STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. Building B. Wing	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on record review, interview, and facility policy review the facility failed to ensure the care plans for Resident's #73 and #85 were comprehensive to include activities of daily living (ADL) needs, incontinence care, and skin integrity. This affected two Resident's (#73 and #85) of five residents reviewed for care plans. The facility census was 97. Findings include: 1. Review of the medical record for Resident #73 revealed an admitted [DATE]. Diagnoses included schizophrenia, anemia, chronic kidney disease stage 4 severe, diabetes mellitus due to underlying condition with diabetic peripheral angiopathy (a disease of the blood or lymph vessels) without gangrene, chronic diastolic congestive heart failure, and chronic peripheral venous insufficiency. Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #73 had no cognitive impairment. Resident #73 required extensive one staff assistance for bed mobility and was dependent on one staff assistance for transfers and toileting. The assessment indicated Resident #73 was occasionally incontinent of urine and always incontinent of bowel. Review of the plan of care initiated 04/23/22 revealed Resident #73 had an ADL self-care deficit related to impaired mobility and visual impairment and was incontinent of bowel and bladder. Interventions included to inspect for skin breakdown and intervene when needed; provide bed mobility and toileting of one staff assistance, and transfers of two staff assistance; and encourage to use the call light when needed. There were no focus or interventions in the care plan regarding the risk for impaired skin integrity. Review of the nurse practitioner (NP) progress notes dated on 04/25/22, 04/27/22, 05/17/22, 05/24/22, and 06/13/22 revealed Resident #73 had an open area to the lateral side of the left foot. Review of the wound physician progress notes dated 06/13/22, 06/16/22 and 06/20/22 revealed Resident #73 was examined and treated for a left lateral foot pressure wound. Interview on 07/11/22 at 10:31 A.M. with the Administrator and Senior Administrator #436 verified there were no focus areas or interventions in Resident #73's care plan for potential for or impaired skin integrity. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #85 revealed an admitted [DATE]. Diagnoses included urinary tract infection, hematuria, adult failure to thrive, legal blindness, retention of urine, disorder of prostate, and dementia without behavioral disturbance. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #85 had no cognitive impairment. Resident #85 required supervision of one staff assistance for bed mobility, locomotion, dressing, eating, toileting, and personal hygiene, and supervision and set-up assistance for transfers and ambulation. Bathing did not occur. The assessment indicated Resident #85 was occasionally incontinent of urine and always continent of bowel. Review of the plan of care initiated 06/23/22 revealed Resident #85 had impaired communication related to vision loss and impaired cognitive process for daily decision making. Interventions included to ask simple yes or no questions; anticipate need; and keep clean, dry, and comfortable every shift. There were no focus areas or interventions in the care plan regarding ADL needs or incontinence care. Interview on 07/05/22 at 11:44 A.M. with Registered Nurse (RN) #350 verified there were no focus areas or interventions in Resident #85's care plan for ADL needs or incontinence care. Review of the facility policy titled Care Planning - Interdisciplinary Team, revised September 2013, revealed the interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident based on the resident's comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review, the facility failed to provide care and services in the areas of incontinence care and bathing for Resident #24. This affected one Resident (#24) of four reviewed for care and services. The facility census was 97. Findings include: Review of the medical record for Resident #24, revealed an admitted [DATE] with diagnoses including respiratory failure, muscle weakness, and peripheral vascular disease. Review of the Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 had no cognitive impairment. Resident #24 required extensive two staff assistance for bed mobility, toileting, and transfers, and required physical help of one staff assistance in part of bathing activity. The assessment indicated Resident #24 was always incontinent of urine and bowel and had a nasogastric feeding tube. Review of the plan of care dated 05/11/22 revealed Resident #24 had an activities of daily living (ADL) self-care performance deficit and was incontinent. Interventions included to provide ADL assistance and incontinence care as needed. Observation on 07/11/22 at 7:51 A.M. of Resident #24 in bed revealed thick dried crust to the inside and outside of the nose surrounding a nasogastric tube and cracked lips. Interview at the time of the observation, Resident #24 stated she had not received a shower in over two weeks and could not recall when the last shower was received. Resident #24 further indicated incontinence care was not provided during the night and stated she was currently incontinent. Interview on 07/11/22 at 9:22 A.M. with Resident #24 revealed staff had not yet provided incontinence care. Observation on 07/11/22 at 9:36 A.M. of incontinence care with State tested Nurse Aides (STNA's) #357 and #433 for Resident #24 verified Resident #24 was incontinent of stool. Interview at the time of the observation with STNA's #433 and #357 confirmed Resident #24 did not receive incontinence care since they started the shift at 7:00 A.M. STNA #357 further stated Resident #24's showers were on second shift and did not know if they were getting completed. Interview on 07/11/22 at 9:43 A.M. with STNA's #357 and #433 verified there was not enough staff to always complete tasks including showers and answering call lights timely. Review of a physician's order dated 05/12/22 revealed Resident #24 was to receive a shower biweekly on day shift on Sunday and Thursday which was discontinued on 06/08/22. Review of the facility submitted shower sheets revealed a shower was provided on 05/08/22, 05/18/22, 06/01/22, and 06/08/22. Review of the nursing assistance flow record dated 07/12/22 with a 30-day look back revealed one shower was documented on 07/06/22 and a bed bath on 07/01/22. There was no evidence a shower was provided between 06/08/22 and 07/06/22 and one bed bath was documented on 07/01/22. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/12/22 at 11:15 A.M. with the Administrator verified there was no evidence a shower was provided for Resident #24 between 06/08/22 and 07/06/22 and stated there was one bed bath documented on 07/01/22. Review of the facility policy titled Personal Care Procedure, revised July 2018, revealed it was the policy of the facility to provide and assist resident care and hygiene based on individual status and needs including bathing or showers which may be bed baths and peri-care. This deficiency substantiates Master Complaint Number OH00133794 and Complaint Number OH00133282.

