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	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodview	2770 Clime Road Columbus, OH 43223

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52020 Based on observations, resident interviews, staff interviews and record review, the facility failed to ensure there was a sufficient supply of washcloths, hand towels and bath towels to complete resident care. This shortage affected two residents (#8 and #21) and had potential to affect all 70 residents residing in the facility. The facility census was 70. Findings include: Resident #8 was admitted to facility on 10/27/22 with primary diagnosis of Parkinson's Disease and additional diagnoses of congestive heart failure, Type II Diabetes, anxiety and depression. Review of Resident #8's Minimum Data Set (MDS) assessment, dated 02/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. Interview on 05/08/25 at 8:28 A.M. with Resident #8 revealed she believed there was a shortage of washcloths and towels every other day. Resident #8 said because of the shortage, her showers had been delayed until 3rd shift on multiple occasions. Resident #8 stated her preference was to receive a shower after breakfast in the morning on day shift. Review of shower schedule revealed Resident #8 was scheduled to receive showers on Mondays and Thursdays between 7:00 A.M. and 7:00 P.M. Interview on 05/08/25 at 9:24 A.M. with Director of Nursing (DON) revealed the shower schedule did not change from week to week between day shift and night shift. Review of facility documentation of Resident #8's shower record revealed on 04/28/25, Resident #8 received a bed bath during 3rd shift between 7:00 P.M. and 7:00 A.M. There was no documentation of Resident #8 either receiving or refusing a bath or shower on day shift of 04/24/25. There was documentation from 04/24/25 that Resident #8 refused a shower the evening of 04/24/25 during third shift. Interview on 05/08/25 at 8:35 A.M. with Certified Nursing Assistant (CNA) #135 revealed the CNA prioritized which residents received towels based on who woke up first. Observation on 05/08/25 at 8:49 A.M. of the room shared by Resident #39 and Resident #4 revealed no washcloths, hand towels or towels were available in the room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/08/25 at 8:59 A.M. of the linen closet revealed a single towel in the linen closet. Staff #147 verified the single towel in the linen closet at the time of the observation. Observation on 05/08/25 at 9:00 A.M. of the laundry room revealed 11 washcloths, no hand towels and no towels on shelving. Interview on 05/08/25 at 9:00 A.M. in the laundry room with Environmental Services Staff #160 confirmed there were no hand towels or towels on shelving. She said they were all being laundered. Observation on 05/08/25 at 9:05 A.M. in the shared room of Resident #54 and Resident #18 revealed no washcloths, hand towels or bath towels in the room. Resident #54 was present during the observation and confirmed the room had no bath linen available. Observation on 05/08/25 at 9:07 A.M. of the room shared by Resident #2 and Resident #23 revealed no washcloths, hand towels, towels or toilet paper in the room. Resident #23 was present during the observation and verified there were no bath linens present and stated at the moment she was more concerned with not having toilet paper. 2. Resident #21 was admitted to the facility on [DATE] with a primary diagnoses of respiratory failure with hypoxia and additional diagnoses of deep vein thrombosis, discitis, morbid obesity, muscle weakness and depression. Review of Resident #21's Minimum Data Set (MDS) assessment, dated 04/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated she was cognitively intact. Observation on 05/08/25 at 9:48 A.M. revealed no washcloths, hand towels or towel in Resident #21's room. Interview with Resident #21 on 05/28/25 at 9:48 A.M. the resident stated the towels were in the room and were taken away to be used for someone else which upset her since she was waiting to be cleaned up. Resident #21 said she really wanted to wash her face. Observation on 05/08/25 at 11:38 A.M. of the laundry room revealed an out of order sign on a dryer and empty linen shelving with no washcloths, hand towels or towels. Interview on 05/08/25 at 11:30 A.M. with Environmental Services Staff #160 who confirmed dryer had been out of order at least since the previous Friday (six days). She confirmed the cart was usually empty. She said they were always coming up short on linens though noted it has been especially bad lately. She said she had asked management multiple times for more. She said staff has tried to take the linens off the stretchers when residents came from the hospital in order to use those, but those sheets didn't fit the beds. She said they are short on washcloths, hand towels, towels, sheets and Hoyer pads. