STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365730	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Euclid	3 Gateway Dr Euclid, OH 44119

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of the facility policy the facility failed to ensure individualized care planned interventions were developed and followed to prevent Resident #17 from developing pressure ulcers, and failed to ensure the pressure ulcers were timely identified, properly treated, and interventions were initiated to promote healing. Actual Harm occurred on 01/06/24 when Resident #17 who was cognitively impaired, at risk for pressure ulcer development, and required assistance with bed mobility, developed new, in-house acquired bilateral heel pressure ulcers that were first assessed to be unstageable (a type of bed sore that occurred due to prolonged pressure on a specific area of the skin, resulting in the lack of blood flow and oxygen to the tissue. It is a full thickness tissue loss where the depth of the wound or bed sore was completely obscured by eschar in the wound bed) without proper prevention, treatment, and interventions implemented. This affected one resident (Resident #17) out of three residents reviewed for pressure ulcers. The facility census was 67. Findings include: Review of Resident #17's medical record revealed an admitted [DATE] and diagnoses included epilepsy, unspecified, intractable, with status epilepticus, edema, and type two diabetes mellitus. Review of Resident #17's care plan dated 10/18/23 included Resident #17 was at risk for potential for alteration in skin integrity related to decreased mobility. Resident #17 would not develop any skin breakdown through the comprehensive review target date of 01/25/24. Interventions included pressure reducing cushion to the chair, pressure reducing mattress to the bed and evaluate Resident #17's specific risk factors. There were no interventions related to turning and repositioning or off loading heels from the mattress. There were no additional care plans or interventions related to Resident #17's bilateral pressure ulcers until 03/04/24 which was two months after pressure ulcers were identified. Review of Resident #17's Braden Scale dated 12/16/23 revealed Resident #17 was at moderate risk for developing a pressure ulcer, injury. Review of Resident #17's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 did not have a pressure ulcer, injury. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #17's Weekly Skin Evaluation dated 01/01/24 included Resident #17's skin was intact and dry. Resident #17 had bilateral lower extremity pitting edema and diuretics were continued. Review of Resident #17's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had severe cognitive impairment. Resident #17 required partial to moderate assistance to roll from lying on back to left and right side, and return to lying on back on the bed, to move from lying on the back to sitting on the side of the bed and with no back support. Resident #17 required substantial to maximal assistance for toileting and personal hygiene. Resident #17 had a pressure ulcer, but the stage was not documented. Review of Resident #17's progress notes dated 01/06/24 at 5:31 P.M. revealed on 01/05/24 at 11:00 P.M. Resident #17 had an open area on the back of his right ankle and heel, area soft and mushy. Resident #17 had an area to the left heel which was soft but unopened. Areas cleansed with normal saline and silver alginate was applied. Medihoney was applied to the right ankle and heel. ABD pad applied to both areas and wrapped with Kerlix. Review of Resident #17's physician orders dated 01/05/24 through 01/08/24 did not reveal orders to cleanse the right ankle and heel open areas with normal saline and apply silver alginate or to apply medihoney to the right ankle and heel. There were no orders to apply an ABD (abdominal) pad and wrap with Kerlix for both heels. Review of Resident #17's physician orders dated 01/06/24 revealed orders for heel protectors while in bed, every shift Resident #17 to have heel protectors while in bed. Review of Resident #17's physician orders from 01/06/24 through 04/09/24 did not reveal orders for turning and repositioning. Review of Resident #17's progress notes from 01/06/24 through 04/09/24 did not reveal evidence Resident #17 was turned and repositioned. Review of Resident #17's aide charting from 01/06/24 through 04/09/24 did not reveal a task for turning and repositioning Resident #17. Review of Resident #17's Weekly Pressure Report Only dated 01/08/24 included Resident #17 had pressure ulcers of the right and left heel, and the pressure ulcers were first observed on 01/06/24. Resident #17 had a right heel unstageable pressure injury and measurements were length 7.9 cm, width 8.7 cm and depth was UTD (unable to determine). Resident #17 had an unstageable left heel pressure ulcer and measurements were length 5.6 cm, width 4.9 cm and depth UTD. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #17's Wound Care notes dated 01/08/24 included Resident #17 presented with heel wounds. Resident #17 was a long term care resident of the facility and was confused, weak, poorly mobile and quite frail appearing. Wound Care Physician (WCP) #260 wrote he was asked to evaluate Resident #17's heels and the right heel had an unstageable pressure ulcer and measurements were length 7.9 centimeters (cm), width 8.7 cm and depth UTD (unable to determine) cm. The wound base was composed of 90 percent granulation tissue and 10 percent eschar. The entire base of the heel is open tissue with pink granulation tissue, and there were a few small patches of eschar. The wound was draining serous fluid. Prevalon boots at all times to relieve pressure. This was the initial evaluation of Resident #17's right heel and treatment was pack wound with alginate, cover with ABD (abdominal