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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 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, record review, interview, and facility policy review, the facility failed to timely initiate and provide adequate care and treatment for pressure ulcers for four Residents (#18, #38, #41 and #73). This resulted in actual harm for Resident #18, who was admitted to the facility on [DATE]. Resident #18 was dependent on two staff assistance for bed mobility and required tracheostomy care. Resident #18 developed a posterior neck pressure wound on 12/15/21. Continued treatments were not administered as ordered and by 06/13/22, Resident #18's pressure wound had reoccurred, received inadequate treatments, and required mechanical debridement. This resulted in actual harm for Resident #38, who was admitted to the facility on [DATE], was dependent on two staff assistance for bed mobility and required tracheostomy care. On 05/02/22, Resident #38 developed a posterior neck pressure ulcer, and by 06/06/22, due to improper and lack of wound treatments the pressure ulcer declined and developed cellulitis which required antibiotic treatment. This resulted in actual harm for Resident #41, who was admitted to the facility on [DATE], was dependent on one staff assistance for bed mobility, and had severe cognitive impairment. Resident #41 had skin areas identified upon admission including to the right and left heel with no descriptive information. By 05/09/22, Resident #41's right and left heel pressure ulcers required debridement. From 05/26/22 to 05/30/22, Resident #41 was treated at the hospital for diagnoses including altered mental status and pressure injury of the deep tissue of the right heel and received intravenous antibiotics. This resulted in actual harm for Resident #73, who was admitted to the facility on [DATE], was extensive one staff assistance for bed mobility, dependent on one staff assistance for transfers, and was assessed to be at low risk for the development of pressure ulcers. On 04/25/22, an open area was identified on the left lateral side of the foot. There were no wound treatments or assessments completed until 06/13/22 when the area was identified as a left lateral foot unstageable pressure wound (full-thickness skin and tissue loss in which the extent of the ulcer cannot be confirmed because it is obscured by slough or eschar) and required sharp debridement. This affected four Residents (#18, #38, #41 and #73) of eight residents identified with pressure ulcers. The facility census was 97. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE]. Resident #18 was transferred to the hospital on 01/27/22 and returned on 02/02/22 and was transferred to the hospital again on 04/05/22 and returned on 04/06/22. Diagnoses included chronic respiratory failure, acquired deformity of head, attention to tracheostomy, essential primary hypertension, chronic obstructive pulmonary disease, and muscle weakness. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 had severe cognitive impairment assessed as rarely or never understood. Resident #18 was dependent on two staff assistance for bed mobility and was dependent on one staff assistance for toileting. Transfers did not occur. The assessment indicated Resident #18 was always incontinent of urine and bowel. Review of the plan of care initiated 04/02/21 revealed Resident #18 was at risk for impaired skin integrity related to confined to bed all or most of the time, incontinence, on a tracheostomy, a history of pressure ulcers, and required staff to reposition. Interventions included to apply protective barrier cream after incontinent episodes; assist with turning and repositioning as needed; and treatments per physician orders. Review of the pressure ulcer risk assessment completed 08/29/21 revealed Resident #18 was at high risk for the development of pressure ulcers. There were no additional pressure ulcer risks completed after 08/29/21. Review of the skin grid pressure assessment dated [DATE] revealed an original wound development of the left posterior neck which measured 2.0 centimeters (cm) length by 3.4 cm width by 0.2 cm depth and described as a stage 3 pressure ulcer (full-thickness skin loss in which subcutaneous fat may be visible but bone, tendon or muscle are not exposed) with maceration and a faint odor. Review of Resident #18's physician orders revealed an undated order for a pressure reducing mattress to the bed which was discontinued on 04/05/22, an order dated 02/28/21 to change tracheostomy ties as needed which was discontinued on 01/27/22, and an order dated 09/24/21 to apply an abdominal dressing (ABD) under the left side of the neck underneath the tracheostomy ties every shift for a protective dressing for the skin which was discontinued on 10/13/21. There were no additional protective dressing orders initiated after 10/13/21 prior to the onset of the stage 3 left posterior neck pressure ulcer. On 12/16/21, an order was initiated for a treatment to the left posterior neck to cleanse with soap and water, pat dry, apply triad (a wound paste used for moist wound beds) to absorb and secure with an ABD four times daily, and to not allow the tracheostomy ties to touch the skin. The order was discontinued on 01/27/22. Review of the weekly skin grid pressure assessments dated on 12/22/21, 12/29/21, 01/05/22, 01/12/22, 01/19/22 and 01/26/22 revealed the left posterior neck stage 3 pressure ulcer was assessed for healing until Resident #18 was transferred to the hospital on 01/27/22. Review of interdisciplinary team progress note dated 02/03/22 revealed