

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Woodview		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 Clime Road Columbus, OH 43223	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on staff and resident interview, medical record review, and policy review, the facility failed to ensure a resident's preference for showers was honored. This affected one (#110) of six resident reviewed for choices. The facility census was 72. Findings include Review of the closed medical record for Resident #110 revealed an admitted [DATE]. Medical diagnoses for Resident #110 included: chronic obstructive pulmonary disease (COPD), acute respiratory failure, osteoarthritis, anxiety, and depression. Review of Resident #110's Minimum Data Set (MDS) quarterly assessment, dated 08/24/24, revealed the resident had intact cognition. The resident's ability to shower/bathe self was coded as resident refused. Review of Resident #110's care plan, dated 04/30/24 and revised on 09/09/24, revealed the resident required assistance for activities of daily living (ADLs) related to diagnoses of COPD, acute respiratory failure, and osteoarthritis. Listed interventions included the resident required weight-bearing assistance with showers by one helper. An additional care plan focus identified Resident #110 as noncompliant with care/treatment ordered by the physician; Resident #110 was listed to refuse treatments, would transfer without assistance, was non-compliant with covid isolation protocols, refused intravenous antibiotic therapy, refused to allow staff members to obtain her weight, and was non-compliant with replacement of intravenous access. There was no mention in the care plan that Resident #110 refused showers. Review of Resident #110's Activity Interview for Daily and Activity Preferences assessment, dated 06/10/24, revealed the resident indicated it was very important for her to choose between a tub bath, shower, bed bath or sponge bath. A subsequent assessment, dated 08/18/24, revealed the resident indicated it was somewhat important for her to choose between a tub bath, shower, bed bath, or sponge bath. Review of the undated facility shower schedule revealed showers were scheduled by room number on assigned days and shifts. While a resident, Resident #110 was scheduled for day shift (7:00 A.M. to 7:00 P. M.) showers on Wednesdays and Saturdays. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #110's shower sheets between 06/19/24 and 09/11/24, revealed the resident was not recorded as offered a shower on 06/29/24, 08/17/24, or 08/31/24. Resident #110 refused her showers on 06/19/24, 07/13/24, 07/17/24, 07/20/24, 07/31/24, 08/01/24, 08/03/24, and 08/28/24 with the reason for refusal listed as the resident preferred nighttime showers. A telephone interview on 09/12/24 at 12:27 P.M., with Resident #110 stated she did not receive adequate care while she as a resident of the facility. Resident #110 specified she did not get her showers routinely. Resident #110 wanted her showers at night, and staff would approach her about showers during the daytime. An interview on 09/25/24 at 11:06 A.M., with the Director of Nursing (DON) revealed showers are scheduled by room numbers and Scheduler #376 tracks shower sheets for shower completion. The DON stated Scheduler #376 had the ability to change or revise the shower schedules to accommodate resident preferences. An interview on 09/25/24 at 1:20 P.M., with the DON and Scheduler #376 confirmed Resident #110 had multiple instances of shower refusals, and verified the frequent refusals recorded due to being offered outside the resident's preferences. Scheduler #376 stated she had never adjusted the written shower schedule to accommodate Resident #110's preferences but thought she had verbally told staff to offer the resident showers at night instead. The DON and Scheduler #376 stated the written schedule should have been adjusted to accommodate Resident #110's preferences. Review of the policy titled, Activities of Daily Living (ADLs), revised 10/01/22, revealed the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for ADLs which included bathing, dressing, grooming, and oral care. Review of the policy titled, Resident Rights, revised 06/01/24, revealed the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to choose activities, schedules, health care and providers consistent with his or her interest, assessments and plan of care. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. The policy listed conditions which may demonstrate unavoidable decline in ADLs as including refusals of care and treatment by the resident to maintain functional abilities after efforts by the facility to inform and educate about benefits/risks of proposed care and treatment, and counsel and/or offer alternatives to the resident. This deficiency represents noncompliance investigated under OH00157521 and OH00157624.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47990 Based on observation, resident interview, staff interview, medical record review, and policy review, the facility failed to timely notify a resident's family of a change in condition. This affected one (#58) of six residents reviewed for notification of change in condition. The facility census was 72. Findings include: Review of the medical record for Resident #58 revealed an admitted [DATE]. Medical diagnoses included vascular dementia, congestive heart failure, and acute COVID-19. Review of Resident #58's Minimum Data Set (MDS) quarterly assessment, dated 08/14/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Review of Resident #58's interdisciplinary progress notes revealed a note dated 09/10/24 at 1:05 P.M. which stated Resident #58 tested positive for COVID-19 infection. Certified Nurse Practitioner (CNP) #825 was notified and new orders were received. Resident #58 was seen by Medical Director (MD) #900 on 09/11/24 who noted the resident had an acute COVID-19 infection. Resident #58 was recorded as asymptomatic, but MD #900's note stated to monitor the resident's hydration and oral intake. Review of subsequent notes revealed no recorded notification to the resident's family recorded in the resident's record. An observation on 09/18/24 at 1:02 P.M., revealed a family member of Resident #58 approached the front desk and asked who she could speak to regarding Resident #58's care. The family member's voice was raised and she stated she arrived at the facility to visit Resident #58, entered his room, and gave him a big hug. Resident #58 informed her to back up as he did not want to get her sick and subsequently told her he had tested positive for COVID-19 approximately a week earlier. The family member stated she was never notified and was one of Resident #58's listed emergency contacts. The family member was escorted to an administrative office for further discussion. An observation and interview on 09/18/24 at 1:15 P.M., revealed Resident #58 seated in his room in his wheelchair. Signage outside the doorway revealed the resident was in transmission based precautions. Personal protective equipment (PPE) was noted as directly outside the resident's room. Resident #58 stated he was not feeling ill and had no symptoms, but he had tested positive for COVID-19 on 09/10/24. Resident #58 stated he was surprised no one notified his family and confirmed his family member who just visited was listed as one of his emergency contacts. An interview on 09/19/24 at 7:26 A.M., with the Director of Nursing (DON) confirmed Resident #58's family member was not notified of his positive COVID-19 test result on 09/10/24. She spoke with Resident #58's family member yesterday and apologized to them for the confusion. The DON stated the facility was utilizing multiple agency nurses at that time who were not aware of the facility's policy regarding notification of changes. The DON confirmed the resident's family should have been notified of Resident #58's positive test result and had initiated re-education of all nurses on notification of change in condition. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Notification of Changes, dated 06/01/24, revealed the facility must inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change. Circumstances requiring notification include circumstances that require a need to alter treatment. This may include a new treatment, or discontinuation of a current treatment, due to adverse consequences, an acute condition, or an exacerbation of a chronic condition. Other circumstances requiring notification include a transfer or discharge of a resident from the facility. The policy stated that for competent individuals, the facility still must contact the resident's physician and notify the resident's representative, if known, of significant changes in the resident's health status because the resident may not be able to notify them personal in the case of sudden illness or accident. This deficiency represents an incidental finding identified during the course of the complaint investigation.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, staff interview, family interview, resident interview, and policy review, the facility failed to ensure Resident #110's family and the Office of the State Long-Term Care Ombudsman was timely notified of the resident's facility-initiated 30-day discharge notice, emergency transfer and subsequent emergency discharge. This affected one (#110) of three residents reviewed for discharges. The facility census was 72. Findings include: Review of the closed medical record for Resident #110 revealed an original admitted [DATE]. Medical diagnoses included bipolar disorder, anxiety, and depression. Resident #110 was emergently transferred to out outside hospital on 09/11/24 and did not return to the facility. Review of Resident #110's Minimum Data Set (MDS) quarterly assessment, dated 08/24/24, revealed the resident had a Brief Interview for Mental Status score of 15 which indicated intact cognition. Resident #110 was not recorded as having any hallucinations, delusions, or behaviors during the review period. Resident #110 was listed as having rejected care on 1-3 days during the lookback period. Review of Resident #110's care plan, dated 06/21/24, revealed the resident does not conform to or understand boundaries of socially accepted behaviors. Resident #110 is verbally abusive towards staff, uses profanity towards staff, and has the potential for continued behaviors. Listed interventions included to discuss with the resident regarding unacceptable behavior, refer to psych services for evaluation if behaviors continue, remind resident of the need to respect other resident's rights, and remove from anger inducing situations immediately. An additional care plan focus indicated the resident exhibited manipulative behavior and had pocketed narcotics, made false accusations toward and threatening staff, attempted to run others over with her motorized wheelchair and attempting to hit staff with her reacher. Listed interventions included to not argue, bargain or debate with the resident, observe the resident's behavior with family, and to initiate 1:1 monitoring with Resident #110 as needed. Review of Resident #110's census status revealed the resident was hospitalized from 09/03/24 to 09/06/24. Resident #110 had an emergency department (ED) transfer on 09/09/24 and returned to the facility on [DATE]. Resident #110 was transferred to a local ED on 09/11/24 and did not return to the facility. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #110's medical record revealed the resident experienced verbal and physical aggression aimed towards staff and other residents. Resident #110 had an inpatient psychiatric hospitalization from [DATE] to 09/06/24 after being placed on a 72-hour hold by Medical Director (MD) #900. Resident #110 readmitted to the facility on [DATE]. Resident #100's behaviors continued to escalate and the resident had an emergency department (ED) visit on 09/09/24, also for behavioral health concerns. Resident #110 returned to the facility on [DATE] at which time she was placed 1:1 with a staff member for enhanced supervision. Resident #110 was noted to have continued verbal and physical aggression, following staff members, verbally aggressive with interactions, and attempting to follow staff into other residents' rooms without permission. Resident #110 was transferred to a local hospital and provided with an emergency transfer notice which stated she was not able to return to the facility. Review of Resident #110's 30-day discharge notice, dated 09/03/24, revealed the resident's reason for discharge was listed as the safety of individuals in the home is endangered or would otherwise be endangered. The form had Resident #110's name on it, listing her address as the facility's address. The section for representative name and address was blank. Underneath the representative's information was a statement the notice was to be sent to the representative by certified mail, with a return receipt requested. The form stated Resident #110's discharge would take place on 10/03/24 and would not be discharged before this date unless the facility and the resident or resident representative agreed to an earlier date. The form indicated that copies of this notice had been sent to the Office of the State Long-Term Care Ombudsman and the Ohio Department of Health, Legal Services Office. Review of Resident #110's Application for Emergency Admission (commonly known as a pink slip or 72-hour hold), dated 09/11/24, revealed the resident remained aggressive towards other residents and staff since hospital observation. Patient is a safety concern following staff and trying to run them over with her wheelchair. She is recording other residents and staff without their permission. She has threatened to kill another resident and is saying she will get on top of her and attempt suffocation. Resident #110's family had tried to break into facility after hours with the local police department involved. The form was signed by MD #900. Review of Resident #110's Transfer Notice, dated 09/11/24, noted due to the circumstances noted on the form, the resident will be transferred from the facility immediately or as soon as appropriate arrangements for transfer can be made. The form noted Resident #110 was currently residing in the facility. The form listing the representative's information (name, email, and address) were blank. The transfer location was blank. The reason for transfer was listed as the safety of individuals in the home is endangered and the reason for urgency was listed as an emergency exists in which the safety of individuals in the home is endangered. The form indicated a copy of the notice has been sent to the Ohio Department of Health (ODH) Office of General Council via email. The form listed the Office of the State Long-Term Care Ombudsman would be notified within 30 days from the date of transfer. A telephone interview with Resident #110 on 09/12/24 at 12:27 P.M., with Resident #110 revealed she was at a local hospital awaiting to find new placement as the facility would not allow her to re-admit. Resident #110 stated although she did not receive great care at the facility, she thought of the facility as her home and wished to return. When asked if she had appealed the discharge, Resident #110 stated she was unsure what the appeal process was and denied receiving a copy of her 30-day discharge notice dated 09/03/24 or immediate transfer/discharge notice dated 09/11/24. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/17/24 at 10:25 A.M., with a family member of Resident #110 revealed she had not been notified of Resident #110's hospital transfers on 09/03/24, 09/09/24 or 09/11/24. The family member stated she found out after-the-fact the facility had pink slipped Resident #110. She was never phoned about any of Resident #110's behaviors, hospital transfer, or her returns to the facility. The family member stated she was contacted by a local hospital a few days ago informing her that the facility evicted Resident #110 and would not allow the resident to return. The family member said none of Resident #110's family members has the ability to care for Resident #110 in the community. The family member indicated she was the resident's emergency contact and had not received a call or letter in the mail regarding any discharge or transfer notices. An interview on 09/25/24 at 11:15 A.M., with the Administrator confirmed the facility did not phone to notify the resident's family upon her transfer to the hospital on 09/03/24, 09/09/24, or 09/11/24. The Administrator stated she overheard Resident #110 on the phone while she was exiting the facility on 09/11/24, believed her to be speaking to a family member, and stated they are sending me back to the hospital. Administrator confirmed she did not have evidence to support Resident #110's family being notified of the transfer, or that the resident was not welcome to return to the facility and confirmed the resident's representative was not provided or sent written copies of Resident #110's 30-day and immediate transfer notices. A subsequent interview on 09/25/24 at 1:50 P.M., with the Administrator confirmed the Office of the State Long-Term Care Ombudsman and ODH had not been notified of the resident's 30-day and immediate discharge/transfer notices dated 09/03/24 and 09/11/24 respectively. The Administrator stated she believed she only had to submit the transfer/discharge log to the ombudsman on a monthly basis. The Administrator confirmed when Resident #110 exited the facility on 09/11/24, it was intended to be permanent and not a temporary therapeutic leave from the facility. Review of the policy titled, Transfer and Discharge (including AMA), revised 01/01/24, revealed the facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: the specific reason and basis for transfer or discharge, effective date of transfer or discharge, the specific location to which the resident is being transferred or discharged to, an explanation of the right to appeal the transfer or discharge to the State, the name, address, and telephone number of the State entity which receives such appeal hearing requests, information on how to obtain an appeal form, information on obtaining assistance in completing and submitting the appeal hearing request, and the name, address and phone number of the representative of the Office of the State Long-Term Care Ombudsman. Generally, the notice must be provided at least 30 days prior to a facility-initiated discharge. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident. In these exceptional cases, the notice must be provided to the resident, resident's representative, and the Long Term Care ombudsman as soon as practicable before the transfer or discharge. The facility will maintain evidence that the notice was sent to the Ombudsman. This deficiency represents non-compliance investigated under Complaint Number OH00157521.		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 47990 Based on observation, medical record review, review of hospital records, review of physician's notes and wound assessments, appointment reminder notice review, interviews with residents, family, outside entities, and staff, and policy review, the facility failed to provide adequate, timely and necessary care and services, including timely re-scheduling of vascular surgeon appointments for Resident #100, who had vascular wounds to meet the resident's total care needs. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm beginning on 07/16/24 when a vascular surgery follow-up appointment (with plans to discuss blood flow to the resident's lower extremities) was canceled with no evidence of attempts by facility staff to re-schedule or schedule a new vascular surgery consult until 08/14/24, when an appointment was made for the following week with a new vascular surgeon. However, prior to the appointment, on 08/18/24, Resident #100 suffered a significant change in condition with increasing lower extremity pain unrelieved by as-needed opioid narcotic analgesics and bleeding from his lower extremity wounds resulting in the resident being transferred to a local hospital. Resident #100 was admitted to the intensive care stepdown unit and required a 25-day inpatient hospitalization for sepsis (systemic infection) and infected vascular wounds. The hospital vascular surgeon noted the resident's potential for lower extremity re-vascularization procedures as limited if not non-existent. Resident #100 required lengthy courses of multiple intravenous antibiotics, extensive wound care, and his hospital course was complicated by an acute kidney injury requiring temporary hemodialysis treatments. Resident #100's wounds and overall health continued to decline, and on 09/06/24, Resident #100's legs were documented to be not salvageable with discussion of possible emergent amputations. Resident #100 and his family considered the options and ultimately decided against amputations and opted for end-of-life care with hospice at another skilled nursing facility. Additionally, the facility failed to transcribe and schedule appointments for Residents #27 and #34, whose hospital after visit summaries listed the need for follow up appointments with outside specialists, which placed Residents #27 and #34 at risk for the potential for more than minimal harm that was not Immediate Jeopardy. This affected three residents (#100, #27, and #34) of eight residents reviewed for missed appointments and changes in condition. The facility census was 72. On 09/19/24 at 10:29 A.M., the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RCDS) #490 were notified Immediate