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 12:06 P.M. with Certified Nursing Assistant (CNA) #132 who confirmed there were times when there was a shortage of towels, hand towels, and washcloths. CNA #132 attributed this to one of the laundry machines being out of order, though noted this was an ongoing issue. The aide shared that more than once when he was unable to find towels in the storage closet, in the laundry room, or on the other unit, he had to resort to using a pillowcase in place of a towel to dry the resident. He said he would rather do this than to not bathe the resident.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51524 Based on observation, interview and record review the facility failed to ensure one (Resident #47) had access to her personal property a motorized wheel chair. This affected one (#47) of two reviewed for personal property. The facility census was 70. Findings include: Resident #47 was admitted to the facility on [DATE] with diagnoses which included acquired absence of left and right leg below the knee, congestive heart failure, chronic obstructive pulmonary disease, osteoarthritis, pain and peripheral vascular disease. Review of Resident 47's admission record reveals she arrived to the facility with an electric wheelchair. Review of the medical record revealed there was no assessments completed for the safe use of the electric wheelchair. Review of the admission minimum data set (MDS) 3.0 dated 02/22/25 revealed Resident #47 mobility is severely limited and requires the use of a wheelchair. Review of progress note dated dated 08/18/24 at 8:23 P.M. revealed Resident #47 ran into another resident in her electric wheelchair. Resident #47 was to be evaluated by occupational therapy for safe operation of her electric wheelchair. Review of Resident #47's record revealed on 09/27/24 occupational therapy noted Resident #47 had poor depth perception when operating a chair and should be evaluated by an optometrist. Review of Resident #47's record revealed on 10/07/24 Resident #47 was discharged from occupation therapy and deemed incapable of safely operating her custom power wheelchair. In an interview with Resident #47 on 05/05/25 at 10:18 A.M. she revealed the facility had taken her electric wheelchair, which was preventing her from being able to move around the premises as she wanted to. Interview with Occupational Therapist (OT) #141 on 05/13/25 at 10:26 A.M. revealed Resident #47 had not yet had her vision evaluated. Interview with DON on 05/13/25 at 10:31 A.M. revealed due to the determination by occupational therapy that Resident #47 could not safely operate her wheelchair, on 12/18/24 the control panel for the wheelchair was moved to the back of the chair so the resident would not be able to operate it herself. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/25 at 10:35 A.M., DON and OT #188 verified there was no order, assessment or plan of care for restricting Resident #47's electric wheelchair operation. They both acknowledged that by limiting the resident's ability to operate the electric wheelchair, it restricted her mobility.

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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** 47987 Based on observations, medical record review, staff interview, and facility policy review, the faciltiy failed to monitor and provide timely/adequate treatments and care for non-pressure skin issues. This affected two (Resident #27 and #47) of six residents reviewed for skin issues. The census was 70. Findings Include: 1. Review of the medical record for Resident #27, revealed an admitted [DATE]. Diagnoses included but were not limited to dementia, cerebral infarction, muscle weakness, anxiety disorder, and chronic kidney disease stage III. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 09 suggested moderate cognitive impairment. The resident was assessed to require total dependence on toilet hygiene, shower/bathe self, bed mobility and transfers. The resident was also assessed to have a foley catheter, to always be incontinent of bowel and to be at risk for pressure ulcer injury. Review of the plan of care dated 3/30/25 for Resident #27 revealed the resident has an actual area of skin impairment and potential for alteration in skin integrity with no interventions involving treatments as ordered. Review of the admission assessment with baseline care plan assessment dated [DATE] for Resident #27 revealed a peri area moisture-associated skin damage (MASD) that measured 8 centimeter (cm) x 15 cm x 0. 