Resident #18 was readmitted to the facility on [DATE] with an ulcer to the coccyx. There was no assessment of the wound. Review of the medical record revealed no skin assessment upon return from the hospital on 02/02/22. Review of Resident #18's physician orders revealed an order dated 02/03/22 for a treatment to the coccyx to wash with normal saline, pat dry, and apply a foam dressing daily, which was discontinued on 02/25/22. A new order was initiated on 02/25/22 for triad paste to the sacrum topically every shift for the skin, which was discontinued on 04/05/22. Review of the medical record revealed no skin grid pressure assessments and no wound physician progress notes for the coccyx wound between 02/02/22 and 04/05/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the weekly skin grid pressure assessment dated on 02/16/22 revealed a posterior neck pressure wound documented as not a new area with no origination date. The area measured 1.0 cm length by 2.5 cm width by 0.1 cm depth. The wound stage was documented as not available. There was no documented appearance or status of the wound. The wound drainage was minimal with odor. Review of the weekly skin grid pressure assessment dated on 02/21/22 revealed a posterior neck pressure wound documented as not a new area with no origination date. There was no documentation of wound measurements, or a general appearance of the wound. The drainage was described as minimal with odor and the status of the wound was not documented. The area was documented as healed. Review of Resident 18's physician orders revealed no treatment order for the posterior neck pressure wound from 02/16/22 through 02/21/22. On 02/25/22, an order was initiated for a treatment to the posterior neck to cleanse with normal saline, pat dry, apply an ABD daily and as needed, which was discontinued on 04/05/22 when Resident #18 was transferred to the hospital. Review of the weekly skin grid pressure assessment dated on 03/28/22 revealed a posterior neck pressure wound, stage 3, documented as not a new area with no origination date. There was no documentation of wound measurements. The wound was described as 100 percent epithelial healed on last wound report and was a check for continued healing. The drainage was described as minimal serosanguinous (thin and watery and pink in color) with odor. The status of the wound was described as improved and healed on 02/21/22. Review of the medical record revealed no wound physician progress notes for the posterior neck pressure wound between 02/16/22 and 04/05/22. Review of the nursing progress note dated 04/06/22 revealed Resident #18 returned from the hospital. There was no documentation of a skin assessment. Review of the respiratory progress note dated 04/12/22 revealed Resident #18 had copious secretions. It was recommended for trach ties to be changed daily to prevent skin breakdown. Review of physician/nurse practitioner (NP) progress note dated 04/15/22 revealed pressure ulcers and to reference wound report. Thick yellow secretions were noted in tracheostomy collar. Review of respiratory note dated 04/18/22 revealed due to neck wounds and copious secretions it was recommended for trach ties to be changed out daily to prevent further skin breakdown and promote healing of current neck wounds, and to keep area as dry as possible. Review of physician/NP progress note dated 04/22/22 revealed pressure ulcers and to reference wound report. Review of Resident #18's physician orders revealed on 04/12/22 an order the medical revealed a treatment to cleanse the neck with normal saline, pat dry and apply an ABD daily and as needed, which was discontinued on 06/08/22. An order initiated 04/07/22 to change the tracheostomy collar and mask weekly on Sundays and as needed was discontinued on 04/13/22 and was re-initiated on 04/13/22 to change weekly on Tuesdays. There were no physician orders to change the tracheostomy collar or tracheostomy ties daily as recommended to prevent further skin breakdown and promote healing of neck wounds as noted in the progress note dated 04/18/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the skin grid pressure assessment dated [DATE] revealed a posterior neck pressure wound was identified with an origination date of 06/06/22. The pressure ulcer stage was documented as not available, measured as 4.0 cm length by 0.3 cm width by 0.2 cm depth. There was no general wound appearance documented. There was erythematous (redness) surrounding the wound with light serosanguinous drainage. The status of the wound was not described. Review of the medical record revealed there were no weekly skin grid pressure assessments completed after 06/08/22. Review of the facility wound tracking log dated week ending 04/25/22 revealed Resident #18 had a posterior neck stage 3 pressure ulcer which originated in the facility on 12/15/21 which was closed for two weeks, healed on 02/28/22, with a continued treatment. Review of the Treatment Administration Record (TAR) for May 2022 and June 2022 revealed the treatment to the neck dated 04/12/22 to cleanse with normal saline, pat dry, apply an ABD daily and as needed daily was not completed as ordered during day shift on 05/21/22, 05/23/22, 05/25/22, 05/28/22, 05/29/22 and 06/03/22. Review of the wound physician progress note dated 06/06/22 revealed Resident #18 was examined for a new posterior neck medical device pressure wound developed from tracheotomy tube ties around the neck and was seen in the past for the same. The plan for the wound was to cleanse with a wound cleanser, pat dry, apply xeroform (occlusive dressing to promote wound healing) to wound bed and ABD pad to cover daily and as needed; perform routine tracheostomy care including daily drain sponge changes and weekly neck tie changes; an air mattress; and a strict regimen of turning and repositioning every two hours and as needed. The treatment plan was provided to the wound care nurse verbally and written. Review of Resident #18's physician orders revealed an order dated 06/08/22 for a treatment to cleanse the wound bed with normal saline, pat dry, apply xeroform and cover with ABD daily and as needed, which was discontinued on 06/20/22. Review of the wound physician progress note dated 06/13/22 revealed Resident #18 was examined for a posterior neck medical device pressure wound. The soiled dressing was removed with dirty odor and positive strike through (the dressing barrier was breached, and