Jeopardy began on 07/16/24 when Resident #100 arrived at a scheduled follow-up appointment and was notified the appointment had been canceled. Resident #100, who was accompanied by a facility staff member, returned to the facility. There was no evidence of attempts by facility staff to re-schedule or schedule a new vascular surgery consult until 08/14/24, when an appointment was made for the following week with a new vascular surgeon. On 08/18/24, Resident #100 suffered a change in condition with increasing lower extremity pain unrelieved by his as-needed opioid narcotic analgesics and bleeding from lower extremity wounds, for which he was transferred to a local hospital. Resident #100 was admitted to the intensive care stepdown unit and required a 25-day inpatient hospitalization for sepsis (systemic infection) and worsening vascular wounds. The hospital vascular surgeon noted the resident's potential for re-vascularization procedure as limited if not non-existent. Resident #100 required lengthy courses of intravenous antibiotics, extensive wound care, and his hospital course was complicated by an acute kidney injury and progressive gangrene to his left lower extremity. Resident #100's wounds and overall health continued to decline, and on 09/06/24 Resident #100's legs were recorded as not salvageable and discussed possible emergent amputations. Resident #100 and his family considered the options and ultimately decided against amputations and opted for end-of-life care with hospice at another skilled nursing facility. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on 09/23/24 when the facility implemented the following corrective actions: On 08/18/24, Resident #100 was transferred to the hospital and admitted for treatment. The resident did not return to the facility. On 09/19/24 at approximately 11:00 A.M., the Administrator, RDCS #490 and Regional Director of Operations (RDO) #485 educated DON, Licensed Practical Nurse (LPN)/ Assistant Director of Nursing (ADON) #238 and Scheduler #376 on proper documentation, uploading of new orders, and setting up transportation for new appointments. On 09/19/24 at approximately 1:25 P.M., all staff education was completed on the facility abuse policy. This was completed by the Administrator. On 09/19/24 at approximately 2:45 P.M., an initial audit of all outside resident appointments for all current residents was completed by the DON and Scheduler #376. Any discrepancies were fixed immediately. On 09/19/24 at 3:25 P.M., all current residents received a head-to-toe assessment completed with no change in conditions or negative outcomes noted. This was completed by LPN #392, Agency Registered Nurse (RN) #645 and Agency RN #678. On 09/19/24 at 3:37 P.M., the DON notified facility Medical Director (MD) #900 of the concerns involving Resident #100 identified by the State agency. On 9/19/2024 at approximately 3:50 P.M., an ad hoc Quality Assurance Performance Improvement (QAPI) committee met to review the facility appointment scheduling process. The Administrator, DON, RDCS #490 and RDO #485 attended. On 09/19/24, a new tracking log was implemented to track additional details of residents outside appointments. The log included the resident's name, the appointment date and time, transportation arrangements, the need for staff assistance, whether the appointment was completed, whether the appointment needed re-scheduled, and if there was any follow up needed. Scheduler #376 is responsible for maintaining and updating the log five days per week with oversight from the Administrator. Pertinent information regarding appointments will be shared with the interdisciplinary team five days a week, weekly on an ongoing basis. Beginning on 09/19/24, the DON or designee will monitor 24-hour report and all new orders 5 days a week on an ongoing basis. Beginning on 09/19/24, an ongoing audit of post-admission chart reviews will be completed to ensure the admitting nurse accurately transcribed physician's orders. This will be completed by LPN/ADON #238 on the first business day following resident admission or re-admission, with the DON as a back-up reviewer. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 09/20/24, an ongoing audit of appointments and transportation will be conducted to ensure appointments are accurately transcribed into the resident's record and are added to the appointment tracking log for verification of appointment attendance. This will be completed by the DON or designee, five times weekly, on an ongoing basis and communicated to the interdisciplinary team during morning meetings. Beginning on 09/20/24, an ongoing audit of outside resident appointments and transportations as listed on the appointment tracking log and will be conducted three times weekly, on random days of the week, by the Administrator. This will be completed 3 times/week on an ongoing basis. Beginning on 09/20/24, a staffing huddle was implemented with direct care staff to communicate upcoming scheduled appointments, needs for the appointment, and transportation arrangements. This huddle will occur five times weekly, Monday through Friday, at approximately 10:00 A.M., following the conclusion of morning meeting. Any potential weekend appointments will be communicated on Fridays. The staffing huddle will be coordinated by the Administrator and/or DON or designee. Beginning on 09/23/24, the Administrator will send the appointment tracking log to RDO #485 and RDCS #490, three times weekly on Monday, Wednesday and Fridays, for four weeks. Beginning the week of 09/23/24, a random audit of outside resident appointments and transportations will be conducted weekly, by RDO #485 or RDCS #490, for additional oversight for a duration of 4 weeks. On 09/23/24 at approximately 4:00 P.M., staff nurses were educated on scheduling appointments, transcribing appointment orders, and monitoring appointment attendance. This was completed by the Administrator. On 09/23/24 at approximately 4:30 P.M., two communication binders were implemented and contained pertinent policies, including written appointment scheduling expectations for communication for both agency and staff nurses. Pertinent policies and updates will be placed in the communication book on an ongoing basis by the DON or designee. Results of ongoing audits will be reported and reviewed through the facility QAPI committee for 6 months and randomly thereafter. The next regularly scheduled QAPI meeting is planned for 09/27/24 at 12:30 P.M. During interviews conducted on 09/23/24 between 3:53 P.M. and 1:10 P.M., and on 09/24/24 between 7:21 A.M. and 3:10 P.M., Licensed Practical Nurse (LPN) #392, Registered Nurse (RN) #294, LPN #300, LPN #222, RN #398, RN #334, LPN #305, LPN/ADON #238, and Scheduler #376 verified receiving education on the facility appointment scheduling process. Although the Immediate Jeopardy was removed on 09/23/24, the deficiency remained at Severity Level 2 (no actual harm with the potential for more than minimal harm as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the closed medical record for Resident #100 revealed an original admitted [DATE]. Medical diagnoses included peripheral vascular disease (PVD), cellulitis, and an unspecified disorder