease (COPD). Further review of the medical record revealed Resident #11's eyeglasses were obtained while at the facility and added to Resident #11's inventory sheet on 09/19/25. Glasses adjustment by 360 Care completed on 11/04/25. On 03/16/26 interview with Resident #11 revealed eyeglasses are not the correct prescription, and I have told someone about this. On 03/17/26 at 2:10 P.M. interview with Associate #216 revealed 360 Care was supposed to be out 03/11/26 to see resident. Associate #216 presented documentation from 360 Care on 03/11/26 and glasses were adjusted. Resident said that he can't see out of the bifocal very well was documented in the note. Associate #216 confirmed there was no next step regarding Resident #11 eyeglasses.		

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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** Based on observation, medical record review, and interview, the facility failed to ensure the physician ordered treatment was implemented. This affected one resident (#9) of three residents reviewed for skin conditions. The facility census was 92. Findings Include: Review of the resident's medical record for Resident #9 revealed an initial admission date of 02/17/21 with the latest readmission date of 08/03/21 with the diagnoses including but not limited to polyneuropathy, chronic obstructive pulmonary disease, diabetes mellitus, dysphagia, speech disturbances, anxiety disorder, schizophrenia, hyperlipidemia, dry eye syndrome, GERD, PTSD, major depressive disorder, BPH and insomnia. Review of the plan of care dated 11/28/25 revealed the resident had impaired skin integrity related to a skin tear to the left outer knee. Interventions included air mattress to promote skin integrity, check patency every shift, encourage resident to elevate feet while in chair, encourage to turn and reposition every two hours, evaluate wound related pain, pre-medicate prior to dressing changes as needed, notify physician if changes are noted to the wound, weekly wound measurements and documentation on wound appearance, drainage and surrounding tissue and wound treatment as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for activities of daily living (ADL). The assessment indicated the resident was at risk for skin breakdown and had skin tears. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problem, application of nonsurgical dressing other than to feet and application of ointments/medication to feet. Review of the progress note dated 11/28/25 at 2:00 P.M. revealed the resident was found to have a skin tear to the left lower anterior leg. The area has some redness and drainage measuring 2.0 centimeters (cm) by 1.5 cm by 0.1 cm. The resident was found to have caused the skin tear by moving his legs while sitting in a wheelchair. Review of the initial weekly non-pressure skin grid dated 11/28/25 revealed the resident was found to have a skin tear to the left anterior leg measuring 2.0 cm by 1.5 cm by 0.1 cm with a scant amount of drainage. The wound was described as resident has open area noted with some drainage. no signs/symptoms of infection noted, outer knee area. Review of the weekly non-pressure skin grid dated 12/01/25 revealed the skin tear to the left anterior shin measured 2.0 cm by 1.5 cm by 0.1 cm with some drainage. Review of the weekly non-pressure skin grid dated 12/08/25 revealed the skin tear to the left anterior shin measured 2.0 cm by 1.5 cm by 0.1 cm with some drainage. The facility determined the wound was unchanged. Review of the weekly non-pressure skin grid dated 12/11/25 revealed the skin tear to the left anterior shin measured 1.0 cm by 1.5 cm by 0.1 cm with some drainage. The facility determined the wound was unchanged. Review of the initial weekly Wound Nurse Practitioner (WNP) progress note dated 12/18/25 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 1.5 cm by 1.0 cm by 0.1 cm and described as 50% granulation and 50% slough. The wound had a moderate amount of serosanguinous exudate. The treatment was cleanse with normal saline, apply Medihoney and cover with bordered gauze dressing daily and as needed. Review of the weekly non-pressure skin grid dated 12/25/25 revealed the skin tear to the left anterior shin measured 1.0 cm by 1.2 cm by 0.1 cm with some drainage. The facility determined the wound had improved. Review of the weekly WNP progress note dated 12/31/25 revealed the WNP had documented the wound to the resident's right lateral lower leg measured 3.5 cm by 3.0 cm by unable to determine (UTD) and described as 20% granulation and 80% slough. The wound had a moderate amount of serosanguinous exudate. The WNP documented the wound had increased in size since the last visit and appeared devitalized with poor vascularization. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.6 cm by 3.2 cm by UTD. The treatment was cleanse with normal saline, apply Medihoney and cover with bordered gauze dressing daily and as (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. Review of the weekly WNP progress note dated 01/08/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measured 3.5 cm by 3.0 cm by UTD and described as 20% granulation and 80% slough. The wound had a moderate amount of serosanguinous exudate. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.6 cm by 3.0 cm by UTD. The treatment was cleanse with normal saline, apply Medihoney, apply calcium alginate and cover with bordered gauze dressing daily and as needed. Review of the weekly WNP progress note dated 01/15/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 4.0 cm by 3.0 cm by UTD and described as 20% granulation, 40% slough and 40% necrotic tissue. The wound had a moderate amount of serosanguinous exudate. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 4.2 cm by 3.2 cm by UTD. The treatment was changed to cleanse with normal saline, apply Mupirocin ointment then calcium alginate and cover with bordered gauze dressing daily and as needed. Review of the weekly WNP progress note dated 01/22/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 4.0 cm by 3.0 cm by UTD and described as 20% granulation, 40% slough and 40% necrotic tissue. The wound had a moderate amount of serosanguinous exudate. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 4.2 cm by 3.2 cm by UTD. The treatment was cleanse with normal saline, apply Mupirocin ointment then calcium alginate and cover with bordered gauze dressing daily and as needed. Review of the weekly WNP progress note dated 01/29/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 4.0 cm by 3.0 cm by UTD and described as 40% granulation, 20% slough and 40% necrotic tissue. The wound had a moderate amount of serosanguinous exudate. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 4.1 cm by 3.1 cm by UTD. The treatment was cleanse with normal saline, apply mupirocin ointment then apply calcium alginate and cover with bordered gauze dressing daily and as needed. Review of the weekly WNP progress note dated 02/05/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 4.5 cm by 4.2 cm by 0.2 cm and described as 70% granulation and 30% slough. The wound had a moderate amount of serosanguinous exudate, and the peri-wound was reddened. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 4.1 cm by 2.6 cm by 0.1 cm. The treatment was cleanse with normal saline, apply mupirocin ointment then apply calcium alginate and cover with bordered gauze dressing daily and as needed. Review of the weekly WNP progress note dated 02/12/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 3.5 cm by 2.0 cm by 0.2 cm and described as 70% granulation and 30% slough. The wound had a moderate amount of serosanguinous exudate and the peri-wound was reddened. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.6 cm by 2.2 cm by 0.2 cm. The treatment was cleanse with normal saline, apply mupirocin ointment then apply calcium alginate and cover with bordered gauze dressing daily and as needed. The facility determined the wound had improved/healing. Review of the weekly WNP progress note dated 02/19/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 3.5 cm by 2.0 cm by 0.2 cm and described as 70% granulation and 30% slough. The wound had a moderate amount of serosanguinous exudate and the peri-wound was reddened. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.6 cm by 2.2 cm by 0.2 cm. The treatment was cleanse with normal saline, apply mupirocin ointment then apply calcium alginate and cover with bordered gauze dressing daily and as needed. The facility determined the wound was unchanged. Review of the weekly WNP progress note dated 02/26/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 3.5 cm by 2.5 cm by 0.2 cm and described as 80% granulation and 20% (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slough. The wound had a moderate amount of serosanguinous exudate, and the peri-wound was reddened. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.6 cm by 2.6 cm by 0.1 cm. The facility implemented a new treatment of cleanse with normal saline, apply mupirocin ointment then start applying silver alginate and cover with bordered gauze dressing daily and as needed. The facility determined the wound was unchanged. Review of the weekly WNP progress note dated 03/05/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 3.0 cm by 2.0 cm by 0.2 cm and described as 80% granulation and 20% slough. The wound had a moderate amount of serosanguinous exudate, and the peri-wound was reddened. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.0 cm by 2.2 cm by 0.2 cm. The treatment was cleanse with normal saline, apply mupirocin ointment then apply silver alginate and cover with bordered gauze dressing daily and as needed. The facility determined the wound had improved/healing. Review of the weekly WNP progress note dated 03/11/26 revealed the WNP had documented the wound to the resident's right lateral lower leg measuring 3.0 cm by 2.0 cm by 0.2 cm and described as 80% granulation and 20% slough. The wound had a moderate amount of serosanguinous exudate and the peri-wound was reddened. A sharp/excisional debridement was performed by the WNP using a curette for removal of slough with post debridement measurements 3.0 cm by 2.1 cm by 0.2 cm. The treatment was cleanse with normal saline, apply mupirocin ointment then apply silver alginate and cover with bordered gauze dressing daily and as needed. The facility determined the wound was unchanged. Review