| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365730 | A. Building<br>B. Wing | 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Embassy of Euclid | 3 Gateway Dr<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #29 received timely incontinence care and was free from skin breakdown. This affected one resident (Resident #29) out of three residents reviewed for incontinence care. The facility census was 66.<br><br>Findings include:<br><br>Review of Resident #29's medical record revealed and admitted [DATE] and diagnoses included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, major depressive disorder, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.<br><br>Review of Resident #29's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed A Brief Interview for Mental Status was not completed due to resident was rarely or never understood. Resident #29 was dependent for toileting, bathing, and personal hygiene. Resident #29 was frequently incontinent of urine and always incontinent of bowel.<br><br>Review of Resident #29's care plan revised on 09/11/24 included Resident #29 had a history of CVA (cerebrovascular accident) with functional impairment. Resident #29 was dependent on staff for activities of daily living (ADL) and exhibits with incontinence. Resident #29's ADL needs would be met through the next review. Interventions included Resident #29 was a total assist with activities of daily living; Resident #29 was a two person assist with a mechanical lift. Resident #29 had bladder and bowel incontinence. Resident #29 would be comfortable, clean, dry and free from skin breakdown through the next review. Interventions included to monitor peri-area and rectal area for redness, irritation, and skin excoriation, breakdown; provide peri-care after each incontinent episode.<br><br>Review of Resident #29's medical record revealed the resident did not have skin break down as of 12/10/24.<br><br>Observations on 12/10/24 from 8:30 A.M. revealed Resident #29 was sitting in a padded wheelchair by a table in the common area.<br><br>Observation on 12/10/24 at 9:21 A.M. revealed Resident #29 was sitting in a padded wheelchair by the same table in the common area. Resident #29's head was laying on the table.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 12/10/24 at 11:16 A.M. revealed Resident #29 was sitting in a padded wheelchair by the same table in the common area and an aide was placing a garment to protect her clothes from food spills around her neck and across her chest.<br><br>Observation on 12/10/24 at 12:43 P.M. of Resident #29 revealed Resident #29 was sitting in the wheelchair by the same table in the common area and Certified Nursing Assistant (CNA) #400 pushed Resident #29's wheelchair from the table to the nurses station and stated she was getting ready to assist Resident #29 to bed, but she needed a mechanical lift and was waiting for a second aide to help her.<br><br>Observation on 12/10/24 at 1:12 P.M. revealed Registered Nurse (RN) #401 assisted CNA #400 to use a mechanical lift to place Resident #29 into her bed and have incontinence care provided. RN #401 stated he was not assigned to care for Resident #29 but was helping CNA #400 because the other aide was at lunch. CNA #400 proceeded to remove Resident #29's incontinence brief and a large amount of yellow urine and a large amount of feces were observed on the brief. CNA #400 began cleaning Resident #29's perineal area using a wash cloth and warm basin of water. CNA #400 wiped down with the wash cloth then back up and when the wash cloth wiped up feces could be seen on the wash cloth. CNA #400 folded the washcloth with the feces on it and kept wiping the perineal area multiple times down and then back up and each time she wiped upward a moderate amount of feces could be seen on the wash cloth. After cleaning Resident #29's perineal area CNA #400 turned Resident #29 on her right side and cleaned her rectal area. A nickel size discolored pink area could be seen in the crease of the right thigh and buttock and in the center of the discolored pink area was a small open area with a reddish-pink wound bed. CNA #400 stated the area was not open and rubbed her finger over the area, but when she rubbed her finger over the open area Resident #29 cried out in pain. CNA #400 and RN #401 confirmed Resident #29 had a small open area in the right crease of her buttock and thigh. After confirming Resident #29's open area CNA #400 took a towel and wet one side of it with water from the basin and used it to wipe Resident #29's buttocks and dry them with the end of towel not placed in water. CNA #400 and RN #401 placed a clean incontinence brief on Resident #29 and CNA #400 stated she would tell the nurse assigned to Resident #29 about the open area, have it evaluated and get treatment orders. CNA #400 stated Resident #29's incontinence brief was dry when she put her in the wheelchair before breakfast and this was the first time Resident #29 received incontinence care since she was placed in her wheelchair. CNA #400 indicated Resident #29 usually stayed in the common area until after lunch because there were activities and there was more stimulation in the common area than in her room.<br><br>Interview on 02/10/24 at 3:46 P.M. of the Director of Nursing (DON) confirmed CNA #400 did not provide incontinence care correctly.<br><br>Review of Resident #29's progress notes dated 12/10/24 at 5:34 P.M. included the nurse was notified by staff that Resident #29 had a small area to the right buttocks, the wound team was made aware, MASD (moisture associated skin damage) was present and new orders were received. Resident #29's son and physician were aware. The interdisciplinary team met, reviewed report, updated Resident #29's care plan, and treatment implemented.<br><br>Review of Resident #29's physician orders dated 12/10/24 at 5:47 P.M. revealed cleanse right and left buttocks with soap and water, pat dry, apply Triad paste and leave open to air every shift and as needed for treatment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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. If the perineum was grossly soiled, turn resident on side, remove any fecal material with toilet paper, then remove and discard. Cleanse buttocks and anus, front to back, vagina to anus in females using a separate wash cloth or wipes. Thoroughly dry. Re-position the resident in the supine position, change gloves if soiled and continue with perineal care. For females separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward anus). Repeat on opposite side using separate section of the washcloth or a new disposable wipe. Clean urethral meatus and vaginal orifice using clean portion of the washcloth or new disposable wipe with each stroke. Pat dry with towel. Always note any skin changes such as rash, red pr pink areas or any discolorations to skin. Report to nurse when applicable.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00160445 and Complaint Number OH00159858. |