of arteries and arterioles. Resident #100 was noted to have chronic vascular wounds to his bilateral lower extremities, for which he had been previously hospitalized and treated from 06/02/24 to 06/07/24. Resident #100 was transferred to a local hospital on 08/18/24 and did not return to the facility. A plan of care initiated on 04/25/24 (and revised on 07/03/24), noted Resident #100 had actual areas of skin impairment related to chronic venous stasis ulcers to multiple locations on the bilateral lower extremities. Listed interventions included to provide the ordered treatment, ask resident regarding pain levels prior to dressing changes and medicate as needed, enhanced barrier precautions in place, elevate legs as tolerate, and encourage movement of legs and walking. A plan of care dated 05/10/24, noted Resident #100 had inadequate blood circulation or ineffective tissue perfusion related to peripheral vascular disease (PVD). Listed interventions included to administer medications as ordered, observed for side effects and effectiveness, complete laboratory/diagnostic work as ordered, and to follow up as indicated. An additional focus care plan dated 07/10/24, listed the resident as noncompliant with care and treatment as ordered by the physician, with specifics listing the resident was non-compliant with a post-operative shoe, COVID isolation precautions, and rolling his own tobacco. There were no recorded specifics about the resident refusing ordered wound care or ADL care. Listed interventions included to stop care when resident upset and try again later, approach calmly, without rushing and speak in a calm voice, explain procedures and observe and document mood and behavior changes in the nurse's notes or monthly tracking forms if indicated. Review of Resident #100's physician's orders revealed an original order dated 04/26/24, for a vascular surgery appointment on 07/16/24. The order was revised on 06/27/24 and 07/11/24 to provide transportation details and to add start and end dates. Review of Resident #100's prior hospitalization discharge summary from Hospital #02, dated 06/07/24, noted Resident #100 was transferred from Hospital #01 on 06/02/24 for an evaluation of his lower extremity wounds. Resident #100 was noted to have sepsis secondary to his lower extremity vascular wounds at this time. Resident #100 was noted to have diffuse peripheral arterial disease (PAD)/PVD and recommended a revascularization evaluation. The summary indicated Resident #100 was not able to have any vascular intervention during the hospitalization as the resident lacked decision-making capacity to consent to a surgery with complex risks due to altered mental status. The discharge summary noted no health care power of attorney (HCPOA) was in place and no alternate decision makers were able to be located or contacted. Resident #100's mental status improved during the hospitalization, but the concern was still present regarding capacity to understand the risks and benefits completely for a serious procedure. Resident #100 had shared he was established with Vascular Surgeon #500, who was affiliated with Hospital #01, and wanted to get a second surgical opinion from him post-hospital discharge. The summary indicated the plan was to discharge Resident #100 back to the facility, and for the resident to follow up with Vascular Surgeon #500 as an outpatient at the provider's office. The discharge summary noted there was a poor prognosis for Resident #100's legs without vascular intervention, with salvage unlikely even if revascularization was possible. The discharge summary listed Resident #100 as having a follow up appointment with Vascular Surgeon #500 on 06/18/24 to discuss blood flow to the legs, and to call the office to confirm the appointment. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #100's hospital after visit summary, dated 06/07/24, revealed Resident #100 had follow up appointments scheduled prior to hospital discharge. On 06/18/24 at 2:00 P.M., Resident #100 was scheduled for a cardiovascular ultrasound of the carotid (neck) arteries, with the address and phone number listed. A second appointment following the ultrasound was listed for 06/18/24 at 3:00 P.M., with Vascular Surgeon #500. A third appointment was listed for 07/16/24 at 10:00 A.M., also with Vascular Surgeon #500, with the provider's office address and phone number listed. Review of Resident #100's interdisciplinary progress notes revealed a note dated 06/18/24 at 1:30 P.M., which stated the resident was transported to his appointment. He was alert and oriented times three (indicating orientation to person, place and time) with no signs of distress as he was escorted to his appointment. A subsequent note also dated 06/18/24 and timed 2:30 P.M., revealed Resident #100 returned to the facility from appointment in stable condition with no signs of distress. The resident's appointment had been rescheduled to 07/16/24 at 10:00 A.M. Review of an appointment reminder notice, dated 06/18/24, revealed Resident #100 was noted to have an upcoming vascular surgery appointment on 07/16/24 at 10:00 A.M. Listed instructions included to bring photo identification, a current list of medications, and any insurance information and a copayment if required. The office address, phone and fax number were listed on the notice and the notice listed to call the office at a provided number to cancel or reschedule the appointment. Resident #100 had an order dated 07/03/24, for bilateral lower extremity wound dressings. The order instructed to cleanse wounds with normal saline and pat dry. Apply normal saline moist-to-dry dressing, cover with abdominal pads, wrap with kerlix (rolled gauze) and wrap with ACE (compression) wraps, change daily and as needed. Review of Resident #100's Treatment Administration Record (TAR) for July 2024 revealed Resident #100's daily bilateral wound dressings were completed as ordered, except on four days, 07/05/24, 07/07/24, 07/11/24, and 07/19/24, on which the resident was recorded to have refused. The TAR was blank for 07/30/24, indicating Resident #100 did not receive his ordered treatment on this date. Review of a nurse's note for July 2024 revealed there was no notation of education being provided on wound care or rationale for why the resident refused ADL and/or wound care on the days listed. Subsequent review of the progress notes revealed no corresponding documentation on the reason Resident #100 refused his wound care, that education was provided, or that staff had re-approached or re-offered wound care on the dates he refused. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Subsequent review of Resident #100's interdisciplinary progress notes between 06/18/24 and 08/14/24, revealed no notes on or around 07/16/24, reflecting attendance to an outside vascular surgery appointment on this date. There were no notes during the time frame regarding any missed appointments, any attempts to reschedule an appointment, or any attempts finding the resident a new vascular surgeon. Resident #100 was recorded as seeing MD #900 on 06/20/24 and 07/10/24, who noted the resident was previously seen by a vascular surgeon while in the hospital who recommended an outpatient visit to discuss a revascularization procedure versus amputation of the lower extremities, and to follow up with Vascular Surgeon #500. Resident #100 was recorded as seeing Certified Nurse Practitioner (CNP) #875 on 06/21/24 and 07/19/24, who noted the resident had a vascular surgery follow up appointment scheduled on 07/16/24. Resident #100 was additionally seen by CNP #825 on 07/01/24, 07/08/24, 07/18/24, 07/22/24, 08/01/24, 08/05/24, and 08/12/24. Each of CNP #825's visits noted the resident needed to follow up with a vascular surgeon. The note dated 08/01/24, indicated specifically to schedule a follow up appointment to discuss bilateral below the knee amputations. CNP #825's note dated 08/05/24, noted a vascular surgery consult was pending, and the note dated 08/12/24, noted Resident #100's prior vascular surgeon no longer accepted his insurance and to refer the resident to a different health system to see a vascular surgeon. A note dated 08/14/24 at 9:00 A.M., authored by LPN/ADON #238 noted an appointment was made with an unnamed vascular surgeon for 08/21/24. Review of Resident #100's Minimum Data Set (MDS) quarterly assessment, dated 08/02/24, revealed the resident had intact cognition. Resident #100 was not recorded to have hallucinations, delusions, verbal or physical behaviors, or rejection of care. Resident #100 was noted to functional limitations in range of motion to both of his lower extremities and required partial/moderate assistance with bathing and applying and removing footwear. Resident #100 required only supervision/set-up assistance with other activities of daily living (ADLs). Resident #100 was non-ambulatory but required only setup or supervision assistance with mobility tasks. Resident #100 was noted to have four venous and/or arterial ulcers at the time of the assessment, for which he received non-surgical dressings. Review of Resident #100's TAR for August 2024 revealed Resident #100's daily bilateral lower extremity wound dressings were documented as administered as ordered on all but two days, 08/10/24 and 08/17/24, on which the resident was recorded as refusing dressing changes. Review of a nurse's note dated 08/18/24 at 5:32 A.M. and 6:55 A.M., noted the resident refused his wound care. A subsequent note dated 08/18/24 at 6:56 P.M., noted the resident refused wound care and ADLs four times. There was no notation education was provided on wound care or rationale for why the resident refused ADL and/or wound care on that day. Subsequent review of the progress notes revealed no corresponding documentation on the reason Resident #100 refused his wound care, that education was provided, or that staff had re-approached or re-offered wound care on the dates he refused. Review of Resident #100's eINTERACT Change in Condition Evaluation, dated 08/18/24, revealed Resident #100 had a noted change to his skin wound or ulcer on 08/18/24. There was no description of what types of wound changes were seen to Resident #100's wounds. Review of Resident #100's eINTERACT Transfer Evaluation, dated 08/18/24, revealed Resident #100 was sent to the hospital on the evening of 08/18/24, due to bleeding from the legs. The form listed the resident as having no pain. The form listed the resident as having pressure ulcers to the lower extremities and provided no description for the number of wounds, appearance of the wound bed or any wound characteristics, nor did the form list what ordered treatments were. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #100's emergency department (ED) records, dated 08/18/24, revealed Resident #100 arrived at the ED of Hospital #01 for bilateral lower leg pain. The ED note indicated Resident #100 voiced he had infections in his legs since January 2024 and was scheduled to see a surgeon somewhere in Ohio later that week to discuss possible amputations. Resident #100 told the ED provider the pain in his bilateral legs was what brought him to the ED, and the note indicated Resident #100 was alert and oriented upon arrival. Resident #100 described his pain as usually controlled with as-needed oxycodone (a narcotic opioid analgesic), but on 08/18/24 the pain was out of control. The ED physician's physical examination described Resident #100 as disheveled with poor personal hygiene upon arrival. Resident #100 was tachycardic (heart rate greater than 100 beats per minute). The physician recorded Resident #100's lower extremity dressings as dirty and saturated upon arrival. Multiple open wounds were observed to Resident #100's bilateral lower extremities, with skin sloughed (dead tissue) from the left foot with surrounding erythema (redness) and edema (swelling). The wounds to the bilateral extremities had a foul odor and purulent drainage (indicative of possible infection). The ED physician was unable to palpate pulses in Resident #100's bilateral lower extremities (a sign of impaired blood flow). Resident #100 was noted to have an elevated white blood cell count (WBC) of 21.00 (normal range 4.5-11.0 K/mcL, indicative of infection). A second ED physician saw Resident #100 and noted the lower extremity wounds to the resident's bilateral lower extremities appeared grossly necrotic with foul smelling drainage, and in conjunction with laboratory evaluation and imaging, there was a concern for significant bilateral lower extremity infection. Imaging of Resident #100's leg showed significant vascular compromise, chronic in nature, and noted the patient would benefit from bilateral lower extremity partial amputation once more stabilized. Resident #100 met criteria for admission to the intensive care stepdown unit for sepsis and severe cellulitis of the bilateral lower extremities. Review of Resident #100's vascular surgery consult note dated 08/19/24 while inpatient at the hospital, noted the resident to have chronic limb-threatening ischemia to his bilateral lower extremities and bilateral lower extremity venous ulcers. The note indicated Resident #100 was known to have chronic bilateral lower extremity wounds that had worsened since the last recorded documentation within the hospital system from June 2024. The note indicated Resident #100's options for revascularization may be limited if not non-existent. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional review of Resident #100's hospital medical records noted the resident required the coordination and care of various specialties throughout a 25-day hospitalization . Resident #100 was seen by an infectious disease physician on 09/19/24. The provider noted leukocytosis (elevated white blood count (WBC) count, indicative of infection), sepsis, and bacteremia (bacteria in the bloodstream) with two multiple infectious organisms identified. The assessment and plan section of the note noted the resident was being treated for bacteremia, bilateral lower extremity wound infections, leukocytosis and PAD. The resident required three intravenous antibiotics to treat the infection and indicated to continue local wound care and supportive care. The note listed Resident #100's prognosis as guarded. Resident #100 was seen by a podiatrist on 08/20/24. The note indicated no podiatric surgery was recommended at that time and agreed with vascular that bilateral below the knee amputations may be the patient's best option. A subsequent note dated 08/22/24, by a second podiatrist noted Resident #100's legs would be salvageable with vascular intervention. The note indicated aggressive surgical intervention could put the resident's legs back together, but without vascular intervention and the levels of disease, an above the knee amputation would be the appropriate course of action. The note stated if Resident #100 did not undergo some procedure, either vascular intervention or above the knee amputation, Resident #100's severe and deep wounds involving the tendons would become severely infected, and Resident #100 would not be able to fight the infection off. Resident #100 saw a nephrologist on 08/23/24, for an acute kidney injury (AKI), severe PAD, hypertension and an elevated vancomycin (antibiotic) level. The note indicated the resident had an AKI related to comorbidity of PAD, receiving intravenous contrast for radiology tests, and multiple intravenous antibiotics with an elevated vancomycin level. The plan indicated the vancomycin was on hold, and nephrology would monitor the patient's laboratory results and symptoms. A subsequent note dated 08/28/24, from an interventional radiologist noted Resident #100 would require the placement of a temporary tunneled internal jugular intravenous line through which the hospital would be able to perform hemodialysis (filtering of the blood when the kidneys are not adequately functioning). Resident #100 received hemodialysis on 08/29/24, 08/30/24, and 08/31/24. A follow-up vascular surgery note dated 09/05/24 revealed the vascular surgeon discussed with Resident #100 that his legs are potentially the source of his deteriorating medical status and that vascular surgery, and his other teams recommend bilateral above the knee amputations. The risks of not proceeding, including worsening infection, sepsis, clinical deterioration to the point of altered mental status (AMS), cardiac arrest, multiorgan failure and death were discussed. Given the risks, Resident #100 declined intervention and was adamant he did not want to live without his legs. The note concluded with a note indicating that the patient was able to properly participate in decision making and the vascular surgery team could not with good conscious proceed with surgery with the patient adamantly declining. The palliative care team was consulted, and after multiple discussions regarding Resident #100's complex and comorbid healthcare needs, Resident #100 and his family ultimately opted to decline amputation and decided to elect for end-of-life care with hospice services at another skilled nursing facility. Interview on 09/12/24 at 10:20 A.M., with Advocate #990, who wished to remain anonymous, revealed familiarity with Resident #100's stays at the facility and hospital admission since 08/18/24. Advocate #990 reported Resident #100, was still inpatient at the hospital, was not doing well. Resident #100 was described as having a lot of pain. Advocate #990 stated Resident #100 and his family had discussed care with the various specialists and elected for end-of-life care with hospice services. Advocate #990 stated Resident #100's legs were so infected that specialists did not believe he would survive a surgery. Advocate #990 stated another concerning aspect to Resident #100's care was that a surgeon was consulted in early June 2024 during a prior hospitalization , and were talking potential lower extremity amputations then, and questioned why Resident #100 did not have any vascular surgery follow up appointments since that time. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on 09/12/24 at 10:32 A.M., with Anonymous Individual #860 revealed the individual was familiar with Resident #100's care and hospital stay. Anonymous Individual #860 stated when Resident #100 arrived at the hospital he appeared to have been neglected at the facility. When he arrived at the ED, he was disheveled; his wound bandages to his lower extremities had been on for a long period of time, and once removed, his vascular wounds appeared infected with a foul odor and purulent drainage. Resident #100 was known to have extensive vascular disease with chronic vascular wounds to his legs. He had previously been seen by a vascular surgeon and had discussed a prior amputation. Anonymous Individual #860 wondered what the hold up was? following up with a vascular surgeon and described Resident #100's decline in condition as heartbreaking and horrifying and questioned how it got to this point. An interview on 09/12/24 at 2:10 P.M., with Scheduler #376 revealed she was the staffing scheduler and scheduled transportation for outside resident appointments. Scheduler #376 assisted in updating a spreadsheet of upcoming appointments but was unable to provide a copy of the current or past months' appointment schedule as entries get deleted after the appointment date had passed. An interview on 09/12/24 at 3:35 P.M., with the Administrator revealed the facility was unable to provide a monthly appointment calendar for outside resident appointments. The facility utilized a spreadsheet to track upcoming resident appointments, but once the appointment date/time passed, the facility deleted the resident and appointment from the spreadsheet. The Administrator reported there was no way to see prior months' data, nor was there a way to see prior versions of the log. The Administrator stated the facility's process was to type orders into the resident's electronic health record (EHR), and the scheduler with review the orders for upcoming appointments to ensure transportation was scheduled. When asked about the process of ensuring residents attend scheduled appointments, the Administrator stated nurses should enter a progress note to indicate the resident attended an appointment and to note any new orders reflected on the hospital paperwork following the appointment. Appointment paperwork would then be scanned into the resident's EHR record as the facility does not have any physical charts. An interview on 09/17/24 at 8:58 A.M., with the DON revealed she was familiar with Resident #100's care. She described Resident #100 as having terrible leg wounds that she believed had progressed because the resident was non-compliant with wound care. The DON reported Resident #100 had longstanding vascular compromise and not enough blood flow to his bilateral lower extremities. The DON reported the resident did see a vascular surgeon and went back and forth with a decision to amputate his legs but was unsure when the resident's last appointment with vascular surgery was. An interview on 09/17/24 at 9:28 A.M., with Certified Nursing Assistant (CNA) #214 revealed she had cared for Resident #100 while he was a resident of the facility. CNA #214 revealed occasionally Resident #100 would refuse showers or hygiene care. CNA #214 was not familiar with the state of Resident #100's wounds or why he had wounds. She heard Resident #100 needed leg amputations and was unsure why he did not return to the facility. During an interview on 09/17/24 at 11:54 A.M., with the Administrator and Scheduler #376 past scheduled appointments for Resident #100 were reviewed. The Administrator