pad), pad and wrap with Kerlix. Change and apply treatment daily and prn (as needed). Please consider Prevalon boots. Further review of the notes included the second wound was an unstageable pressure injury located on the left heel. Half of the wound was thick, dry well adhered eschar and half black non-blanching tissue. The area was dry and not draining. Start skin prep to mature the eschar and measurements were length 5.6 cm, width 4.9 cm and depth UTD cm. The wound base was composed of 50 percent DTPI (deep tissue pressure injury) tissue. This was the initial evaluation of Resident #17's left heel wound and treatment was apply skin prep, cover with ABD pad and wrap with Kerlix daily and prn. Additional orders were Prevalon boots (heel protection boots which lift the heel to help prevent the development of heel pressure injuries). Review of Resident #17's care plan dated 03/04/24 included Resident #17 had actual skin integrity related to an unstageable wound of the left heel and a stage three pressure ulcer of the right heel. Resident #17's skin injury would be healed by the review date of 04/18/24. Interventions included to educate resident, family, caregivers of causative factors and measures to prevent skin injury, and pressure relieving device in bed. There was no evidence of interventions related to Prevalon boots, off loading heels from the mattress or a turning and repositioning schedule. Review of Resident #17's Braden Scale dated 03/16/24 revealed Resident #17 was at moderate risk to develop a pressure ulcer or injury. Review of Resident #17's Wound Care notes dated 04/09/24 included Resident #17's right heel wound was a stage three pressure ulcer (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible but do not obscure the depth of tissue loss). and measurements were length 4.2 cm, width 3.4 cm and depth was 0.2 cm with intact skin bridge present. The wound base was 100 percent granulation tissue with moderate serous drainage. Wound status was slightly larger but remained clear. Continue to wear protective boots. Treatment was cleanse wound with normal saline, pat dry, cover with ABD pad and wrap with Kerlix. Skin prep heel, pack deepest part of the wound bed with moistened collagen. Change and apply treatment daily and prn. Continue to wear protective boots. Further review revealed Resident #17's left heel wound was an unstageable pressure ulcer and measurements were length 1.1 cm, width 2.2 cm and UTD cm. Wound base was 100 percent slough with moderate serous drainage. Sharp, excisional debridement was performed using a scalpel and forceps. The tissue was debrided down to the muscle and eschar was removed. Post debridement measurements were length 1.1 cm, width 2.2 cm and depth UTD cm. Area debrided was three square cm. Treatment orders were cleanse left heel wound with normal saline, pat dry, apply Santyl ointment followed by calcium alginate to wound bed. Cover with ABD pad and wrap with Kerlix, Change and apply treatment daily and prn. Recommendations included pressure reduction mattress per facility protocol, offload heels per facility protocol, reposition per facility protocol. The plan of care was discussed with nursing staff and resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #17's physician orders dated 04/09/24 revealed orders for Santyl ointment 250 Unit/Gram, apply to left heel topically every night shift for wound care. There was no evidence calcium alginate was ordered to be applied to the left heel after Santyl ointment was applied. Review of Resident #17's Treatment Administration Record (TAR) dated 04/09/24 revealed Santyl Ointment 250 Unit/Gram, apply to left heel topically every night shift for wound care. Registered Nurse #252 signed the TAR on 04/09/24 that she applied Santyl Ointment to the left heel, but there was no evidence calcium alginate was applied to Resident #17's left heel after the Santyl ointment was applied. Further review of the TAR dated 04/10/24 at 1:02 A.M. revealed Registered Nurse (RN) #252 documented she applied Santyl Ointment topically to both feet. Observation on 04/09/24 at 4:10 P.M. of Resident #17 revealed he was lying on his back in bed, had slid down in the bed, both feet were pressed firmly against the footboard, and his heels were resting directly on the mattress. Both Resident #17's right and left ankles and heels had dressings noted, and the dressings were not dated. Resident #17 did not have Prevalon boots on and was not lying on a low air loss mattress. Interview on 04/09/24 at 4:10 P.M. of Resident #17 revealed he was pleasantly confused and unable to answer questions. Observation on 04/09/24 at 4:12 P.M. of Resident #17 with Wound Nurse/Licensed Practical Nurse (WN/LPN) #235 revealed Resident #17 was lying on his back in bed, had slid down in the bed, both feet were pressed firmly against the footboard, and his heels were resting directly on the mattress. Both Resident #17's right and left ankles and heels had dressings, and the dressings were not dated. Resident #17 was not wearing Prevalon boots and was not lying on a low air loss mattress. WN/LPN #235 confirmed Resident #17 did not have Prevalon boots on, the dressings were not dated, his feet were pressed up against the footboard and his heels were directly on the mattress. WN/LPN #235 confirmed Resident #17 was not lying on a low air loss mattress, but his current mattress was a pressure reduction mattress with a perimeter mattress. WN/LPN #235 stated Resident #17 was very tall and staff had to keep moving him up in his bed. Observation on 04/10/24 at 8:00 A.M. of Resident #17 with Licensed Practical Nurse (LPN) #204 revealed Resident #17 was lying in bed on his back, had slid down in the bed, his left foot was pressed firmly against the footboard, his right leg was bent and both heels were resting directly on the mattress. Resident #17 was not wearing