bacteria can access the wound), it was dried into the wound bed and black mold was beginning to form on the xeroform. The wound nurse was made aware of the dressing changes to be done daily. The wound measured 4.0 cm length by 0.3 cm width by 0.2 cm depth and was debrided mechanically. There was no change in treatment. Review of the wound physician progress note dated 06/20/22 revealed Resident #18 was examined for a posterior neck medical device pressure wound and there was no change from the previous visit. The soiled dressing was removed with dirty odor and positive strike through, it was dried into the wound bed and black mold was beginning to form on the xeroform. The wound nurse was made aware of the dressing changes to be done daily. The wound measured 4.0 cm length by 0.3 cm width by 0.2 cm depth and was debrided mechanically. There was no change in treatment. Review of the TAR for June 2022 revealed the treatment dated 06/08/22 to the wound bed to cleanse with normal saline, pat dry, apply xeroform, and cover with ABD daily and as needed were signed as completed prior to the wound physician's examinations on 06/13/22 and 06/20/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	2. Review of the medical record for Resident #38 revealed an admitted [DATE]. Resident #38 was transferred to the hospital on 04/23/22 and returned on 04/26/22 and was transferred to the hospital again on 06/27/22 and returned on 06/30/22. Diagnoses included chronic respiratory failure, anxiety disorder, diabetes mellitus type two without complications, essential primary hypertension, heart failure, and attention to tracheostomy. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #38 had severe cognitive impairment and was assessed as rarely or never understood. Resident #38 was dependent on two staff assistance for bed mobility, transfers, and toileting. The assessment indicated Resident #38 was always incontinent of urine and bowel. Review of the plan of care initiated 02/10/22 revealed Resident #38 had impaired skin integrity due to a wound to the posterior neck and had potential for alteration in skin integrity. Interventions included to assist with turning and repositioning as needed; a pressure redistribution mattress to bed; use barrier cream with showers and incontinence care; and treatments per physician orders. Review of the pressure ulcer risk assessment completed on 11/22/21 revealed Resident #38 was at moderate risk for the development of pressure ulcers. A repeated pressure ulcer risk assessment was not completed until 04/26/22 which determined Resident #38 was at very high risk for the development of pressure ulcers. Review of the skin grid pressure assessment dated [DATE] revealed a posterior neck stage 3 pressure ulcer with no origination date. There were no wound measurements documented. The wound was described as 100 percent granular with minimal drainage. Review of the wound physician progress note dated 05/02/22 revealed Resident #38 was examined for a pressure injury to the posterior neck with a tracheostomy present. Resident #38 had a history of neck cellulitis which resolved 03/22/21, and the date of the onset of the wound was unknown. The medical device related pressure injury to the posterior neck was sustained from tracheostomy tie and tracheostomy oxygen mask straps embedded in the neck. The wound was a stage 3 pressure ulcer which measured 0.3 cm length by 7.8 cm width by 0.2 cm depth and macerated wound edges. At the time of the examination, the xeroform was not in place and the serosanguineous drainage dried causing the tracheostomy ties to embed in the wound. The treatment plan was to cleanse with wound cleanser, apply xeroform then an ABD daily and as needed. The treatment plan was either written or given orally. Review of Resident #38's physician orders revealed an order dated 04/27/22 to turn and reposition every two hours every shift which was discontinued on 06/27/22. There were no orders initiated for a treatment to the posterior neck wound prior to 05/11/22. Review of the skin grid pressure assessment dated [DATE] revealed a posterior neck stage 3 pressure ulcer with no origination date. The wound measured 0.3 cm length by 9.0 cm width by 0.1 cm depth. The wound was described as 100 percent granular with an irregular ovoid shape, full thickness with epithelial bridges in between. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the wound physician progress note dated 05/09/22 revealed Resident #38 was examined for the posterior neck stage 3 pressure wound. The xeroform was not in place again this week and the serosanguineous drainage dried causing the tracheostomy ties to embed in the wound. The wound measured 0.3 cm length by 9.0 cm width by 0.1 cm depth with macerated wound edges and black moldy drainage. The wound was declined. Review of the skin grid pressure assessment dated [DATE] revealed a posterior neck stage 3 pressure ulcer with no origination date. The wound measured 0.3 cm length by 9.0 cm width by 0.1 cm depth. The wound was described as 100 percent granular with an irregular ovoid shape, full thickness with epithelial bridges in between. Review of Resident #38's physician orders revealed an order dated 05/11/22 to apply xeroform and an ABD to behind the neck daily and as needed which was discontinued on 06/27/22. Review of the skin grid pressure assessment dated [DATE] for Resident #38 revealed it was not completed. Review of the wound physician progress note dated 05/16/22 revealed Resident #38 was examined for the posterior neck stage 3 pressure wound. The xeroform was not in place again this week and the serosanguinous drainage dried causing the tracheostomy ties to embed in the wound. The wound measured 0.3 cm length by 9.0 cm width by 0.1 cm depth with macerated wound edges and black moldy drainage. Review of the wound physician progress note dated 06/06/22 revealed Resident #38 was examined for the posterior neck stage 3. There were new findings of surrounding wound cellulitis. The xeroform dressing was not in place again as ordered. Routine dressing changes were not completed. The wound measured 2.0 cm length by 10.0 cm width by 0.2 cm depth with redness, warmth and swelling surrounding the wound. There was black moldy drainage. The wound declined due to improper wound treatment and lack of treatments completed. There was cellulitis surrounding the wound. Keflex (antibiotic) was ordered for seven days. Review of the skin grid pressure assessment dated [DATE] for Resident #38 revealed a posterior neck stage 3 pressure ulcer with an origination date of 02/21/22. The wound measured 2.0 cm length by 10.0 cm width by 0.2 cm depth. The wound was described as 100 percent granular with surrounding cellulitis and minimal drainage. Review of Resident #38's medical record revealed there were no weekly skin grid pressure assessments completed between 05/16/22 and 06/08/22 and after 06/08/22 for the posterior neck stage 3 pressure ulcer. Review of the TAR for May 2022 and June 2022 revealed the order dated 05/11/22 to apply xeroform and an ABD to behind the neck daily and as needed was not completed as ordered on 05/21/22, 05/23/22, 05/26/22, 05/28/22, 05/29/22, 06/03/22, 06/08/22, 06/10/22, 06/13/22 and 06/16/22. 