and Scheduler #376 reported the resident attended an appointment with Vascular Surgeon #500 on 06/18/24 and again on 07/16/24. When prompted to provide evidence the resident was seen, the Administrator checked Resident #100's progress notes and confirmed the progress notes reflected the 06/18/24 appointment was rescheduled to 07/16/24. The Administ [TRUNCATED]		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff interview, record review, and policy review, the facility failed to ensure safe and sanitary infection control practices were maintained during a dressing change. This affected one (#27) and had the potential to affect sixteen residents who the facility identified as receiving wound care. The facility census was 72. Findings include: Review of Resident #27's medical record revealed an admitted [DATE]. Medical diagnoses included sepsis, chronic kidney disease stage III, and peripheral vascular disease. Review of Resident #27's Minimum Data Set (MDS) Admission assessment, dated 07/20/24, revealed the resident was identified as cognitively intact. He had no recorded behaviors or rejection of care. Resident #27 was identified to require partial/moderate to dependent assistance with activities of daily living and utilized a wheelchair for mobility. Review of Resident #27's care plan, dated as initiated 07/13/24 and revised on 09/12/24, revealed the resident had actual areas of skin impairment as the resident was admitted with vascular wounds to his bilateral lower extremities. Listed interventions included enhanced barrier precautions, wound care treatments as ordered by the provider, and for nursing staff to observe the wound dressing daily to ensure the dressing remains intact and that there are no signs or symptoms of infection or increased drainage. Review of Resident #27's physician's orders revealed an order dated 07/16/24 for gown and gloves to be worn when providing dressing, bathing/showering, transferring, providing hygiene, changing linens or briefs, assisting with toileting, and providing wound care. Resident #27 also had orders dated 09/06/24 for his left plantar foot, right heel and left heel wounds to cleanse with normal saline and pat dry. Apply collagen, cover with a foam dressing, cover with ABD (abdominal pad, an absorbent dressing), wrap with kerlix (rolled gauze) and wrap with an ACE (compression) wrap. Change daily on night shift and as needed. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/18/24 at 7:29 A.M., revealed Certified Nurse Practitioner (CNP) #825 arrived outside Resident #27's room and prepared to perform his weekly wound assessment rounds and dressing changes. CNP #825 stated he was usually assisted by Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #238 but LPN/ADON #238 was out sick. Signage outside of Resident #27's room indicated enhanced barrier precautions were required. CNP #825 was observed to apply a disposable blue gown and clean gloves, knocked, and entered Resident #27's room. The treatment cart was placed in the doorway of the resident's room. CNP #825 removed Resident #27's bilateral lower extremity dressings. He measured the areas, applied the resident's ordered Ammonium Lactate cream to the intact skin on the resident's bilateral lower extremities, and wrote the measurements from each area on a piece of paper on top of the treatment cart. CNP #825 was still wearing the same original pair of gloves he entered the room with, and was observed to open two drawers of the treatment cart, touch supplies inside the drawers, and then close the drawers to the treatment cart. CNP #825 stated he was looking for wound care supplies but they were not located in the cart. CNP #825 exited the resident's room and walked down to the end of the 100-hallway, approximately 60 feet while still wearing his gown and soiled gloves. CNP #825 was observed to open drawers of a second treatment cart positioned against the wall directly in front of the coral nurse's station, and rummage through the drawers, while still wearing the gown and gloves. CNP #825 retrieved supplies from the second treatment cart and proceeded to return towards Resident #27's room. CNP #825 was still wearing the same blue gown and gloves. Just before getting to the doorway of Resident #27's room, CNP #825 removed his gown, previous gloves and applied a new disposable gown and gloves before re-entering Resident #27's room. He was not observed to perform hand hygiene before applying the new gown or gloves. CNP #825 completed the ordered treatment, removed his PPE, performed hand hygiene and exited the resident's room. An interview on 09/18/24 at 7:42 A.M., with CNP #825 confirmed he should have removed his gloves after removing the soiled dressing change, and should have removed both his gown and gloves prior to exiting the resident's room. CNP #825 confirmed it was not good infection control practice to touch the resident's soiled dressings, apply his ordered cream, and touch wound care supplies inside two separate treatment carts with soiled gloves. CNP #825 additionally confirmed he did not wash his hands between PPE changes. An interview on 09/19/24 at 7:26 A.M., with the Director of Nursing (DON) confirmed gloves and gown should be worn in rooms requiring enhanced barrier precautions, such as for residents with chronic wounds. The DON stated gloves and gowns should be removed prior to leaving the resident's room and hand hygiene performed. Gloves worn to remove soiled dressings should be removed and hand hygiene performed prior to application of a new pair of gloves. The DON stated CNP #825 was likely out of sorts without his usual helper, LPN/ADON #238. Review of the policy titled, Enhanced Barrier Precautions, dated 07/13/22, revealed it is the policy to implement enhanced barrier precautions for preventing transmission of novel or targeted multi-drug resistant organisms. An order for enhanced barrier precautions will be obtained for residents with wounds and other indwelling medical devices. Gowns and gloves will be available immediately outside the resident's room. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). Position a trash can inside the resident's room and near the exit for discarding personal protective equipment (PPE) after removal, prior to exit of the room, or before providing care for another resident in the same room. (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: 365673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Woodview		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 Clime Road Columbus, OH 43223	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Clean Dressing Change, dated 06/01/24, revealed it is the policy of the facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. The policy included steps to wash hands and put on clean gloves. Remove the existing dressing. Remove gloves, pulling inside out over the dressing and discard into appropriate receptacle. Wash hands and put on clean gloves. Cleanse the wound as ordered, taking care not to contaminate other surfaces and pat dry with gauze. Measure the wound, wash hands and put on clean gloves. Apply topical ointments or creams and dress the wound as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00157624.		