Prevalon boots. Observation revealed Resident #17's Prevalon boots were lying on the floor next to the wall in his room. LPN #204 confirmed Resident #17 was not wearing Prevalon boots, his heels were not offloaded to reduce pressure on his heels, and LPN #204 left the room to find an aide to help move Resident #17 up in the bed. LPN #204 returned to the room with State tested Nursing Assistant (STNA) #212 and moved Resident #17 up in the bed. LPN #204 stated Resident #17 slid down in the bed frequently, his feet pressed against the footboard, and it could be because he was tall and the bed was not long enough for him. LPN #204 indicated the facility could order a longer bed for Resident #17. Neither LPN #204 or STNA #212 put Resident #17's Prevalon boots on him to offload his heels from the mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/10/24 at 8:00 A.M. with STNA #212 revealed she was not assigned to care for Resident #17 today, and right now there was no aide assigned to care for Resident #17 because STNA #232 had not arrived to work and Resident #17 was in STNA #232's assignment. STNA #212 stated all the aides were watching over STNA #232's residents until she arrived. STNA #212 stated she had not repositioned Resident #17 or provided care for him today. STNA #212 stated she was not usually assigned to care for Resident #17 and did not know anything about his bilateral heel wounds. Observation on 04/10/24 at 9:15 A.M. of Resident #17 revealed STNA #223 was feeding Resident #17 and LPN #204 was completing dressing changes of his heels. Observation of LPN #204 revealed she was changing Resident #17's right heel dressing. LPN #202 stated she cleansed Resident #17's right heel with normal saline, patted it dry, and applied skin prep before the surveyor entered the room. LPN #204 held Resident #17's right heel up and with the surveyor observed Resident #17's right heel wound. The wound was about one and half inches by one inch, was reddish-pink in color, small amount of clear drainage and a skin bridge was intact. Further observation revealed Resident #17's right heel had a very dark, blackened area to his right heel about the size of a quarter, and the blackened area was close to the wound LPN #204 was completing a dressing change on. LPN #204 confirmed the dark, black area on Resident #17's right heel. Observation revealed LPN #17 provided a clean barrier under Resident #17's right heel, donned clean gloves, applied collagen, an ABD pad, then wrapped the heel with Kerlix. LPN #204 stated she had already completed Resident #17's left heel dressing, the tissue was soft, a small amount of reddish-brown drainage was noted, and she cleansed the left heel wound with normal saline, applied Santyl ointment, followed by an ABD pad and then wrapped the heel with Kerlix. LPN #204 stated she did not apply alginate to the wound. When asked about Resident #17 not having Prevalon boots on to offload his heels from the bed, LPN #204 stated she was just getting ready to put them on and walked over to the Prevalon boots lying against the wall and put them on Resident #17's heels. Interview on 04/10/24 at 9:15 A.M. with STNA #223 revealed she was only feeding Resident #17 to help out, did not have him in her assignment, and had not provided care or repositioning for him. STNA #223 stated she did not know Resident #17 and was not usually assigned to work on the nursing unit he resided on. Interview on 04/10/24 at 9:48 A.M. with STNA #233 revealed there was no permanent STNA assigned to take care of residents residing on the nursing unit Resident #17 resided on. STNA #233 stated she did not routinely take care of Resident #17 and could not name any aide who would know him and would be able to talk about his bilateral heel sores. STNA #233 stated she never looked at Resident #27's heels when she cared for him, but she did know he had sores on them. Interview on 04/10/24 at 10:52 A.M. with WN/LPN #235 revealed she was made aware Resident #17 was not wearing his Prevalon boots while he was in bed and his heels were not offloaded off the mattress. WN #235 stated she would need to educate the staff about the importance of Resident #17 wearing Prevalon boots. Interview on 04/10/24 at 12:22 P.M. with Certified Wound Nurse Practioner (CWNP) #261 revealed she did not see a quarter sized, very dark and blackened area on Resident #17's right heel close to his existing wound when she saw him on 04/09/24. CWNP #261 stated if she had seen it she would have documented the observation and ordered a treatment if needed. CWNP #261 stated she would have skin prep applied to the area and would evaluate the area on her next visit to the facility. CWNP #261 stated a pressure injury could happen very quickly, and could happen in one day or even in an hour. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/10/24 at 12:45 P.M. with WN/LPN #235 revealed Resident #17's right and left heel pressure ulcers were found on 01/06/24, it was a weekend, she was not working, but the nurse who found the pressure ulcers notified her via a text message on her phone. WN/LPN #235 was not aware Resident #17 had a blackened area on his right heel close to his existing pressure ulcer, and she would look at it on 04/11/24 when his dressing change was completed. WN/LPN #235 did not want to take the dressing off on 04/10/24 to observe the area because he just had his dressing changed and she did not want to put him at risk by doing a second dressing change. Interview on 04/10/24 at 1:07 P.M. with STNA #212 revealed she had Resident #17 in her assignment because STNA #232 took a different assignment when she arrived. STNA #212 stated she took care of Resident #17 since around 9:30 A.M. STNA #212 stated she assisted Resident #17 to his chair in his room because his son came to visit and asked her to help Resident #17 get out of bed and into his