1 cm. Review of the medical record dated 03/30/25 through 04/01/25 at 10:10 A.M. for Resident #27 revealed no treatments in place for the peri-area MASD. Further review of physician orders dated 04/01/25 at 10:10 A.M. for this resident revealed MASD to peri-area, cleanse with soap and water, rinse, pat dry and apply triad paste every shift for wound care. Review of the skin grid non pressure assessment dated [DATE] for Resident #27 revealed a left hip skin tear that measured 0.5 cm x 3 cm x 0.10 cm. Review of the medical record dated 04/02/25 through 04/04/25 at 5:15 P.M. for Resident #27 revealed no treatments in place for the left hip skin tear. Review of the physician order dated 04/04/25 at 5:15 P.M. for Resident #27 revealed left hip skin tear to cleanse with wound cleanser, pat dry, and cover with hydrocolloid dressing to wound base every Monday, Wednesday and Friday, and as needed for wound care. Review of the skin grid non pressure assessment dated [DATE] for Resident #27 revealed a right inner thigh abrasion that measured 4.7 cm x 2.2 cm x 0.10 cm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record dated 04/23/25 through 04/25/25 at 11:40 A.M. for Resident #27 revealed no treatments in place for the right inner thigh abrasion. Review of the physician order dated 04/25/25 at 11:40 A.M. for Resident # 27 revealed a right inner thigh wound, cleanse with wound cleanser, pat dry, apply collagen to the wound base and cover with a foam dressing every shift and as needed. Interview on 05/12/25 with the Director of Nursing verified for the peri area MASD documented on admission on 03/30/25 did not have a treatment in place until 04/01/25 at 10:10 A.M., the left hip skin tear documented on 04/02/25 did not have a treatment in place until 04/04/25 at 5:15 P.M. and the right inner thigh abrasion documented on 04/23/25 did not have an order in place until 04/25/25 at 11:40 A.M. 51524 2. Review of the medical record revealed Resident #47 admitted to the facility on [DATE]. Diagnoses included moisture associated skin damage, (MASD) of the right and left buttocks, respectively, venous ulcer of the left lateral shin, and a venous ulcer of the left lateral ankle. Review of Resident # 47's physician's order dated 09/24/24 revealed she was to wear pressure relief boots daily for preventative skin and comfort. There was no end date for the order. Review of Resident #47's medical record revealed the order was discontinued by the facility staff on 10/14/24. Interview with DON on 05/13/25 at 1:36 P.M. confirmed that the order was discontinued by the facility staff and there was no corresponding order from the physician to discontinue donning the boots daily. Review of Resident #47's provider order dated 09/23/24 revealed the left and right buttocks wounds were to be cleansed and an adhesive foam dressing applied to each wound daily. Review of Resident #47's medical record revealed the treatments were not initiated as ordered until 09/27/24. Review of Resident #47's provider order dated 09/23/24 revealed the venous ulcer of the left lateral shin was to be cleansed and an adhesive foam dressing applied. Review of Resident #47's medical record revealed the treatments were not initiated as ordered until 09/26/24. Review of Resident #47's provider order dated 09/23/24 revealed the venous ulcer of the left lateral ankle was to be cleansed, silver alginate applied and covered with an adhesive foam dressing three times per week. Review of Resident #47's medical record revealed the treatments were not initiated as ordered until 09/30/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 05/13/25 at 1:38 P.M. confirmed the treatments were not completed as ordered. Review of the facility policy titled Wound Treatment Management, dated 1/08/25, revealed to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing and frequency of dressing change.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on interviews, record reviews, hospital documentation, observation and review of facility policy, the facility failed to initiate treatment and complete an accurate assessment for a suspected deep tissue injury (SDTI) [persistent non-blanchable deep red, maroon or purple discoloration of the skin] to the bilateral buttocks upon admission on 04/29/25 for Resident #174. Actual Harm occurred on 05/07/25 when Resident #174's SDTI to the bilateral buttocks worsened to four stage III pressure ulcers (full thickness skin loss in which the fat is visible in the ulcer and granulation tissue as well as rolled wound edges are often present) due to not following the Wound Certified Nurse Practitioner's recommendations. The facility also failed to implement pressure ulcer wound care treatments timely for two additional residents (#27 and #47) that placed the residents at risk for the potential for more than minimal harm that was not actual harm. This affected three of three residents reviewed for pressure ulcer treatments and care. The facility census was 70. Findings include: 1. Review of the medical record for Resident #174, revealed an admitted [DATE]. Diagnoses included but were not limited to acute embolism and thrombosis unspecified deep