of the weekly WNP progress note dated 03/18/26 revealed the WNP had documented the wound to the resident's left lateral lower leg measuring 2.5 cm by 1.2 cm by 0.2 cm and described as 100% granulation. The wound had a moderate amount of serosanguinous exudate, and the peri-wound was reddened. The treatment was cleanse with normal saline, apply mupirocin ointment then apply silver alginate and cover with bordered gauze dressing daily and as needed. The facility determined the wound was improving. Review of the resident's monthly physician orders for March 2026 identified orders dated 03/06/26 cleanse left lower leg skin alteration with in-house wound cleanser or normal saline, pat dry, apply mupirocin, cover with calcium alginate and cover with dry clean dressing daily and as needed. On 03/17/26 at 2:12 P.M., an interview with the Director of Nursing (DON) verified the facility had not implemented the treatment cleanse with normal saline, apply mupirocin ointment then apply silver alginate and cover with bordered gauze dressing daily and as needed as ordered by the WNP. An interview with Licensed Practical Nurse (LPN) #114 verified the resident's skin tear was on the left lateral leg and not on the right lateral leg. She verified the WNP documentation was not accurate to reflect the actual location of the skin tear being treated. On 03/18/26 at 9:02 A.M., observation of LPN #112 and #114 provide the physician ordered treatment to Resident #9's skin tear to his left out leg revealed a quarter size wound with a reddish wound bed. No concerns were observed with the dressing change.		

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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. Based on medical record review, interview and policy review the facility failed to follow physician recommended parameters for medication. This affected one resident (Resident #5) of five residents reviewed for unnecessary medication. The census was 92. Review of the medical record for Resident #5 revealed an admission date of 10/31/25 and diagnoses of cerebral infarction, unspecified and unspecified asthma, uncomplicated. Review of medical orders revealed an order from 01/30/26 for Metoprolol Tartrate Oral Tablet 25 milligrams (MG) oral tablet 25 MG (Metoprolol Tartate). Give 1.5 tablet by mouth two times a day for hypertension (HTN). Hold if static blood pressure (SBP) below 110 or heart rate (HR) below 60. Review of the medical administration record revealed no documented SBP or HR from 01/30/26-02/26/26. On 02/26/26 pharmacy recommended to give 1.5 tablet by mouth two times a day for hypertension (HTN). Hold if static blood pressure (SBP) below 110 or heart rate (HR) below 60. On 03/18/26 at 11:36 A.M. interview with Associate #114 confirmed medication should have been held on 03/10/26 evening dose and 03/11/26 morning and evening doses. On 03/19/26 at 1:56 P.M. interview with Associate #157 confirmed no SBP/HR documented from 01/30/26-02/26/26. On 03/19/26 review of Medication Administration Policy dated 08/22/22, revealed the facility is to obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. This deficiency represents non-compliance investigated under Complaint Number 2696141.		

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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** Based on observation, medical record review and interview, the facility failed to maintain a complete and accurate medical record. This affected three residents (#5, #9 and #12) of 19 sampled residents. The facility census was 92. Findings Included:1. Review of the resident's medical record for Resident #9 revealed an initial admission date of 02/17/21 with the latest readmission date of 08/03/21 with the diagnoses including but not limited to polyneuropathy, chronic obstructive pulmonary disease, diabetes mellitus, dysphagia, speech disturbances, anxiety disorder, schizophrenia, hyperlipidemia, dry eye syndrome, GERD, PTSD, major depressive disorder, BPH and insomnia. Review of the plan of care dated 11/28/25 revealed the resident had impaired skin integrity related to a skin tear to the left outer knee. Interventions included air mattress to promote skin integrity, check patency every shift, encourage resident to elevate feet while in chair, encourage to turn and reposition every two hours, evaluate wound related pain, pre-medicate prior to dressing changes as needed, notify physician if changes are noted to the wound, weekly wound measurements and documentation on wound appearance, drainage and surrounding tissue and wound treatment as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for activities of daily living (ADL). The assessment indicated the resident was at risk for skin breakdown and had skin tears. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problem, application of nonsurgical dressing other than to feet and application of ointments/medication to feet. Review of the progress note dated 11/28/25 at 2:00 P.M. revealed the resident was found to have a skin tear to the left lower anterior leg. The area has some redness and drainage measuring 2.0 centimeters (cm) by 1.5 cm by 0.1 cm. The resident was found to have caused the skin tear by moving his legs while sitting in a wheelchair. Review of the initial weekly non-pressure skin grid dated 11/28/25 revealed the resident was found to have a skin tear to the left anterior leg measuring 2.0 cm by 1.5 cm by 0.1 cm with a scant amount of drainage. The wound was described as resident has open area noted with some drainage. no signs/symptoms of infection noted, outer knee area. Review of the weekly non-pressure skin grid dated 12/01/25 revealed the skin tear to the left anterior shin measured 2.0 cm by 1.5 cm by 0.1 cm with some drainage. Review of the weekly non-pressure skin grid dated 12/08/25 revealed the skin tear to the left anterior shin measured 2.0 cm by 1.5 cm by 0.1 cm with some drainage. The facility determined the wound was unchanged. Review of the weekly non-pressure skin grid dated 12/11/25 revealed the skin tear to the left anterior shin measured 1.0 cm by 1.5 cm by 0.1 cm with some drainage. The facility determined the wound was unchanged. Review of the weekly Wound Nurse Practitioner (WNP) progress note from 12/19/25 to 03/11/25 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the skin tear to the resident's left lateral leg on his right lateral leg. Review of the resident's monthly physician orders for March 2026 identified orders dated 03/06/26 cleanse left lower leg skin alteration with in-house wound cleanser or normal saline, pat dry, apply mupirocin, cover with calcium alginate and cover with dry clean dressing daily and as needed. On 03/17/26 at 2:12 P.M., an interview with Licensed Practical Nurse (LPN) #114 verified the resident's skin tear was on the left lateral leg and not on the right lateral leg. She verified the WNP documentation was not accurate to reflect the actual location of the skin tear being treated. On 03/18/26 at 9:02 A.M., observation of LPN #112 and #114 provide the physician ordered treatment to Resident #9's skin tear to his left outer leg revealed a quarter size wound with a reddish wound bed. No concerns were observed with the dressing change. 2. Review of the medical record for Resident #12 revealed an initial admission date of 04/11/24 with the diagnoses including but limited to cerebrovascular accident, diabetes mellitus, dementia, hyperlipidemia, obesity, gout, major depressive disorder, carotid artery syndrome, osteoarthritis, osteoporosis, peripheral vascular disease, hammer toes, chronic pain, schizoaffective disorder, bipolar type, generalized epilepsy, hypothyroidism, anxiety disorder, anemia and Rheumatoid arthritis. Review of the resident's comprehensive MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no issues with her teeth. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no mouth or facial pain, discomfort or difficulty chewing. Review of the medical record revealed the resident had refused dental services on 09/19/24. Review of the medical record revealed the resident had no documented evidence the resident was seen by a dentist since being admitted to the facility. Review of the plan of care dated 03/17/26 revealed the resident is at risk for dental or chewing problems related to poor dental hygiene. Interventions include apply lip balm/ moisturizer to lips as needed, arrange for periodic dental consult, assist as needed with oral hygiene, including denture care if applicable, diet as ordered by the physician, discuss food preferences and attempt to incorporate them in the special diet, encourage resident to report any oral discomfort, follow up visits by dentistry as scheduled and as needed with coordinating pain management if needed and may use dental swabs if unable to tolerate toothbrush. Review of the dental visit provided by the facility contracted dental assistant revealed the resident was seen on 07/17/25 for her annual visit. The resident's teeth were cleaned and a silver diamine fluoride was applied to several teeth with the intent to arrest decay and prevent further decay. A follow-up appointment would be based on insurance. On 03/18/26 at 2:00 P.M., an interview with the Licensed Social Worker (LSW) #216 revealed the 07/17/25 was probably in an email somewhere. She verified the dental progress noted was not on the resident's medical record. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 03/19/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Logan		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #5 revealed an admission date of 10/31/25 and diagnoses of cerebral infarction, unspecified and unspecified asthma, uncomplicated. Resident #5 was admitted to Buckeye Hospice on 02/05/26. On 03/17/26 at 3:00 P.M. interview with Associate #178 confirmed hospice documentation is not uploaded in resident medical record. Associate #178 confirmed hospice documentation is available in email. Email request sent at 3:11 P.M. Hospice documentation provided. On 03/18/26 at 8:40 A.M. interview with Associate #157 confirmed medical records position was eliminated and there are resident documents in emails that have not been uploaded to medical records. On 03/19/26 at 10:14 A.M. interview with Associate #178 revealed no medical records policy addressing completeness of medical records exists. This deficiency represents non-compliance investigated under Complaint Number 2629172.		