chair. STNA #212 stated she got another aide to help her assist Resident #17 to his chair. STNA #212 stated Resident #17 was lying on his back in bed and she had not repositioned him from 7:00 A.M. until about 10:30 A.M. when she transferred him to his chair. STNA #212 stated Resident #17 did not typically refuse care or repositioning. Interview on 04/10/24 at 1:13 P.M. with WN/LPN #235 and the Director of Nursing (DON) revealed the physician orders placed on 04/09/24 in Resident #17's electronic record for his left heel were not correct and when WN/LPN #235 placed the orders she forgot to put Santyl ointment followed by calcium alginate, ABD pad and Kerlix. WN/LPN #235 stated because she did not place the orders correctly the TAR was also wrong and on 04/10/24 LPN #204 did not apply calcium alginate after the Santyl was applied and before placing the ABD pad and wrapping with Kerlix. The DON stated the documentation on the TAR of Santyl to Resident #17's both feet was probably a mistake. Interview on 04/10/24 at 2:35 P.M. with the DON revealed she could explain why there were no orders for treatments to Resident #17's right and left heel wounds in his electronic record on 01/05/24. The DON stated the facility was transitioning from one electronic system to another in early January and Resident #17's orders were placed on a paper TAR and did not get transcribed into his electronic record. The DON indicated she would try to find Resident #17's paper TAR which was in the medical records area in the basement of the facility, left the room to find it and arrived a short time later with Resident #17's paper TAR dated 01/05/24 with orders for treatments to the right and left heel wounds. Interview on 04/11/24 at 1:05 P.M. with Minimum Data Set (MDS) Nurse #234 revealed the Annual MDS assessment dated [DATE] had a mistake which she corrected. MDS #234 stated Resident #17 did not have a pressure ulcer on that assessment and the question if Resident #17 had a pressure ulcer should have been marked no. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Pressure Injury Prevention and Management reviewed 08/22/22 included the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer, injury, prevent infection and the development of additional pressure ulcers, injuries. Licensed nurses would conduct a Braden Scale pressure injury risk assessment whenever the resident's condition changed significantly. Evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure injury present. Interventions included to redistribute pressure such as repositioning, protecting and, or offloading heels etcetera, provide appropriate, pressure-redistributing, support surfaces. Interventions on a resident's plan of care would be modified as needed. Considerations for modifications included new onset or recurrent pressure injury development. Review of the policy titled Specialty Mattresses revised 07/2018 included specialty mattresses were not typically used for extremities that could be elevated or would benefit from the use of pressure reduction devices such as pillows, pressure reduction boots. Use of low-air-loss mattresses was reserved for residents with stage three and stage four pressure ulcers. This deficiency represents non-compliance investigated under Complaint Number OH00151992.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident's #1, #24 and #55 received proper, timely incontinence care. This affected three resident's (Resident's #1, #24 and #55) out of four resident's reviewed for incontinence care. Findings include: 1. Review of Resident #55's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, pseudobulbar affect, and type two diabetes mellitus with ketoacidosis without coma. Review of Resident #55's Annual Minimum Data Set (MDS) 3.0 assessment revealed Resident #55's Brief Inteview for Mental Status was not assessed. Resident #55 was always incontinent of urine and bowel. Resident #55 was dependent for all ADL's (Activity of Daily Living) including toileting and personal hygiene. Review of Resident #55's care plan revised 05/18/22 included Resident #55 experienced bowel incontinence. Resident #55's toileting needs would be met by staff, with interventions aimed at the prevention of infection and, or skin impairment. Interventions included inspect for skin breakdown and intervene when needed, and provide incontinence care every two hours and as needed, apply house moisture barrier cream as needed. Observation on 04/08/24 at 5:35 A.M. of State tested Nursing Assistant (STNA) #251 preparing to provide incontinence care for Resident #55 revealed STNA #251 prepared a basin of warm soapy water, gathered supplies including two incontinence briefs and proceeded to provide incontinence care for Resident #55. STNA #251 removed Resident #55's incontinence brief, and when the incontinence brief was removed it was revealed Resident #55 was wearing two incontinence briefs. STNA #251 confirmed Resident #55 was wearing two incontinence briefs and said Resident #55 was a heavy wetter. Both incontinence briefs were soaked with urine, and further observation revealed the folded sheet under Resident #55 used as a draw sheet was extremely wet with urine. Observation revealed Resident #55's fitted sheet covering his mattress was dirty and had dried unidentified material stuck to it. STNA #251 confirmed the sheet had dried material on it, scraped some of the dried material with his fingers and brushed it on the floor. STNA #251 continued with Resident #55's incontinence care, picked up one of the two clean incontinence briefs, tore the tabs off and placed the brief inside the second brief. STNA #251 stated he had to use two incontinence briefs for Resident #55 because he was a heavy wetter, and he made a liner by ripping the tabs off one of the incontinence briefs. STNA #251 put the incontinence brief with the makeshift liner on Resident #55, finished with the incontinence care and left Resident #55's room. Interview on 04/08/24 at 10:00 A.M. with the Director of Nursing (DON) revealed it was not acceptable to have two incontinence briefs on residents and she would start educating the staff right away. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Perineal Care undated included it was the practice of the facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. 2. Review of Resident #1's medical record revealed an admitted [DATE] and diagnoses included pruritus, dementia and unspecified psychosis not due to a substance or known physiological condition. Review of Resident #1's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #1 had severe cognitive impairment. Resident #1 was always incontinent of urine and bowel. Resident #1 was dependent on staff for toileting hygiene and bathing. Review of Resident #1's care plan revised 08/31/21 included Resident #1 had episodes of bladder and bowel incontinence related to impaired mobility and diagnoses. Resident #1 would be at a reduced risk for complications from incontinence through the next review. Resident #1 would be comfortable, clean, dry and free from skin breakdown through the next review. Interventions included to assist Resident #1 with toileting needs, provide peri care after each incontinence episode, apply house barrier cream after incontinence care. Review of Resident #1's aide charting in the electronic medical record revealed on 04/08/24 at 1:25 A.M. Resident #1 was incontinent of urine and care was provided. There was no further evidence on 04/08/24 from 1:25 A.M. through 7:00 A.M. that Resident #1 was incontinent of urine and care was provided. Further review revealed there was no evidence on 04/08/24 from 12:00 A.M. through 6:59 A.M. that Resident #1 was incontinent of bowel and incontinence care was provided. Observation on 04/08/24 at 6:17 A.M. of Resident #1 revealed Resident #1 was in the bathroom sitting in her wheelchair next to the sink, the water was running, and a very unpleasant strong odor of feces and urine was noted in the room. STNA #201 was standing next to Resident #1 assisting her to wash her hands and clean her nails. STNA #201 stated Resident #1 had feces under her fingernails and she was helping her clean her hands and fingernails. Further observation revealed Resident #1's bed did not have any sheets on it, a very large wet spot covered the bare mattress, and dirty feces covered sheets were on the floor under Resident #1's bed along with a dirty incontinence brief with feces covering the inside and outside of the brief in multiple areas. STNA #201 confirmed the feces covered incontinence brief and sheets were under Resident #1's bed and on the floor, she left them on the floor because when she entered the room Resident #1 was already in the bathroom and she needed to assist her before tending to the bed, incontinence brief and sheets on the floor. Further observation revealed two additional incontinence briefs covered in urine and feces were in the trash can in the room. STNA #201 stated those incontinence briefs were from earlier, and she had not taken them out of the room yet. STNA #201 stated the large wet spot on the mattress was urine and she needed to clean the area before putting sheets back on the bed. STNA #201 stated Resident #1 often took her incontinence briefs off and sometimes they were found in the bed and sometimes on the floor. STNA #201 was vague when she was asked about the last time she provided incontinence care for Resident #1. (continued on next page)

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Embassy of Euclid	3 Gateway Dr Euclid, OH 44119

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Perineal Care undated included it was the practice of the facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. 3. Review of Resident #24's medical record revealed an admitted [DATE] and diagnoses included chronic obstructive pulmonary disease, aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension), cerebral infarction, and major depressive disorder. Review of Resident #24's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 was always incontinent of urine and bowel. Resident #24 was dependent on staff for toileting hygiene and bathing and required substantial to maximal assistance for personal hygiene. Review of Resident #24's care plan revised 02/06/24 included Resident #24 had episodes of bladder and bowel incontinence related to impaired mobility, physical limitations and diagnoses. Resident #24 would be at reduced risk for complications from incontinence through the next review. Interventions included to assist Resident #24 with toileting needs, provide disposable incontinence products. Observation on 04/08/24 at 6:30 A.M. of STNA #251 revealed he was preparing for incontinence care of Resident #24. STNA #251 gathered two clean incontinence briefs, towels, prepared a basin of warm soapy water, and proceeded to provide Resident #24's incontinence care. Observation of Resident #24 revealed STNA #251 removed two incontinence briefs, and they were both saturated with urine and a large bowel movement. STNA #251 stated he had to put two incontinence briefs on Resident #24 so her briefs did not leak. STNA #251 stated Resident #24 liked a bigger incontinence brief, and he used a larger incontinence brief, then ripped the tabs off a second incontinence brief to make a liner. Resident #24 stated the incontinence briefs pinched her and that was why she asked for a larger brief. Further observation revealed Resident #24's draw sheet and fitted sheet were soaked with urine, and a large dried urine ring could be seen around the wet urine on the sheets. Resident #24 stated the last time she was changed was before she went to sleep. When asked if she put her call light on to be changed Resident #24 