veins of left lower extremity, anxiety disorder, need for assistance with personal care, muscle weakness, unspecified lack of coordination, and Type two Diabetes Mellitus without complications. Review of the hospital discharge documentation dated 04/24/25 for Resident #174 revealed a SDTI to the bilateral buttocks that measured 6 centimeters (cm) x 12 cm x 0.5 cm with a treatment of zinc oxide hydrophilic paste (triad) cream to be applied twice a day and as needed. Review of the admission assessment dated [DATE] revealed the resident required one-person assist with toilet hygiene, bathing and bed mobility. Further review revealed a skin assessment with scattered wounds described as wounds, scrapes, redness with bleeding and weeping on the entire body. The assessment had no documented measurements and no documentation of the SDTI to the bilateral buttocks as indicated on the hospital paperwork. There was no documentation of Resident #174 refusing a full body assessment. Review of a Brief Interview for Mental Status (BIMS) dated 04/29/25 revealed Resident #174 scored a 15 out of 15 indicating the resident was cognitively intact. Review of the plan of care dated 04/29/25 for Resident #174 revealed the potential for alteration in skin integrity with the intervention including but not limited to a complete head to toe assessment upon admission. Resident #174 additionally had a care plan focus of actual area of skin impairment with interventions including but not limited to initiate wound treatment and continue treatments as ordered by the MD/NP. Review of Resident #174's Braden Scale for Predicting Pressure Sore Risk dated 04/29/25 revealed a score of 11.0 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at high risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #174's physician orders dated 04/29/25 revealed the triad cream to the SDTI twice daily and as needed was not included in the physician orders as indicated in the hospital discharge documentation. Review of a skin grid pressure documentation dated 04/30/25 for Resident #174 revealed a SDTI on the bilateral buttocks with no measurements indicating it was acquired in the hospital on 04/21/25. The skin grid revealed the resident refused a full assessment with no indication of the reason, or education provided for the importance of the evaluation, and no follow up attempt to reassess the area. Review of Wound Certified Nurse Practitioner #203's (CNP) note dated 04/30/25 at 2:16 P.M. for Resident #174 revealed when hospitalized prior to admission, it was noted the resident had a SDTI to his bilateral buttocks and was treated with triad cream upon discharge. The Wound CNP #203 documented they were unable to do a complete assessment of the bilateral buttocks at this time due to resident pain, per hospital records recommends triad application twice a day and as needed following the hospital's treatment and will plan to reevaluate and amend recommendations at next visit. Review of the physician's orders from 04/30/25 through 05/07/25 for Resident #174 revealed the treatment for the SDTI to the bilateral buttocks of triad cream twice a day and as needed, as recommended by Wound CNP # 203, was not present in the orders. Further review of Resident #174's record revealed no attempts to reassess the SDTI area and complete a full body assessment. Interview on 05/07/25 at 8:35 A.M. with Resident #174 revealed the facility had not been applying any cream to his buttocks since he had been at the facility and he only refuses care due to pain, if he is medicated prior, he is willing to comply with treatments and care. Interview on 05/07/25 at 8:43 A.M. with the Director of Nursing (DON) revealed when a resident is admitted , the floor nurse does the full body assessment which includes measurements of all wounds and skin conditions. The DON stated Resident #174 was admitted on [DATE], he did not want a full body assessment due to pain, so the admitting nurse described the all over skin in the assessment. Upon assessment of the potential SDTI to the bilateral buttocks on 04/30/25 it was not fully completed due to the resident refusing so she stated she used the last hospital assessment of the wound prior to admission to the facility for the wound type and wound measurements and confirmed she did not actually assess Resident #174's SDTI to the bilateral buttock. Observation on 05/07/25 at 9:45 A.M. of Resident #174's SDTI to the bilateral buttocks with Wound CNP #203 revealed no triad cream present on the SDTI of the bilateral buttocks. There were four areas to the bilateral buttocks observed that were stage III pressure ulcers. The areas were: left inferior buttock measured 1 cm x 0.5 cm x 0.2 cm, left medial buttock measured 1 cm x 1 cm x 0.2 cm, left lateral buttock measured 1.5 cm x 2 cm x 0.2 cm and the right buttock measured 11 cm x 7 cm x 0.3 cm. Treatment orders