3. Review of the medical record for Resident #41 revealed an admitted [DATE]. Resident #41 was transferred to the hospital on 05/26/22 and returned on 05/30/22. Diagnoses included multiple sclerosis, muscle weakness, contracture of right and left knee, dementia without behavioral disturbance, and essential primary hypertension. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 had severe cognitive impairment and was assessed as rarely or never understood. Resident #41 was dependent on one staff assistance for bed mobility, transfers, and toileting. The assessment indicated Resident #41 had a urinary catheter and was always incontinent of bowel. Review of the plan of care initiated 06/24/22 revealed Resident #41 was at risk for impaired skin integrity related to incontinence of bowel and dependent with mobility. Interventions included to apply protective barrier cream after incontinent episodes and as needed; assist with turning and repositioning as needed; a pressure redistribution mattress to bed; and provide incontinence care as needed. Review of the pressure ulcer risk assessment completed on 04/04/22 revealed Resident #41 was at high risk for the development of pressure ulcers. Review of the admission assessment with baseline care plan dated 04/04/22 revealed skin areas to the left buttock, right heel, left heel, and left lateral foot. There were no measurements or a description of the wounds. Review of Resident #41's physician orders revealed an order dated 04/05/22 for a treatment to the left heel and left lateral foot to cleanse with normal saline, cover heel with xeroform and ABD with Eucerin moisturizer to surrounding skin and leg with light gauze wrap every 48 hours and as needed, which was discontinued on 04/11/22, and an order dated 04/05/22 to apply menthol zinc oxide ointment 0.44-20.6 percent topically every shift for incontinent care to bilateral buttocks and sacrum which was discontinued on 05/26/22, and orders dated 04/05/22 to turn and reposition every two hours every shift and float heels when in bed every shift which were discontinued on 05/26/22. There were no physician orders initiated for the right heel area identified on the 04/04/22 admission assessment. Review of Resident #41's medical record revealed there were no weekly skin grid assessments completed for the skin areas identified on the 04/04/22 admission assessment. Review of the weekly skin grid pressure assessments dated on 04/11/22 revealed a left heel unstageable pressure ulcer documented as present upon admission with an origination date of 03/20/22. The wound measured 5.0 cm length by 2.0 cm width by undetermined depth. The general appearance was described as debridement for necrotic tissue, and drainage was moderate. The left lateral medial area was healed. Review of the weekly skin grid pressure assessments dated 04/18/22, 04/25/22, 05/02/22 and 05/09/22 revealed completed assessments for Resident #41's left heel pressure ulcer. On 05/09/22, the left heel pressure wound measured 4.0 cm length by 3.2 cm width by 0.1 cm depth, was described as a stage 3 area and had declined. The weekly skin grid pressure assessment completed on 05/16/22 was not completed. Review of Resident #41's physician orders revealed an order dated 04/11/22 for a treatment to the left heel to cleanse with normal saline, pack with collagen, cover with ABD, wrap with kerlix daily, which was discontinued on 05/26/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the wound physician progress note dated 05/09/22 revealed Resident #41 had a left heel stage 3 pressure wound. The wound was debrided manually and a new dressing change to cleanse with wound cleanse, apply collagen powder, then an ABD and gauze wrap daily was made. The right heel stage 3 pressure wound was also debrided at the beside with orders to cleanse the right heel with wound cleanser, apply collagen, an ABD and gauze wrap daily and as needed. Review of Resident #41's physician orders revealed there was no order for the right heel pressure wound as initiated on the wound physician progress note dated 05/09/22. Review of the wound physician progress note dated 05/16/22 revealed Resident #41 had a left heel stage 3 pressure wound and a right heel stage 3 pressure wound. The right heel treatment plan was to clean with wound cleanser, apply collagen, cover with ABD, wrap with gauze wrap daily and as needed. Review of the TAR for May 2022 revealed there were no treatments administered to the right heel from 05/01/22 and when Resident #41 was transferred to the hospital on 05/26/22. Review of the hospital discharge information dated 05/26/22 to 05/30/22 revealed Resident #41 was admitted for altered mental status and pressure injury of the deep tissue of the right heel. Intravenous antibiotics were administered during the hospital stay. Treatment orders upon discharge included to cleanse the right and left heels with wound cleanser, cover with xeroform gauze, an ABD and Eucerin moisturizer to surrounding skin and leg with light gauze wrap daily and as needed; apply to the sacrum, coccyx, and buttocks a Calmoseptine, Desitin and vitamin A and D ointment mixture twice daily and as needed without a foam dressing or may use Vaseline gauze and ABD to cover. Review of Resident #41's physician orders revealed an order dated 05/30/22 for a treatment to the feet, ankles, and heels to cleanse with wound cleaner, apply three packages of xeroform, then apply an ABD and wrap with gauze wrap daily and as needed; and a treatment to the sacral area to apply Calmoseptine, Desitin and vitamin A and D ointment twice daily and as needed without a foam dressing or may use