stated she did not think about putting her call light on to be changed and it was uncomfortable to lay in urine. STNA #251 confirmed the sheets were soaked and there was a dried urine ring around the wet urine. STNA #251 stated there were only three aides working last night, he had a split assignment which made it difficult to give the residents he was assigned to the care they needed. STNA #251 finished the incontinence care, dipping clean towels into the soapy water each time he needed a new towel, using the same gloves each time and put two clean incontinence briefs on Resident #24, one of which had the tabs ripped off to make a liner. STNA #251 did not remove his soiled gloves used for incontinence care and after Resident #24's incontinence care was complete, using the same soapy water he used for incontinence care he dipped a clean towel in the water and proceeded to clean Resident #24's face with the towel dipped in the water. STNA #251 confirmed he did not change his gloves and stated but I used a clean towel each time. When explained to him he did not change his gloves, and his gloves were soiled from the incontinence care STNA #251 stated I see what you are getting at and he would keep that in mind when he provided resident incontinnce care. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Perineal Care undated included it was the practice of the facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. This deficiency represents non-compliance investigated under Complaint Number OH00151992.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #45 had an individualized care plan with appropriate interventions in place to manage symptoms of dementia to prevent wandering in other residents rooms. This affected one resident (Resident #45) out of three resident reviewed for dementia care. The facility census was 67. Findings include: Review of Resident #45's medical record revealed an admitted [DATE] and diagnoses included dementia, major depressive disorder, and morbid obesity. Review of Resident #45's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #45 had severe cognitive impairment. Resident #45 used a manual wheelchair. Resident #45 was independent for bed mobility, the ability to transfer from a bed to a wheelchair, and the ability to come to a standing position from sitting in a wheelchair or the side of the bed. Review of Resident #45's care plan revised 01/24/24 included Resident #45 had impaired cognitive process for daily decision making. Resident #45 was at risk for further decline in cognitive status. Resident #45 would not exhibit further decline in cognitive status and Resident #45's needs would be met daily through the next review on 04/16/24. Interventions included to reorient and redirect as needed. Further review did not reveal a care plan for monitoring Resident #45 to ensure he did not go in resident rooms and upset residents when he tried to take their belongings. Review of Resident #45's progress notes from 10/08/23 through 03/30/24 revealed many notes stating Resident #45 required continuous supervision and redirection because Resident #45 roamed around the facility and entered other resident rooms unannounced and went through their belongings. Resident #45 was sometimes agitated, aggressive and combative with staff when they attempted to redirect him. Review of Resident #10, Resident, #45, Resident #53 medical records, and facility Self Reported Incidents revealed the following incidents related to Resident #45's wandering behavior: a. Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses included peripheral vascular disease, nontraumatic intracranial hemorrhage, and dementia. Review of Resident #10's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #10 was cognitively intact. Resident #10 had impaired cognitive function related to dementia. Resident #10 would cope with his cognitive impairment evidenced by having no episodes of anxiety or frustrations through the next review. Interventions included to reassure Resident #10 of safety and redirect as needed. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Self Reported Incident Form (SRI) tracking number 244499 dated 02/23/24 included Resident #45 wandered into Resident #10's room and began going through his belongings. Both residents had a diagnosis of dementia. Resident #45 was verbally aggressive and saying he wanted to fight with Resident #10. Housekeeper #262 redirected Resident #45 out of Resident #10's room and before she could intervene Resident #45 reentered Resident #10's room and Resident #10 hit Resident #45 on the head with his cane to get him out of the room. Resident's #10 and #45 were immediately separated. Resident #45 had a small nickel size bump on his head and neither resident had a significant injury. Resident #10 and #45 were referred to psych services for evaluation. Resident's #10 and #45 were monitored and there was no further incident. b. Review of Resident #53's medical record revealed an admitted [DATE] and diagnoses included epilepsy, major depressive disorder, factitious disorder imposed on self and schizoaffective disorder, bipolar type. Review of Resident #53's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 was cognitively intact. Resident #53 was independent with ADL's (Activity of Daily Living) and required setup or clean-up assistance with bathing. Review of Resident #53's care plan dated 03/07/24 included Resident #53 had the potential to make false allegations. Resident #53 would be educated on how false allegations can affect other people. Interventions were to help Resident #53 make positive decisions. Resident #53 refused Psych services despite education and encouragement from staff. Staff would encourage Resident #53 to talk with Psych services. Interventions included to keep Resident #53 safe during episode of behavior, and attempt to redirect. There