for all four areas were ordered to be cleanse with wound cleanser, apply medical grade honey, and silver alginate, secure with abdominal pad with triad twice a day and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/07/25 at 10:09 A.M. with Wound CNP #203 revealed she is a consulting company for the facility for wound care and comes to the facility on ce a week. The facility is required to enter her orders, and the house physician signs off on the treatments. She completes her notes prior to leaving the facility for the day so her recommendations can be entered for the residents. When she first assessed Resident #174 on 04/30/25, she reviewed his discharge paperwork from the hospital and he had SDTI to the bilateral buttocks and she was unable to fully assess the area herself, so she recommended continuing the triad cream twice a day and as needed continuing the hospital recommended treatment and felt it was an appropriate treatment. Interview on 05/07/25 at 11:26 A.M. with the DON revealed the facility did not reattempt to do a full body assessment upon admission on 04/29/25 of Resident #174 with no documentation of the resident refusing due to pain. The DON also verified no re attempts to assess the SDTI to the bilateral buttocks from 04/30/25 through 05/07/25 since the assessment on 04/30/25 was copied from the hospital paperwork and not an actual assessment completed by the facility. The DON was also aware this resident was receiving triad cream in the hospital for the SDTI to bilateral buttocks, but it was not ordered upon admission through 05/07/25 even after CNP #203 recommended it on 04/30/25. Interview via telephone on 05/13/25 at 2:20 P.M. with Facility CNP #202 revealed for wound care, she refers to Wound CNP #203 for all recommendations and treatments. She would also expect the facility to reattempt a full body skin assessment on admission and an assessment of a potential pressure ulcer area if unable to do so at the first attempt. Review of the facility policy titled Pressure Injury Prevention and Management revised 01/08/25 revealed a licensed nurse will conduct a full body skin assessment on all residents upon admission and weekly and treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. 2. Review of the medical record for Resident #27, revealed an admitted [DATE]. Diagnoses included but were not limited to dementia, cerebral infarction, muscle weakness, anxiety disorder, and chronic kidney disease stage 3. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of nine indicating moderate cognitive impairment. The resident was assessed to require total dependence on toilet hygiene, shower/bathe self, bed mobility and transfers. This resident was also assessed to have a Foley catheter, to always be incontinent of bowel and to be at risk for pressure ulcer injury. Review of the plan of care dated 3/30/25 for Resident #27 revealed this resident has an actual area of skin impairment related to pressure ulcers and potential for alteration in skin integrity with no interventions involving treatments as ordered. Review of the admission assessment dated [DATE] for Resident #27 revealed a left elbow unstageable pressure ulcer that measured 4 cm x 5 cm x 0.1 cm. Review of the medical record for Resident #27 from admission on 03/30/25 through 03/31/25 at 2:46 P.M. revealed no treatment order for the left elbow unstageable pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the physician order dated 03/31/25 at 2:46 P.M. for Resident #27 revealed wound care for the left arm (elbow) cleanse with normal saline, pat dry. Apply mepilex and change every three days. Review of the skin grid pressure assessment dated [DATE] for Resident #27 revealed a pressure ulcer stage II to the scrotum that measured 1.5 cm x 0.3 cm x 0.10 cm. Review of the medical record for Resident #27 from 04/02/25 through 04/04/25 at 5:20 P.M. revealed no treatment order for the scrotum stage II pressure ulcer. Review of physician orders dated 04/04/25 at 5:20 P.M. for Resident #27 revealed a scrotal wound, cleanse with wound cleanser, pat dry, apply triad paste to wound base and leave open to air every shift and as needed. Interview on 05/12/25 at 11:35 A.M. with the Director of Nursing (DON) verified for the left elbow unstageable pressure ulcer documented on admission on 03/30/25, no treatments were in place until 03/31/25 at 2:46 P. M. The DON also verified for the scrotum stage II pressure ulcer documented on 04/02/25, no treatments were in place until 04/04/25 at 5:20 P.M. Review of the facility policy titled Pressure Injury Prevention and Management revised 01/08/25 revealed treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. 