STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365329	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Marion	175 Community Drive Marion, OH 43302

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of hospital notes, review of facility timeline, interview, and review of facility policies and procedures, the facility failed to follow interventions to prevent a fall. This affected one resident (#3) out of three residents reviewed for falls. The facility also failed to ensure the safety and security of Resident #75 who was admitted to the memory care unit and was an elopement risk. This affected one resident (#75) of three reviewed for elopement. The facility census was 67.Findings include: 1. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #3 included congestive heart failure, chronic obstructive pulmonary disease, obesity, depression, diabetes type two, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition, required two person assistance with Activities of Daily Living (ADLs) and was a fall risk. Review of Resident #3's care plan dated 09/25/21 revealed a focus identifying a risk of falls. Interventions included bedside table to be within reach at all times, maintain call light within reach, resident prefers the call light to be wrapped around the transfer handle on bed, initiated on 11/26/25 and revised on 02/12/26. Review of the facility's incident log dating from October 2025 to February 2026 revealed Resident #3 had an unwitnessed fall in his room on 11/26/25. Review of the fall investigation dated 11/26/25 revealed the Director of Nursing (DON) documented Resident #3 was observed lying on the floor on his left side. The resident's bed was noted to be in a raised position. Resident #3 stated he was reaching for his call light and fell out of bed. Emergency services were called and the resident was assessed by the emergency squad and refused to go to the hospital. Resident #3 was placed back in bed and was provided as-needed pain medication. Per the investigation the care plan was updated to keep call light within reach by wrapping it around the transfer handle. Observation on 02/10/26 at 11:00 A.M. revealed Resident #3 was resting in bed, the bed was raised to an elevated height and the resident's call light was clipped to the bed sheet at the head of the bed. Interview on 02/10/26 at 11:00 A.M. with Resident #3 revealed the resident reported he had received a new bed at the facility and it did not have the two transfer bars attached for the first few days he was using the bed. Resident #3 stated he had raised the bed up to high level and he was (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempting to get his call light that was out of his reach on the table, which was also out of his reach, and he rolled out of the bed onto the floor. Resident #3 stated he had been educated to not raise the bed to the highest level, but he preferred to have the bed raised up despite the fall risk. Resident #3 stated he would not have rolled out of the bed and fallen had the call light been within his reach or if the grab bars had been in place for him to use. Resident #3 stated he believed the fall was both his fault for raising the bed so high and the fault of the facility staff for not placing his call light within his reach and not applying the grab bars on his new bed. Interview on 02/12/26 at 11:00 A.M. with Licensed Practical Nurse (LPN) #285 revealed Resident #3 was non-compliant with not raising his bed to a high level by himself. LPN #285 stated at the time of the fall on 11/26/25 the resident had been provided care by the staff, and the bed was at a low position when the LPN last visited the room, but the resident raised the bed after the staff left his room. LPN #285 stated she could not recall if the call light was placed within the reach of the resident when she left the room. LPN #285 stated when the resident was found he was alert and stated his call light was out of reach and he was attempting to get it when he rolled out of bed. LPN #285 stated the resident has not fallen since the 11/26/25 incident. Interview on 02/17/26 at 11:50 A.M. with the DON revealed at the time of the fall Resident #3 had received a new bariatric bed and there was no grab bars attached to the bed. DON verified the new bed had not been assessed and there had not been a bed rail assessment completed for Resident #3 in the new bed until 12/08/25. DON stated she had discussed with the resident having the call light clipped to his person, but he preferred to have the call light wrapped around the transfer bar above his bed so he could reach up and push it. DON verified per the investigation the call light was not within reach of the resident when he rolled out of bed on 11/26/25. 2. Review of the medical record for Resident #75 revealed an admission date of 02/05/26. Diagnoses included Alzheimer's disease, diabetes, hypertension, and dementia. Review of the admission elopement assessment dated [DATE] revealed Resident #75 scored a three and was found to be a low risk for elopement. The only items marked off included his cognition, diagnosis and physical ability to ambulate. This was the only elopement assessment completed from admission until 02/23/26. Review of the plan of care dated 02/06/26 revealed Resident #75 had impaired cognitive function/dementia or impaired thought process related to Alzheimer's and dementia. It was updated on 02/23/26 (after surveyor intervention) and changed to also state the resident was at risk for elopement due to poor cognition. Resident resided in the secured unit for a structured environment. Interventions included the secured unit and to communicate with the resident, family and caregiver regarding the residents' capabilities and needs. The care plan dated 02/12/26 revealed the resident was a long-term resident. The resident's wife was not allowed to take the resident out of the facility and the daughter/POA (power of attorney) was to be contacted if this occurred. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 08 indicating impaired cognition and identified the resident required supervision or touching assistance with activities of daily living. Review of the progress notes dated 02/11/26 revealed the resident's daughter/POA requested the residents cell phone be taken away due to calling the police and continually calling about getting out of here. A note dated 02/12/26 from the unit manager at 10:30 A.M. revealed the resident went LOA (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(leave of absence) with his wife and stated the resident's daughter was notified. A progress note dated 02/12/26 at 12:00 P.M. stated this writer spoke with Resident #75's secondary POA (wife) regarding her taking resident on a LOA. Resident #75's wife stated they would return after lunch. The notes also stated although staff knew the resident was leaving with her, she needed to follow the LOA procedure and sign him out. A progress note dated 02/12/26 at 8:15 P.M. revealed the nurse was notified the resident was on his way to the hospital due to aggressive behaviors. A follow up progress note on 02/12/26 at 10:20 P.M. revealed the hospital informed the facility that the resident would be returning around 11:30 P.M. to the facility. A progress note dated 02/12/26 at 11:50 P.M. revealed the resident returned to the facility. The POA (daughter) informed staff that resident was not to leave the facility with anyone and the male visitor (who he had left with) was not to visit with the resident at all. The POA would come in on 02/13/26 to discuss concerns with management. The progress note dated 02/13/26 at 1:01 P.M. revealed a care conference was held with the POA (daughter). The progress notes revealed no documented evidence that Resident #75 left the facility with an unknown male on 02/12/26. Review of the hospital record dated 02/12/26 revealed the resident came to the emergency department due to aggression. It stated Resident #75 was removed from a locked Alzheimer's unit with a friend against the POA (power of attorney)'s wishes and taken home. Upon arrival he became increasingly agitated and once family stated they would take him back, Resident stated I'll just kill myself. The hospital record stated he remained agitated upon arrival to the hospital and was cleared to return to the facility around 11:00 P.M. Review of the medical record found a special instruction dated 02/13/26 at 12:32 P.M. stating must get authorization from daughter for any visitor other than his wife and daughter was the only person authorized to take the resident off the unit. Review of the undated facility timeline of events revealed a friend visited and asked to accompany the resident outside to assist in gathering laundry, and the Unit Manager (UM) agreed. Resident #75 got into the friend's vehicle without notifying staff. Staff spoke with Resident #75's wife who was with him at lunch and also spoke with the daughter who reported he had left town and she requested the facility make a wellness check with the police department to get resident to return to the facility. Interview on 02/23/26 at 10:07 A.M. with Licensed Practical Nurse (LPN) #285 revealed the memory care unit had a dedicated nurse and two aides on day shift. The LPN revealed Resident #75 had recently admitted and had been observed to walk the hallways and press on the locked exit doors. The LPN revealed the resident had eloped on 02/12/26 when a male visitor took him out of the facility without the resident's daughter/POA's knowledge. The LPN revealed facility staff should be checking in the medical record to determine who the main contact person was and if they were not listed, they were not allowed to take resident off the memory care unit without approval from the POA. The LPN confirmed Resident #75 left with an unapproved person with a plan to go to the parking lot and they ended up leaving the facility parking lot and driving away without memory care staff knowing the whereabouts of Resident #75. The LPN was concerned as the resident had packed up his belongings and went outside without staff supervision. The LPN also revealed the documentation in the medical record did not give an accurate portrayal of the incident and downplays that the resident had been missing. Observation on 02/23/26 at 10:40 A.M. found a sign/note taped to the nursing station desk stating staff must check in the residents medical record and get approval from the POA. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/23/26 at 10:25 A.M. with Resident #75 revealed he had been at the facility for a while and stated he had called a friend to get him out of here. He confirmed his friend came and said this place was horrible and agreed to sneak me out. He reported they packed up his belongings and just walked out and was unsure if the friend spoke with staff prior to them leaving. He stated he left [NAME] and went and visited some friends. Resident #75 reported he did not remember returning to the facility or going to the hospital and reported he was admitted for his dementia diagnosis and memory issues. Interviews on 02/23/26 from 11:04 A.M. to 11:20 A.M. with Certified Nursing Aide (CNA) #166 and Registered Nurse (RN) #237 revealed the assigned nurse took a break and Unit Manager (UM) #244 was covering for her when Resident #75 exited the memory care unit. They reported the friend asked UM #244 about taking Resident #75 to the parking lot to exchange some clothing items and resident was allowed by UM #244 to go outside with a duffle bag of belongings. When staff later went to gather residents for lunch they were unable to find Resident #75. Staff started looking for the resident and informed the nurse and unit manager that he never returned from being outside with the friend. Staff also checked the parking lot and found the friends vehicle was also gone. They started looking for resident and calling family. They found the resident had been gone for about 30 to 60 minutes before they started looking for him. They revealed staff reached out to Resident #75's POA (daughter) to let her know a male visitor had taken the resident out of the facility and the daughter reached out and found Resident #75 was at lunch with his wife. They reported the resident should not have been allowed outside the facility with a male visitor without approval from the POA. They reported Resident #75's wife was not in the facility and was not seen by these staff members on 02/12/26 prior to Resident #75 leaving the facility property. Interview on 02/23/26 at 11:47 A.M. with CNA #165 revealed she heard