STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365673	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodview	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews, staff interviews, review of a Medication Error form, and review of facility policy, the facility failed to ensure residents medications were administered as ordered. This affected four (#42, #50, #63 and #71) out of the seven residents reviewed for medication administration. The facility census was 70. Findings include: 1. Record review for Resident #42 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure with hypoxia, cerebral infarction, and anoxic brain damage. Review of the physicians order, dated [DATE], revealed the resident was to be administered the anticoagulant Lovenox 15 milligrams (mg) once a day to prevent deep vein thrombosis (blood clot). Review of the physicians order, dated [DATE], revealed the resident was to be administered the anticonvulsant levetiracetam 7.5 mg twice a day for seizures. Review of the Medication Administration Record (MAR) for ,d+[DATE] revealed scheduled doses of Lovenox were documented to have not been administered on [DATE] or [DATE]. The scheduled doses of levetiracetam were documented to have not been administered in the evening on [DATE] or the morning on [DATE]. Review of the progress note, dated [DATE] and timed 8:50 P.M., revealed levetiracetam was not available for administration, waiting on pharmacy to supply. Review of the progress note, dated [DATE] and timed 2:13 P.M. revealed levetiracetam was not available for administration, waiting on pharmacy to deliver. Review of the nurses progress note, dated [DATE], revealed the nurse notified the physician the resident did not receive levetiracetam on [DATE] or [DATE] as ordered due to the pharmacy not delivering the medication. Review of the progress note, dated [DATE] and timed 10:28 A.M., revealed the Lovenox was not available, reordered from pharmacy. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note, dated [DATE] and timed 10:30 A.M., revealed the physician and resident's spouse were notified of the missed dose of Lovenox. The medication was reordered from pharmacy. Review of the progress note, dated [DATE] and timed 9:51 A.M., revealed the Lovenox was not available for administration, will call pharmacy. Interview with the Director of Nursing (DON) on [DATE] at 3:00 P.M. confirmed Resident #42 did not receive doses of Lovenox and levetiracetam as ordered due to the medications not being available. Review of the facility policy titled Medication Errors, dated [DATE], revealed the facility shall ensure medications will be administered according to physicians orders. 2. Record review for Resident #63 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute osteomyelitis of the right of the right ankle and foot, sepsis, and diabetes mellitus. Review of the physicians order, dated [DATE], revealed the resident was to be administered the antidiabetic medication Rybelsus 3 mg once daily in the morning. Review of the MAR for for ,d+[DATE] revealed scheduled doses of Rybelsus were documented to have not been administered as ordered on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], or [DATE]. Review of the progress note, dated [DATE], revealed Rybelsus not available, awaiting medication to arrive from pharmacy. Review of the progress note, dated [DATE], revealed Rybelsus not available, waiting on medication to arrive from pharmacy. Review of the progress note, dated [DATE], revealed Rybelsus not available, awaiting medication to arrive from pharmacy. Review of the progress note, dated [DATE], revealed Rybelsus not available, pending pharmacy delivery. Review of the progress note, dated [DATE], revealed Rybelsus not available, pending pharmacy delivery. Review of the progress note, dated [DATE], revealed awaiting Rybelsus to arrive from pharmacy. Review of the progress note, dated [DATE], revealed Rybelsus to arrive from pharmacy today. Review of the progress note, dated [DATE], revealed Rybelsus pending delivery from pharmacy. Review of the progress note, dated [DATE], revealed awaiting Rybelsus from pharmacy. Review of the progress note, dated [DATE], revealed awaiting Rybelsus to arrive from pharmacy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note, dated [DATE], revealed awaiting Rybelsus to arrive from pharmacy. Review of the physicians order, dated [DATE], revealed the resident was to be administered the antibiotic Bactrim ,d+[DATE] mg twice daily for 10 days for signs and symptoms of a wound infection. Review of the MAR for ,d+[DATE] and ,d+[DATE] revealed scheduled doses of Bactrim were documented to have not been administered in the morning or evening on [DATE] or [DATE]. Review of the progress note, dated [DATE] and timed 12:23 P.M., revealed Bactrim on order and supply in the emergency kit depleted. Review of the progress note, dated [DATE] and timed 9:03 P.M., revealed Bactrim not available, on order from pharmacy. Review of the progress note, dated [DATE] and timed 9:43 A.M., revealed Bactrim not available. Pharmacy was notified and will send medication on next delivery. Review of the progress note, dated [DATE] and timed 11:46 P.M., revealed waiting for pharmacy to deliver Bactrim. Interview with the DON on [DATE] at 12:10 P.M. confirmed Resident #63 was ordered to receive Rybelsus 3 mg once a day, but the medication was not sent to the facility until [DATE] according to pharmacy records. The DON confirmed the medication was not kept in the emergency drug kit maintained at the facility so the resident could not have received ordered doses of the medication from the time the resident was admitted on [DATE] until the medication was delivered on [DATE]. The DON confirmed additional doses were documented to have not been administered after [DATE] and was unsure why since the medication should have been available. The DON additionally confirmed doses of Bactrim were not administered as ordered due to the medication not being available. 3. Review of the medical record for Resident #71 revealed this resident was admitted to the facility on [DATE]. Diagnoses included urinary tract infections, osteomyelitis, hypertension, hyperlipidemia, respiratory failure, morbid obesity, chronic left leg ulcer, and bacteremia. Review of physician orders revealed the resident was to receive Methadone 35 mg by mouth twice daily for chronic pain. Review of the MAR for the month of [DATE] revealed the resident had missed the evening dose of this medication on [DATE], both doses on [DATE] and [DATE], and the morning dose on [DATE] as they were not available from the pharmacy due to an expired prescription. Review of the Medication Error form, completed on [DATE], revealed Resident #71 received Oxycodone 5 mg (7 tablets) by mouth instead of Methadone 5 mg (7 tablets). Resident #71 received the wrong medication on that date. Interview with the DON [DATE] at 3:00 P.M. verified Resident #71 had received the wrong medication of Oxycodone 35 mg instead of Methadone 35 mg. The Director of Nursing also verified this resident had multiple missed dosages of Methadone. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #50 revealed the resident was admitted to the facility on [DATE]. Diagnoses included osteomyelitis, anemia, bacteremia, Hepatitis C, opioid dependence, muscle weakness, anxiety, and depression. Review of physician orders revealed the resident was to receive Methadone 35 mg by mouth twice daily for chronic pain. Review of the Medication Error form, completed on [DATE], revealed the resident received Methadone 10 mg (7 tablets) by mouth instead of Methadone 5 mg (7 tablets). Interview with the DON on [DATE] at 3:00 P.M. verified Resident #50 had received the wrong dosage of Methadone 70 mg instead of Methadone 35 mg. This citation represents noncompliance identified during the investigation of Complaint OH00163995.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews, staff interview, review of a Medication Error form, and review of facility policy, the facility failed to ensure accurate and complete documentation was maintained in residents medical records. This affected three (#50, #63, and #71) out of the seven residents whose medical records were reviewed. The facility census was 70. Findings include: 1. Record review for Resident #63 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute osteomyelitis of the right of the right ankle and foot, sepsis, and diabetes mellitus. Review of the physicians order, dated 12/24/24, revealed the resident was to be administered the antidiabetic medication Rybelsus 3 mg once daily in the morning. Review of the Medication Administration Record (MAR) for 01/2025 revealed scheduled doses of Rybelsus were documented to have been administered as ordered on 01/01/25, 01/02/25, 01/07/25, 01/08/25, and 01/10/25. Review of the progress note, dated 01/05/25, revealed Rybelsus not available, awaiting medication to arrive from pharmacy. Review of the progress note, dated 01/06/25, revealed Rybelsus not available, waiting on medication to arrive from pharmacy. Review of the progress note, dated 01/09/25, revealed Rybelsus not available, awaiting medication to arrive from pharmacy. Review of the progress note, dated 01/11/25, revealed Rybelsus not available, pending pharmacy delivery. Review of the progress note, dated 01/13/25, revealed Rybelsus not available, pending pharmacy delivery. Review of the progress note, dated 01/14/25, revealed awaiting Rybelsus to arrive from pharmacy. Review of the progress note, dated 01/15/25, revealed Rybelsus to arrive from pharmacy today. Review of the progress note, dated 01/16/25, revealed Rybelsus pending delivery from pharmacy. Review of the progress note, dated 01/23/25, revealed awaiting Rybelsus from pharmacy. Review of the progress note, dated 01/28/25, revealed awaiting Rybelsus to arrive from pharmacy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note, dated 01/29/25, revealed awaiting Rybelsus to arrive from pharmacy. Interview with the Director of Nursing (DON) on 04/09/25 at 12:10 P.M. confirmed Resident #63 was ordered to receive Rybelsus 3 mg once a day, but the medication was not sent to the facility until 01/15/25 according to pharmacy records. The DON confirmed the medication was not kept in the emergency drug kit maintained at the facility so the resident could not have received ordered doses of the medication from the time the resident was admitted on [DATE] until the medication was delivered on 01/15/25. The DON confirmed doses of Rybelsus documented to have been administered on the MAR from 01/01/25 through 01/15/25 were completed in error and were inaccurate. 2. Review of the medical record for Resident #71 revealed this resident was admitted to the facility on [DATE]. Diagnoses included urinary tract infections, osteomyelitis, hypertension, hyperlipidemia, respiratory failure, morbid obesity, chronic left leg ulcer, and bacteremia. Review of physician orders revealed the resident was to receive Methadone 35 mg by mouth twice daily for chronic pain. Review of the Medication Error form, completed on 02/18/25, revealed Resident #71 received Oxycodone 5 mg (7 tablets) by mouth instead of Methadone 5 mg (7 tablets). Resident #71 received the wrong medication on that date. This form was provided by the facility and was not included in the permanent resident record. The form states these pages are privileged and confidential and not part of the medical record. The medical record contained no documentation of this error. Interview with the DON on 04/07/25 at 3:00 P.M. verified Resident #71 had received the wrong medication of Oxycodone 35 mg instead of Methadone 35 mg. Review of the the facility policy titled Medication Error, revision date of 01/01/25, revealed all medications are to be provided per physician orders. It also states that if a medication error occurs the facility will document medication errors in the official medical record. 3. Review of the medical record for Resident #50 revealed the resident was admitted to the facility on [DATE]. Diagnoses included osteomyelitis, anemia, bacteremia, Hepatitis C, opioid dependence, muscle weakness, anxiety, and depression. Review of physician orders revealed this resident was to receive Methadone 35 mg by mouth twice daily for chronic pain. Review of the Medication Error form completed on 03/15/25 revealed this resident received Methadone 10 mg (7 tablets)by mouth instead of Methadone 5 mg (7 tablets). This form was provided by the facility and was not included in the permanent resident record. The form states these pages are privileged and confidential and not part of the medical record. The medical record contained no documentation of this error. Interview with the DON on 04/07/25 at 3:00 P.M. verified Resident #50 had received the wrong dosage of Methadone 70 mg instead of Methadone 35 mg. The Director of Nursing also verified this medication error should be included in the permanent medical record of this resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This represents an incidental finding of non-compliance discovered during the complaint investigation.