51524 3. Review of the medical record revealed Resident #47 admitted to the facility on [DATE]. Diagnoses included a pressure ulcer of the left heel, deep tissue and a pressure ulcer of the right heel, unstageable. Review of Resident #47's physician's order dated 09/24/24 revealed she was to wear pressure relief boots daily for preventative skin and comfort. There was no end date for the order. Review of Resident #47's medical record revealed the order was discontinued by the facility staff on 10/14/24. Interview with DON on 05/13/25 at 1:36 P.M. confirmed the order was discontinued by the facility staff and there was no corresponding order from the physician to discontinue donning the boots daily. Review of Resident #47's physician order dated 10/25/24 revealed the left heel wound was to be cleansed with normal saline, betadine and wrapped with gauze daily. Review of Resident #47's medical record revealed there was no documentation the treatments were completed 10/26/24, 10/27/24 and 10/30/24. Review of Resident #47's physician order dated 10/25/24 revealed the right heel wound was to be cleansed with normal saline, betadine applied and wrapped with gauze daily. (continued on next page)

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Embassy of Woodview	2770 Clime Road Columbus, OH 43223

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #47's medical record revealed there was no documentation the treatments were completed 10/26/24, 10/27/24 and 10/30/24. Interview with DON on 05/13/25 at 1:38 P.M. confirmed the treatments were not completed as ordered. Review of the facility policy titled Wound Treatment Management, dated 1/08/25, revealed to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing and frequency of 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to provide proper parameters for as needed pain medications. This affected two (Resident #3 and #48) of five residents reviewed for medications. Also, the facility failed to follow parameters prior to administering medications. This affected two (Residents #48 and #5) of five residents reviewed for medications. The census was 70. Findings Include: 1. Resident #3 was admitted to the facility on [DATE]. His diagnoses were alcoholic cirrhosis of liver, hypertension, hyperlipidemia, depression, anemia, adult failure to thrive, alcohol dependence, schizoaffective disorder, personal history of traumatic brain injury, diabetes mellitus, type II diabetes, dementia, cognitive communication deficit, dysphagia, and bipolar II disorder. Review of his Minimum Data Set (MDS) assessment, dated 04/17/25, revealed he was cognitively intact. Review of Resident #3 current physician orders found the following: Ibuprofen (non steroidal anti inflammatory) 800 milligrams (mg) every eight hours as needed for pain and Acetaminophen (analgesic) 325 mg, two tabs every six hours as needed for pain. Review of Resident #3 current orders of these two medications found no pain parameters as to when each medication should be administered. 2. Resident #48 was admitted to the facility on [DATE]. His diagnoses were cellulitis, dependence on respirator, morbid obesity, chronic embolism and thrombosis, muscle weakness, anxiety disorder, depression, shortness of breath, hyperlipidemia, difficulty in walking, chronic obstructive pulmonary disease, anemia, alcohol dependence, palpitations, vitamin A deficiency, acute infection following transfusion, atrial fibrillation, history of pulmonary embolism, lymphedema, hypertension, and acute and chronic respiratory failure with hypercapnia. Review of his minimum data set (MDS) assessment, dated 04/05/25, revealed he was cognitively intact. Review of Resident #48 current physician orders found the following: Tylenol 325 mg, two tablets every eight hours as needed for pain, starting 03/06/25, Oxycodone (opioid) five mg, one tab every six hours as needed for pain ranking four to seven and Oxycodone five mg, two tablets every six hours as needed for pain raining eight to ten, which was ordered from 02/20/25 to 03/03/25 and 03/24/25 to 04/27/25; Review of the as needed pain medication orders, there were no parameters for pain levels one to three for any of the as needed pain medications, and there were no parameters for pain levels eight to ten from 03/04/25 to 03/23/24, and 04/27/25 to current. Interview with Assistant Director of Nursing (ADON) #116 on 05/12/25 at 2:31 P.M. confirmed there should have been pain parameters for both residents regarding their as needed pain medications. She confirmed there needed to be pain parameters for the as needed pain medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #48 current physician orders found the following: Oxycodone five mg, one tablets every six hours as needed for pain ranking four to seven, which was started on 03/06/25; Oxycodone five mg, two tablets every six hours as needed for pain raining eight to ten, which was ordered from 02/20/25 to 03/03/25 and 03/24/25 to 04/27/25; Metoprolol Tartrate (used to control high blood pressure) 25 mg, give 0.5 tablet by mouth twice