the friend ask UM #244 about taking the resident to the parking lot to exchange some items at his vehicle. She reported the UM confirmed the resident would be brought back from the parking lot and the friend agreed the resident would be back once items were exchanged. The CNA revealed the UM approved and instructed her to use the door code and let them off unit and the CNA reported if a member of the management team said it was okay she thought it was fine. The CNA reported it had been some time (estimated at 30 minutes) without seeing Resident #75 and he did not return, so she informed the nurse and UM who stated, Oh crap. CNA #165 reported residents should not be allowed off the unit unless they had approval from the POA. Interview on 02/23/26 at 12:05 P.M. with LPN #124 revealed Residents daughter had informed staff prior to the incident on 02/12/26 that resident was not to leave the unit without anyone but her. LPN reported she was unsure if this was documented in the record but stated it was known to several staff members. LPN revealed she would consider this an elopement due to the staff not knowing where resident had gone for a period of time and he had made it clear he wanted to leave and get out of facility. The LPN revealed residents POA (daughter) informed her the facility called and asked her who resident had left with, and at the time she was not aware of the friend visiting or taking him out of the facility. LPN confirmed their were also issues with the resident having a phone and calling friends and family to get him out of the facility. LPN confirmed the incident documentation in the medical record was not accurate as a male visitor came in and took resident off property without the memory care staff knowledge and the facility management documented his wife took him on a LOA. Interview on 02/23/26 at 12:20 P.M. with Unit Manager (UM) #244 reported the resident's friend had asked to take him to his vehicle to exchange some items and was supposed to return to the facility. She stated she was informed shortly after that resident had not returned to the memory care unit and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they searched the parking lot and found the resident and visitor had left. They called the residents wife and she had reported she was at lunch with the resident and they would return him to the facility. The UM revealed the facility completed staff education and added a special instruction in Resident #75's medical record that he was not to leave with anyone but the POA (daughter) and the only visitors were to be the wife and daughter, unless approved by family. Interviews on 02/23/26 from 12:35 P.M. to 3:20 P.M. with Administrator #188, Unit Manager #244 and Director of Nursing #272 revealed Resident #75 went on a leave of absence with his wife. They would not acknowledge the concern of the resident leaving with a visitor without memory care staffs knowing he was leaving and without contacting the POA. The UM reported it was about 10 to 15 minutes later when resident did not come back inside, staff alerted the bosses who also looked at the parking lot and did not see Resident #75 or the male visitor. At that time they contacted Resident #75's wife who reported the resident was with her at a restaurant. The Unit Manager revealed when she left around 7:00 P.M., Resident #75 still had not returned. The Administrator reported she entered the special instructions in the medical record when the resident returned to the facility and after speaking with the residents POA (daughter). They stated facility management staff knew the resident's wife was in the car and stated he was not missing but acknowledged if they knew, the facility would not have needed to call and find him, and staff on the memory care unit should have known the resident's wife was present prior to him leaving. They reported the resident left with a capable adult, but also acknowledged that the individual asked for the resident to come out to exchange belongings and would return, and instead took off with the resident without informing staff. The Administrator also stated the facility contacted the police for a wellness check to get the resident back to the facility. They confirmed the resident was out of the facility for about 12 hours. The Administrator and Director of Nursing (DON) confirmed the facility had completed an elopement assessment upon admission and they would update it quarterly. They reported they did not expect staff to repeat the assessment when changes to resident's conditions occurred and/or changes in behavior. They reported they would not have completed an updated assessment even after the resident stated pressing on doors, pacing the halls and calling family and friends to get him out of here. They also confirmed the care plan was not updated about his elopement risk until the state survey 02/23/26 brought up concerns and also confirmed changes in interventions were not initiated when the resident started showing risky behaviors for elopement but were initiated after the incident occurred. The Administrator acknowledged the elopement risk assessment and care plan were not timely updated. Interview on 02/23/26 at 2:44 P.M. with Ombudsman #600 revealed they were completing an investigation related to elopement concerns of Resident #75. They reported being onsite 02/18/26 and were waiting for the facility to provide a timeline/investigation related to the incident where Resident #75 was allowed to leave the locked memory care with a friend/unknown individual without the POA (daughter) approval. Interview on 02/23/26 at 2:52 P.M. with Social Services (SS) #640 revealed she saw Resident #75 leaving the facility and getting in a car with a male visitor. She stated the residents wife was seen in the car and she observed them drive out of the parking lot. SS #640 revealed knew Resident #75 was from the memory care unit and did not inform staff of this when resident left. She also revealed she was not aware staff did not see Resident #75's wife on the memory care unit when he left. Review of facility policy titled Signing Residents Out, dated 08/2024, revealed all resident leaving the premises must be signed out. This deficiency represents non-compliance investigated under Master Complaint Number 2748011.