Vaseline gauze and ABD to cover. Review of the admission assessment with baseline care plan dated 05/30/22 revealed skin areas to the sacrum, left foot, and right foot. There were no measurements or a description of the wounds. Review of Resident #41's medical record revealed there were no weekly skin grid assessments completed for the skin areas identified on the 05/30/22 admission assessment. Review of the nursing progress note dated 05/30/22 revealed Resident #41 had dressing for the feet. Review of the wound physician progress note dated 06/06/22 revealed Resident #41 had a left heel stage 3 pressure wound and a right heel stage 3 pressure wound which was debrided at the bedside. The right heel stage 3 pressure wound plan was to continue with wound cleanser, apply collagen to wound bed, cover with ABD and wrap with gauze wrap daily and as needed. Review of the weekly skin grid pressure assessment dated [DATE] revealed Resident #41 had a stage 3 pressure area to the left heel which measured 4.0 cm length by 1.5 cm width by 0.1 cm depth and was debrided at the bedside to promote healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #41's physician orders revealed an order dated 05/30/22 for a treatment to the feet, ankles, and heels to cleanse with wound cleaner, apply three packages of xeroform, then apply an ABD and wrap with gauze wrap daily and as needed and to apply to the sacral area Calmoseptine, Desitin and vitamin A and D ointment twice daily and as needed without a foam dressing or may use Vaseline gauze and ABD to cover; an order dated 06/08/22 to cleanse the right heel with normal saline, apply collagen to the wound bed, cover with an ABD, wrap with gauze wrap daily and as needed which was discontinued on 06/17/22; an order dated 06/17/22 to cleanse the left heel with normal saline, apply collagen to the wound bed, cover with an ABD, wrap with gauze wrap daily and as needed which was discontinued on 06/20/22; and an order dated 06/20/22 to cleanse the left heel with normal saline, apply an ABD and wrap with gauze wrap daily and as needed. Review of Resident #41's medical record revealed there were no weekly skin grid pressure assessments completed for the right heel on or after 06/08/22, and none completed for the left heel after 06/08/22. 4. Review of the medical record for Resident #73 revealed an admitted [DATE]. Diagnoses included schizophrenia, anemia, chronic kidney disease stage 4 severe, diabetes mellitus due to underlying condition with diabetic peripheral angiopathy (a disease of the blood or lymph vessels) without gangrene, chronic diastolic congestive heart failure, and chronic peripheral venous insufficiency. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #73 had no cognitive impairment. Resident #73 required extensive one staff assistance for bed mobility and was dependent on one staff assistance for transfers and toileting. The assessment indicated Resident #73 was occasionally incontinent of urine and always incontinent of bowel. Review of the plan of care initiated 04/23/22 revealed Resident #73 had an activities of daily living (ADL) self-care deficit related to impaired mobility and visual impairment and was incontinent of bowel and bladder. Interventions included to inspect for skin breakdown and intervene when needed; provide bed mobility and toileting of one staff assistance, and transfers of two staff assistance; and encourage to use the call light when needed. There were no focus or interventions in the care plan regarding the risk for impaired skin integrity. Review of the pressure ulcer risk assessment completed on 04/22/22 revealed Resident #73 was at low risk for the development of pressure ulcers. A repeated pressure ulcer risk assessment completed on 05/13/22 revealed Resident #73 was at low risk for the development of pressure ulcers. Review of the skin observation completed for admitted d 04/29/22 revealed Resident #73's skin was intact. There were no skin impairments identified. Review of NP progress notes dated on 04/25/22, 04/27/22, 05/17/22, 05/24/22 and on 06/13/22 revealed Resident #73 had an open area to the lateral side of the left foot. On 06/13/22, Resident #73 was requested to be seen by wound management in the facility. Review of Resident #73's physician orders revealed an order dated 04/23/22 for skin checks biweekly and an order dated 04/25/22 for skin checks weekly on day shift. There were no treatment orders for the open area to the lateral side of the left foot identified on 04/25/22 through 06/13/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #73's medical record revealed there were no weekly skin assessments completed for the open area identified on 04/25/22. Review of the wound physician progress note dated 06/13/22 revealed Resident #73 had a left lateral foot unstageable pressure wound covered with hard black eschar (dead skin) which measured 1.5 cm by 1.0 cm by undetermined depth. An order was given to cleanse the wound with wound cleanser, apply skin prep, cover with an ABD, and wrap with gauze wrap daily and as needed. An air mattress was recommended. Review of Resident #73's physician orders revealed an order dated 06/16/22 to cleanse the left foot, pat dry, apply skin prep, cover with an ABD, and wrap with gauze dressing daily. There was no order for an air mattress. Review of the wound physician progress note dated 06/20/22 revealed Resident #73 was examined for the left lateral foot unstageable pressure wound. The old dressing was not intact. There area was debrided sharply manually with a #15 blade and forceps to improve wound healing and reduce the risk of infection. The wound measured 1.5 cm length by 1.2 cm width by 0.2 cm depth. A new treatment was ordered to cleanse, apply collagen to the wound bed, cover with an ABD and wrap with gauze daily and as needed. Review of Resident #73's medical record revealed there were no weekly skin assessments completed for the left lateral foot unstageable pressure wound identified on 06/13/22 or thereafter. Interview on 07/05/22 at 11:44 A.M. with Registered Nurse (RN) #350 and Director of Nursing (DON) reviewed and verified the above findings for Resident #38. RN #350 indicated substituting for having no wound nurse and was only making rounds with the wound doctor. The DON verified skin grids were supposed to be completed independently from the wound physician, on admission and weekly with treatment initiated for new identified areas. The DON stated staffing was an issue and past DON's were working on the floor which contributed to lack of tracking so there were things that fell by the wayside and assessments did not get completed. The DON verified the facility still did not have a nurse to oversee wound care, but weekly wound logs were being updated and stated for now the weekly wound grids were too much to keep up. Interview on 07/05/22 at 6:05 A.M. with RN #401 revealed it was better to have two nurses to complete all the heavier care