daily and hold for systolic blood pressure (SBP) was less than 110 starting 03/06/25, and Hydrochlorothiazide (diuretic) oral tablet 12.5 mg once daily and hold for SBP less than 110, which was ordered from 03/08/25 to 05/05/25. Review of Resident #48 medication administration records (MAR), dated December 2024 to May 2025, revealed the following medications given outside of parameters: May 2025: Oxycodone five mg was given 10 times for pain outside of pain level four to seven on the following dates: 1st at 8:51 A.M. for a pain rating of eight, 2nd at 8:41 A.M. for a pain rating of an eight; 3rd at 10:01 A.M. for a pain rating of eight, 4th at 11:31 P.M. for a pain rating of eight, the 5th at 8:00 A.M., 3:39 P.M. and 10:54 P.M. for a pain rating of eight, 6th at 3:20 P.M. for pain rating of eight, 7th at 4:57 P.M. for pain rating of eight, and 10th at 10:22 P.M. for a pain rating of eight. April 2025: Hydrochlorothiazide 12.5 mg was given twice when SBP was below 110, Metoprolol Tartrate 25 mg, 0.5 tablet was given twice when SBP was below 110, on the 1st with a blood pressure reading of 100/78 and on the 25th with a blood pressure reading of 108/62. Oxycodone five mg, two tablets was given eight times for pain outside of pain level eight to ten on the following days; 2nd at 11:50 P.M. for a pain rating of seven, 5th at 1:01 A.M. for a pain rating of five, 6th at 12:41 A.M. for a pain rating of seven, 7th at 12:52 A.M. for a pain rating of seven, 10th at 10:22 P.M. for a pain rating of zero, 13th at 3:00 P.M. with no pain rating provided, 24th at 4:12 P.M. for a pain rating of seven and on the 27th at 12:31 A.M. for a pain rating of six. March 2025: Oxycodone five mg, one tablet was give one time for pain outside of pain level four to seven on the 20th at 11:44 P.M. for a pain rating of eight, and Oxycodone five mg, two tablets was given 17 times for pain outside of pain level eight to ten on the following days: 1st at 12:48 A.M. for a pain rating of zero, 8th at 10:08 P.M. for a pain rating of six, 12th at 4:24 P.M. for a pain rating of five, 13th at 5:32 P.M. for a pain rating of five, 15th at 12:36 A.M. for a pain rating of zero, and at 3:16 P.M. for a pain rating of six, 16th at 3:05 P.M. for a pain rating of five, 17th at 5:31 P.M. for a pain rating of six and at 11:25 P.M. for a pain rating of seven, 18th at 3:15 P.M. for a pain rating of six, 19th at 4:10 P.M. for a pain rating of five, 20th at 12:03 A.M. for a pain rating of seven, and at 3:23 P.M. for a pain rating of six, 21st at 9:09 P.M. for a pain rating of zero, 23rd at 1:44 A.M. for a pain rating of seven, 24th at 4:17 P.M. for a pain rating of six, and 27th at 3:50 P.M. for a pain rating of zero. February 2025: Oxycodone five mg, two tablets was given six times for pain outside of pain level eight to ten on the following days: 22nd at 5:49 P.M. for a pain rating of seven, 23rd at 6:12 P.M. for a pain rating of four, 25th at 12:55 A.M. for a pain rating of six, 26th at 11:14 A.M. and 5:25 P.M. for a pain rating of three, and 27th at 5:17 P.M. for a pain rating of four. Interview with Assistant Director of Nursing (ADON) #116 on 05/12/25 at 2:31 P.M. confirmed the above medications were administered outside the parameters. She confirmed they will have to review the medications and the parameters to ensure they remain appropriate for the resident. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Pain Management policy, dated 08/22/22, revealed based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team may necessitate gathering the following information, as applicable to the resident: current prescribed pain medications, dosage and frequency, and the resident's goals for pain management and his/her satisfaction with the current level of pain control. Based upon the evaluation, the facility, in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. 47987 4. Review of the medical record for Resident #5, revealed an admitted [DATE]. Diagnoses included but were not limited to cerebrovascular disease, mild cognitive impairment, essential primary hypertension, and unspecified disorder of adult personality and behavior. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14. The resident was assessed to require set up or clean up assistance with toilet hygiene, shower/bathe self, bed mobility and transfers. Review of the plan of care dated 02/05/25 for Resident #5 revealed an alteration in tissue perfusion related to hypertension (high blood pressure) with interventions that included but are not limited to administer medications as ordered. Review of the physician order dated 05/31/24 at 4:30 P.M. for Resident #5 revealed Hydralazine Hydrochloride (blood pressure medication) oral tablet 50 milligrams (mg) give one tablet by mouth every eight hours as needed for treatment of high blood pressure (bp). Give hydralazine if systolic pressure is over 