was no care plan or evidence Resident #53 had self-inflicted injuries. Review of Resident #53's progress notes dated 03/26/24 at 5:25 P.M. revealed Resident #53 saw Resident #45 reaching for his belongings located in his drawer and snatched the item out of Resident #45's hand causing him to hit his hand on the dresser. Resident's #45 and #53 were separated. Resident #53 had pain from hitting his hand on the dresser, his physician was notified and an x-ray of his right hand was ordered. Review of Resident #53's progress notes dated 03/26/24 at 11:21 P.M. revealed the portable x-ray company was called for Resident #53's right hand x-ray results and the results were pending. Review of Resident #45's medical record revealed Resident #45 was moved to a different room on 03/27/24 and not on 03/26/24 the date of incident. Review of Resident #45's progress notes dated 03/28/24 at 1:11 P.M. revealed Resident #45 was moved from room [ROOM NUMBER] to 107A. Family aware. There were no notes regarding the reason Resident #45 was moved and no notes about Resident #45 entering Resident #53's room and going through his belongings. Review of Resident #53's progress notes dated 03/28/24 at 7:56 P.M. included Resident #53 returned from the local hospital with a cast on his right hand due to a closed displaced fracture of the neck of the fourth metacarpal bone of his right hand. Resident #53's physician aware. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's hospital After Visit Summary dated 03/28/24 revealed Resident #53 was seen for a hand injury. Resident #53's diagnosis was hand injury, right, initial encounter, right hand pain, closed displaced fracture of the neck of the fourth metacarpal bone of the left (right) hand. Review of Resident #45's progress notes dated 03/29/24 at 7:02 P.M. included Resident #45 was in another unidentified resident's room which he destroyed, throwing items all over the room, and also throwing items including a candle and flower pot at the resident whose room he destroyed. The resident then struck Resident #45 and Resident #45 was escorted out of the room by staff. Resident #45 grabbed a metal fork and held in a threatening way towards staff. Resident #45 refused to allow a head to toe assessment. Resident #45's physician made aware, family was unable to be contacted. Resident #45 to be sent out for behaviors via 911 and EMS (Emergency Medical Services). Review of Resident #45's progress notes dated 03/30/24 at 2:18 P.M. revealed Resident #45 was admitted to the hospital for dementia with behavioral disturbances. Review of Resident #53's progress notes dated 04/03/24 at 5:38 P.M. written by Resident #53's physician included Resident #53 was seen on rounds following a recent ER (emergency room) visit which revealed a fracture to the metacarpal on Resident #53's right hand. Resident #53 was involved in an altercation with another resident, resulting in swelling of the hand. An x-ray was ordered and did not reveal any fractures. Two days later Resident #53 left following an appointment and went to the ER. Asked Resident #53 numerous different ways if Resident #53 had any other injury following the altercation and initial x-ray that might have resulted in an injury. Resident #53 denied another injury and stated I've used that x-ray company before, they are no good, they do not know what they are doing, there was a fracture and they missed it. Resident #53's physician showed Resident #53 the portable x-ray pictures taken at the facility which showed no fracture and Resident #53 stated they must not have turned it the right way or something. Resident #53's physician wrote given Resident #53's history he was suspicious there might have been subsequent trauma (possible self-inflicted) that Resident #53 was not forthcoming with. Resident #53 reported having a lawyer. Resident #53 was currently in an ulnar gutter splint. Interview on 04/08/24 at 10:20 A.M. with Licensed Practical Nurse (LPN) #206 revealed she was working on 03/26/24, the day Resident #45 entered Resident #53's room uninvited. LPN #206 stated she heard a noise in Resident #53's room, Resident #53 was screaming and yelling because Resident #45 was trying to steal his belongings. Resident #53 told her he hit the money out of Resident #45's hand and his hand hit the dresser. LPN #206 stated she notified Resident #53's physician, the Director of Nursing (DON), and removed Resident #45 from Resident #53's room and transferred Resident #45 immediately to another room, right after the altercation happened. LPN #206 stated Resident #45 had dementia, was really confused and could be redirected. LPN #206 indicated she never saw the money in Resident #53's drawer. LPN #206 stated Resident #53's physician ordered an x-ray of his right hand, and the x-ray was negative for a fracture. LPN #206 stated Resident #53 did not tell her Resident #45 pushed his wheelchair into him, causing him to fall forward and hit his hand while he was trying to hit the money out of Resident #45's hand. LPN #206 stated she was told Resident #53 had a fracture and had a cast on his arm and hand. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/08/24 at 10:54 A.M. of Resident #53 revealed he was lying in bed and had a cast on his right arm and hand. Resident #53 stated Resident #45 came into his room about four to five times uninvited and sometimes he would get violent. Resident #53 stated he told the nurses about it but nothing was done and Resident #45 continued to enter his room uninvited. Resident #53 indicated on 03/26/24 Resident #45 again came into his room uninvited, started going through his dresser, and had Resident #53's money in his hand. Resident #53 stated he tried to grab his money out of Resident #45's had, Resident #45 was getting violent and pushed against him with his wheelchair causing Resident #53 to fall forward and hit his right hand on the dresser. Resident #53 stated his hand swelled up, the facility took an X-ray and told him the X-ray did not show he had a fracture. Resident #53 stated two days after this happened he went to the hospital ER, had his hand evaluated and the hospital x-rays showed he had a fracture of his right hand. Resident #53 stated Resident #45 came into his room uninvited two more times after they had the situation with his money. Resident #53 indicated they finally moved Resident #45 across the facility to another room which was not close to his. Resident #53 stated he was in worst shape now than when he was admitted . Interview on 04/09/24 at 8:18 A.M. with State tested Nursing Assistant (STNA) #212 revealed Resident #53 told her he knew his hand was broken, and he was going to sue the physician who said it was not broken. STNA #212 stated Resident #53 was extremely upset Resident #45 came into his room uninvited and tried to steal his belongings. STNA #212 stated Resident #45 wandered in and out of all the residents rooms and became aggressive if staff or other residents tried to stop him from going through their belongings. STNA #212 indicated Resident #45 used his wheelchair as a weapon when he was agitated and combative, and had pushed his wheelchair into her when he was upset. STNA #212 stated she had seen Resident #45 push his wheelchair into other staff and residents when he was upset. STNA #212 stated Resident #45 was very strong and was in the hospital now. Interview on 04/09/24 at 8:53 A.M. with the Administrator and the Director of Nursing (DON) revealed Resident #53 said a resident with dementia (Resident #45) came into his room and took things out of his drawers and when Resident #53 was attempting to get his belongings back he hit his arm on the nightstand and said he was in a lot of pain. The Administrator stated Resident #53's physician ordered an x-ray and the x-ray was negative for a fracture, and he did not know how Resident #53 fractured his hand. The DON stated Resident #53 told her the facility x-ray was wrong and that was why he went to the hospital ER for an x-ray. The Administrator stated Resident #53 went on an unsupervised LOA (leave of absence) and he did not know what happened, but he thought Resident #53 went to the hospital ER and when he returned to the facility Resident #53 had a cast on his arm and said he had a fracture of his hand. The Administrator and DON stated they did not remember Resident #53 saying Resident #45 pushed his wheelchair against him causing him to fall forward. The Administrator stated last week Resident #53 came to him, said he did not want to cause trouble, but he just wanted compensation for the work he would be missing. Resident #53 said he would call off the state if we compensated him. The Administrator indicated he knew Resident #53 from other nursing homes and Resident #53 always had problems. The Administrator and DON stated Resident #53 told them he fractured his hand at the facility because he hit it on his dresser, but they thought it was possible he self-inflicted the fracture because his goal was to receive money. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/24 at 10:53 A.M. with the Administrator and Physician #263 revealed Resident #53 told him Resident #45 was in his room uninvited in his wheelchair looking through his belongings and allegedly had Resident #53's money in his hands. Resident #53 reached for his money, ended up on the ground and the injury to his hand happened when Resident #45 was leaving the room he ran over his hand with the wheelchair. Physician #263 stated there were other concerns with Resident #53, but following the episode an x-ray of Resident #53's hand was ordered and did not show a fracture. Two days later Resident #53 went to the ER, and the x-rays at the ER showed he had a fracture. Physician #263 stated he looked at the x-rays taken at the facility and did not see a fracture, and he asked Resident #53 several ways if there was another incident following the incident with Resident #45 when he hit his hand. Resident #53 denied another incident occurred. Physician #263 stated he had a suspicion either something else happened or the injury was self-inflicted and resulted in a fracture. Physician #263 stated he reviewed the hospital notes and there was nothing that led him to believe the injury was self-inflicted except that the location of the fracture is where things tend to break when folks improperly punch something. Physician #263 stated he was not sure the fracture was consistent with Resident #53's hand hitting a dresser and his general demeanor was suspicious. Interview on 04/11/24 at 2:11 P.M. with Resident #53 via a phone call revealed Resident #45 was back in the facility and had already been in a resident room next door to Resident #53 causing problems. Resident #53 stated he heard yelling and screaming and then Resident #45 was removed from the room and redirected to another part of the facility. Resident #53 stated he was going to have to sleep with one eye open until he was discharged from the facility. Review of the facility policy titled Dementia Care undated included it was the policy of the facility to provide the appropriate treatment and services to every resident who displayed signs of, or was diagnosed with dementia, to meet his or her highest practicable physical, mental and psychosocial well-being. Care plan interventions would be related to each resident's individual symptomology and rate of dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illnesses. Care and services would be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety. If needed, the environment would be modified to accommodate individual resident care needs. This deficiency represents non-compliance investigated under Master Complaint Number OH00152659 and Complaint Number OH00151992.