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, and record review the facility failed to provide sufficient staff to meet the needs of the residents. This affected seven residents (Resident's #16, #24, #37, #46, #62, #81 and #87) and had the potential to affect all 97 residents residing in the facility. Findings include: Interview on 06/30/22 at 10:25 A.M. with State tested Nursing Assistant (STNA) #308 confirmed there were not enough aides assigned to complete rounds in pairs, so it took longer to complete; therefore, rounds were not completed every two hours, and showers were not always completed if there was not enough time. STNA #308 verified it took longer to answer call lights at times, especially during mealtimes, depending on what the staff were busy doing. Interview on 06/30/22 at 10:50 A.M. with Resident #37 revealed a complaint that it took too long for call lights to be answered, the call light was turned off and staff did not return, and it took longer to receive assistance when requested on all shifts. Interview on 06/30/22 at 11:24 A.M. with Resident #62 revealed it took a long time to receive assistance when requested on all shifts. Interview on 06/30/22 at 12:35 P.M. with Licensed Practical Nurse (LPN) #430 verified it would be better with one additional STNA; without an additional aide it took longer to get tasks completed. Review of the staffing tool from 06/19/22 through 06/25/22 revealed the facility did not meet the daily direct care requirement of 2.50 hours per resident on 06/19/22. Interview on 06/30/22 at 3:24 P.M. with STNA #420 who completed scheduling for the facility verified on the staffing tool completed from 06/19/22 through 06/25/22, the facility was below the required daily direct care requirement of 2.50 hours per resident on 06/19/22. STNA #420 indicated the facility staff and agency staff were used to cover staff call-offs, but some days the facility just met the minimum; on 06/19/22 there were two call-offs which were not covered. Observation on 07/05/22 at 5:55 A.M. of the critical recovery unit (CRU) revealed one nurse and two STNAs assigned to 31 residents on the night shift assignment. Interview on 07/05/22 at 6:01 A.M. with STNA #364 revealed since there was only one other STNA in the CRU area, it was necessary to split the area in half and perform rounds separately; it took longer to complete rounds and answer call lights. STNA #364 verified rounds for incontinence care and turning and repositioning were completed approximately every three hours. Interview on 07/05/22 at 6:05 A.M. with Registered Nurse (RN) #401 revealed it was better to have two nurses to complete all the heavier care due to the amount of tracheostomy residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 07/05/22 at 6:07 A.M. of the second-floor resident care area revealed one nurse and two STNAs assigned for 35 residents on the night shift assignment. There was a lingering odor of excrement and urine in the hallways. Interview on 07/05/22 at 6:09 A.M. with LPN #384 revealed it was better to have three STNAs because there were several residents who required mechanical lifts for transfers or were dependent on staff for care. LPN #384 stated it was harder on the STNAs with only two, especially if they were inexperienced. LPN #384 confirmed resident care, incontinence care rounds, and answering call lights took longer with only two STNAs. Interview on 07/05/22 at 6:14 A.M. with STNA #362 verified there was an odor of excrement and urine in the hallways and indicated it was from a lot of residents who were incontinent with bowel movements. STNA #362 stated because there were only two STNAs, rounds were performed separately rather than in pairs. STNA #362 confirmed it took longer to complete rounds which were not done every two hours but at least every three hours, it took longer to answer call lights and showers were not always completed. Interview on 07/05/22 at 7:32 A.M. with Resident #81 stated there was not enough staff and it took too long to receive assistance. Resident #81 indicated showers were received depending upon how much staff showed up, and staff did not come around every two hours to help. Interview on 07/05/22 at 7:40 A.M. with Resident #46 stated on 06/05/22 there was not enough staff to receive timely incontinence care and indicated having to wear a soiled brief for an extended period. Resident #46 verified there was not an incident since 06/05/22 but it still took a long time to receive incontinence care and care assistance. Resident #46 stated the staff do not do incontinence care every two hours. Observation on 07/11/22 at 7:51 A.M. of Resident #24 in bed revealed thick dried crust to the inside and outside of the nose surrounding a nasogastric tube (plastic tube inserted through the nose, past the throat, and down into the stomach) and cracked lips. Interview at the time of the observation with Resident #24 , she stated she had not received a shower in over two weeks and could not recall when the last shower was received. Resident #24 further indicated incontinence care was not provided during the night and stated she was currently incontinent. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including respiratory failure, muscle weakness, and peripheral vascular disease. A physician's order dated 05/12/22 revealed Resident #24 was to receive a shower biweekly on day shift on Sundays and Thursdays which was discontinued on 06/08/22. Review of the facility submitted shower sheets revealed a shower was provided on 05/08/22, 05/18/22, 06/01/22 and 06/08/22. Review of the nursing assistance flow record dated 07/12/22 with a 30-day look back revealed one shower was documented on 07/06/22 and a bed bath on 07/01/22. There was no documented evidence a shower was provided between 06/08/22 and 07/06/22 and one bed bath documented on 07/01/22. Interview on 07/11/22 at 9:22 A.M. with Resident #24 revealed staff had not yet provided incontinence care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 07/11/22 at 9:28 A.M. with Resident #16 revealed his blood sugar was not yet checked and he had not received his insulin and breakfast had already been eaten. Resident #16 stated this has happened before. Interview on 07/11/22 at 9:31 A.M. with Resident #87 revealed he ate his breakfast, and his blood sugar was not yet checked, and insulin not received. Resident #87 indicated not receiving incontinence care since the previous night stating it took longer to receive assistance using the call light usually during the morning because there was not enough staff. Observation on 07/11/22 at 9:36 A.M. of incontinence care with STNA #357 and #433 for Resident #24 verified Resident #24 was incontinent of stool. Interview at the time of the observation with STNA #433 and #357 confirmed Resident #24 did not receive incontinence care since they started the shift at 7:00 A.M. STNA #357 further stated Resident #24's showers were scheduled to be completed on second shift and did not know if they were getting completed. Interview on 07/11/22 at 9:43 A.M. with STNA #357 and #433 verified there was not enough staff to always complete tasks including showers and answering call lights timely. Observation on 07/11/22 at 9:52 A.M. of RN #332 preparing insulin for Resident #16. Interview at the time of the observation verified Resident #16 should have received the insulin prior to breakfast; however, stated there was not enough time because there were 35 residents and only one nurse so not all medications and treatments could be completed on time. Review of Resident Council minutes from 04/26/22 to 07/10/22 revealed during the 05/31/22 meeting residents requested the facility use agency nursing assistants and nurses to help with staffing. During the 06/28/22 meeting, residents stated nurses needed to hold STNAs accountable for daily tasks and call lights were not being answered timely. Review of the concern log from March 2022 to June 2022 revealed Resident #46 submitted a concern on 06/06/22 related to care. Review of investigation dated 06/06/22 regarding care concern for Resident #46 revealed Resident #46 reported to the Administrator she had not received incontinence care by 2:30 P.M. The Administrator contacted the nurse on duty and instructed staff to address Resident #46's needs immediately. On 06/06/22 Resident #46 reported receiving care and had no other concerns. Review of the written statements by Senior Administrator #436 revealed the nursing assistant staff identified providing incontinence care at the start of the shift and at multiple times throughout the shift but were unable to recall the last time Resident #46 was previously changed prior to the complaint and stated no knowledge Resident #46 needed care at the time. Review of the facility policy titled Personal Care Procedure, revised July 2018, revealed it was the policy of the facility to provide and assist resident care and hygiene based on individual status and needs including bathing or showers which may be bed baths and peri-care. This deficiency substantiates Master Complaint Numbers OH00133794 and Complaint Number OH00133282.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41526 Based on observation, interview, facility policy review, and the review of guidelines from the Centers for Disease Control and Prevention (CDC), the facility failed to maintain infection control practices for the spread of infectious diseases by not ensuring staff properly donned and maintained the wearing of facemasks while in resident care areas. This affected Resident #33 and had the potential to affect all 97 residents residing in the facility. Findings include: 1. Observation on 06/30/22 at 10:35 A.M. of Registered Nurse (RN) #350 in Resident #33's room conducting conversation in close proximity while wearing an N95 (respirator) facemask with the top strap not properly donned and dangling inappropriately. Interview on 06/30/22 at 10:38 A.M. with RN #350 upon exit from Resident #33's room confirmed the N95 facemask was not properly donned with the upper strap secured appropriately. 2. Observation on 07/05/22 at 7:45 A.M. of Medication Technician (Med Tech) #385 at the second-floor medication cart near Resident #46's room wearing an N95 facemask with the lower strap dangling beneath the chin. Interview at the time of the observation with Med Tech #385 verified the N95 facemask was not properly donned with the lower strap secured appropriately. 3. Observation on 07/05/22 at 8:26 A.M. of State tested Nursing Assistant (STNA) #413 near Resident #49's room wearing an N95 facemask with the lower strap dangling beneath the chin. Interview at the time of the observation with STNA #413 verified the N95 facemask was not properly donned with the lower strap secured appropriately. 4. Observation on 07/11/22 at 7:44 A.M. of Licensed Practical Nurse (LPN) #327 and STNA #357 at the nurses station with LPN #327 observed without a facemask donned and STNA #357 observed with an N95 facemask placed beneath the chin and not donned appropriately. Upon seeing the surveyor, LPN #327 donned an N95 facemask but did not secure the bottom strap appropriately, and STNA #357 placed the N95 over the nose and mouth but did not secure the bottom strap appropriately. Both LPN #327 and STNA #357 verified the observation and confirmed knowledge they were required to wear the facemask while in resident care areas. Interview on 06/30/22 at 4:44 P.M. with the Administrator and Director of Nursing confirmed the facility staff were required to appropriately wear facemasks in resident care areas. Review of the facility policy titled Staff Mask and Eye Wear Use, revised May 2021, revealed it was the policy of the facility to ensure source control as possible with the use of a facemask to prevent the spread of respiratory secretions. Review of Personal Protective Equipment (PPE), reviewed 10/21/21, from the CDC Healthcare-Associated Infections (HAIs), located at https://www.cdc.gov/hai/prevent/ppe.html, revealed to put on a mask or respirator, secure ties or elastic bands at the middle of the head and neck; fit the flexible band to the nose bridge; and fit it snug to the face and below the chin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. Building B. Wing	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This is an example of continued noncompliance from the survey completed on 06/02/22.