160. Review of the physician order dated 05/31/24 at 4:31 P.M. for Resident #5 revealed to measure and record blood pressure, give Hydralazine Hydrochloride if systolic blood pressure is greater than 160 every eight hours. Review of the medication record administration (MAR) for July 2024 revealed for the 28th at midnight Resident #5's blood pressure was 169/77 with no administration of hydralazine hydrochloride. Review of the MAR for August 2024 revealed for the following dates and time Hydralazine Hydrochloride was not administered for Resident #5: the 1st bp was 163/78 at midnight, the 5th bp was 163/89 at 4:00 P.M., the 21st bp was 173/109 at 8:00 A.M. and 165/100 at 4:00 P.M. Review of the MAR for October 2024 revealed the following dates and times Hydralazine Hydrochloride was not administered for Resident #5: the 5th bp was 162/92 at midnight and the 29th bp was 164/99 at midnight. Review of the MAR for November 2024 revealed the following dates and times Hydralazine Hydrochloride was not administered for Resident #5: the 9th bp was 164/88 at midnight, the 11th bp was 162/59 at midnight, the 13th bp was 161/78 at midnight and 199/122 at 4:00 P.M., the 16th bp was 166/78 at midnight, the 17th bp was 166/93 at midnight, the 21st bp was 161/78 at midnight, the 22nd bp was 169/67 at 8:00 A.M., the 23rd bp was 170/96 at 8:00 A.M., and the 28th bp was 179/102 at 8:00 A.M. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for December 2024 revealed the following dates and times Hydralazine Hydrochloride was not administered for Resident #5: the 2nd bp was 168/116 at 8:00 A.M., the 6th bp was 186/120 at 4:00 P.M., the 7th bp was 195/110 at 8:00 A.M., the 11th bp was 177/91 at midnight, the 16th bp was 167/97 at midnight, the 20th bp was 169/98 at midnight, the 30th bp was 162/97 at midnight and 176/98 at 4:00 P.M. Review of the MAR for January 2025 revealed the following dates and times Hydralazine Hydrochloride was not administered for Resident #5: the 1st bp was 168/101 at 8:00 A.M. and 182/102 at 4:00 P.M., the 3rd bp was 162/108 at 8:00 A.M., the 7th bp was 163/109 at midnight, the 8th bp was 166/76 at midnight, the 13th bp was 166/85 at midnight, and the 16th bp was 169/90 at 8:00 A.M. Review of the MAR for April 2025 revealed the following date and time Hydralazine Hydrochloride was not administered for Resident #5: the 3rd bp was 164/88 at midnight. Interview on 05/08/25 at 10:31 A.M. with the Director of Nursing verified Resident #5 had missing doses of Hydralazine Hydrochloride from July 2024 through April 2025 for systolic blood pressures over 160 per order. Review of the facility policy titled Medication Administration revised on 08/22/22 revealed medications are administered by licensed nurses as ordered by the physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on observation, interview, record review and facility policy review, the facility failed to implement enhanced barrier precautions for Resident #174. This affected one resident of one resident reviewed for enhanced barrier precautions and had the potential to affect all 23 residents on the hall. The facility census was 70. Findings include: Review of the medical record for Resident #174, revealed an admitted [DATE]. Diagnoses included but were not limited to acute embolism and thrombosis unspecified deep veins of left lower extremity, anxiety disorder, need for assistance with personal care, muscle weakness, unspecified lack of coordination, and Type II Diabetes Mellitus without complications. Review of a Brief Interview for Mental Status (BIMS) dated 04/29/25 revealed Resident #174 to be a 15 indicated cognitive intactness. Review of the plan of care dated 04/29/25 for Resident #174 revealed the resident had an actual area of skin impairment with no interventions for enhanced barrier precautions. Review of a skin grid pressure documentation dated 04/30/25 for Resident #174 revealed a SDTI on the bilateral buttocks. Review of the physician's orders dated 04/30/25 through 05/07/25 for Resident #174 revealed no order for enhanced barrier precautions. Observation on 05/07/25 at 9:40 A.M. of Resident #174's room revealed no sign for enhanced barrier precautions and no enhanced barrier precautions cart with items for staff to wear when entering the residents room. Verified with the Assistant Director of Nursing this resident was supposed to be on enhanced barrier precautions, and he was not. Review of the facility policy titled Enhanced Barrier Precautions revised 07/13/22 revealed an order for enhanced barrier precautions will be obtained for residents with wounds. Also, implementation of enhanced barrier precautions which includes making gowns and gloves available immediately outside of the residents room and positioning of a trash can inside the resident room and hear the exit for discarding of the personal protection equipment after removal.