STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on interview and record review, the facility failed to ensure the care plan included comprehensive psychosocial interventions to address identified behaviors. This affected one resident (#64) out of thirty residents reviewed for care planning. The facility census was 105.Findings include:Review of the medical record for Resident #64 revealed an admission date of 05/30/25 with diagnoses including depression, anxiety disorder, hypertension, and insomnia.Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #64 was cognitively intact and has no mood or behavioral concerns.Review of the care plan dated 07/14/25 revealed the resident was known to make inappropriate and sexual comments to staff. Interventions included one-on-one supervision, every 15-minute and 30-minute checks as needed for safety of both this resident and others, referral to psych as needed, and staff monitoring for any inappropriate behaviors.Interview on 08/18/25 at 3:52 P.M. with Resident #64 revealed he wanted to grow a relationship with a cognitively impaired resident located within the facility. Resident #64 was unhappy the facility had forbidden him from seeing this resident in person and was forced to have supervised visits or visits behind glass walls.Interview on 08/19/25 at 8:19 A.M. with the Administrator confirmed Resident #64 voiced a desire to grow a relationship with a cognitively impaired resident, Resident #107. They informed Resident #107's Power of Attorney (POA) who requested the resident have no contact with Resident #64. The facility agreed, stating they wanted Resident #64 to cool off. The Administrator was unsure if Resident #64 was seeing psych services at this time but believed it could be beneficial. The Administrator reported that staff are well aware that Resident #64 was to stay away from Resident #107. The Administrator shared Resident #64 had become obsessed with Resident #107, and staff are diligent to ensure that during the entire friendship, interactions were only under supervised visits. The facility will continue to keep Resident #64 and Resident #107 separate until Resident #107's POA agreed otherwise, at which time the situation would be revisited. The Administrator confirmed these current concerns were not noted on the resident's care plan. This deficiency represents non-compliance investigated under Complaint number 2592657.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 medical record review, observations, and staff interview, the facility failed to ensure fall interventions were in place. This affected two residents (#1 and #43) of five residents reviewed for fall safety. The facility census was 105. Findings include:1.Review of the medical record for Resident #1 revealed an initial admission date of 10/06/21 and a re-entry date of 03/09/25. Diagnoses included peripheral vascular disease, embolism and thrombosis of deep veins of the lower extremities, and unsteadiness on feet. Review of the physician orders for Resident #1 dated 02/25/25 revealed an order for the resident's bed to be in the lowest position when occupied. Review of the care plan dated 03/10/25 for Resident #1 revealed this resident was at risk for falls related to medication use, decrease mobility, non-ambulatory, and obesity comorbidities. Fall interventions included to be sure the call light is in reach, bed in lower position when occupied, and to follow facility fall protocol. Review of Resident #1's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #1 was noted to experience impairment to both lower extremities and was dependent on staff for bed mobility. Observations made on 08/11/25 at 9:30 A.M, on 08/14/25 at 11:00 A.M., and 2:30 P.M., on 08/19/25 at 3:00 P.M., and again on 08/20/25 at 10:40 A.M., revealed Resident #1's in bed at the time of each observation. During each observation, the bed was not in the lowest position. Interview on 08/18/2025 at 3:19 P.M. with Licensed Practical Nurse (LPN) #403 confirmed Resident #1 had an order for his bed to be in the lowest position when occupied and per current observation, Resident #1's bed was not in the lowest position. 2.Review of the medical record for Resident #43 revealed an initial admission date of 04/05/24 and a re-entry date of 07/27/24. Diagnoses included a pathological fracture of the left femur, vascular dementia, muscle weakness, and difficulty walking. Review of Resident #43's quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 09 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Review of the undated care plan revealed Resident #43 was at risk for falls due to a cerebral vascular accident with hemiplegia to the left side, use of psychotropic medications, cognitive status, and vitamin d deficiency. Interventions include to place a reminder sign in the resident's room to remind him to call for assistance. Observations completed on 08/12/25 at 3:10 P.M. and again on 08/20/25 at 9:40 A.M. revealed no signs were posted in Resident #43's room to remind him to call for assistance. Interview on 08/20/25 at 10:00 A.M. with Registered Nurse (RN) #999 confirmed there was not a sign posted in Resident #43's room to remind him to call for assistance as per order and fall interventions. Review of the policy Managing Falls and Fall Risk, revised 03/2021 revealed the staff will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of a fall. This deficiency represents noncompliance investigated under Complaint Number 2582471.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review, and interviews, the facility failed to ensure an adequate stock of controlled substances were on-hand to adequately treat pain. This affected two residents, Resident #46 and Resident #65.Actual Harm occurred when the facility failed to ensure scheduled pain medication was reordered timely and available for Resident #65 and Resident #46. Resident #65's pain medication was not documented as administered on 08/09/25, 08/10/25, 08/11/25, and 08/12/25 leading to Resident #65 reporting pain, rating the pain a ten on a one to ten scale, with 10 being the worst pain ever experienced. Resident #65's pain medication was not documented as administered and on 08/11/25 at 10:43 A.M. and 12:01 P.M., Resident #46 reported constant and intense pain in the legs where an amputation had been performed. Resident #46 rated his pain at a level of 1000 out of ten on the numeric pain scale and complained he could not get out of bed. Resident #46 resident reported the nurse was aware of his severe pain and was working on obtaining his ordered medication. This affected two (Residents #46 and #65) of four residents reviewed for pain. The facility census was 105. Findings include:1. Review of the medical record for Resident #65 revealed an initial admission date of 05/05/18 and a re-entry date of 11/01/18. Medical diagnoses included rheumatoid arthritis, osteoarthritis, and right temporomandibular joint disorder. Review of the undated care plan for Resident #65 revealed the resident had complaints of pain related to inconsistent bowel pattern, rheumatoid arthritis, osteoarthritis, temporomandibular joint dysfunction and gout with multiple comorbidities. Interventions noted for the care plan included administering medications as ordered by the physician and to notify the physician if the current pain medication regimen was ineffective. Review of the physician orders for Resident #65 revealed an order dated 04/11/24 for Methadone (opioid) Hydrochloride (HCL), 10 milligram (mg) tablet, give one tablet in the morning for pain management. Resident #65 had an order dated 09/07/24 for Oxycodone HCL 10 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Review of Resident #65's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making. Resident #65 had impairment to the bilateral lower extremities and was receiving opioid pain medication daily. Review of the Medication Administration Record (MAR) for August 2025 for Resident #65 revealed the scheduled Methadone HCL 10 mg tablet was not administered on 08/09/25, 08/10/25, 08/11/25, or 08/12/25. This medication was not administered again until 08/13/25, where Resident #65 reported a pain level of a 10 on a one to ten scale. Review of a nursing progress note dated 08/11/25 at 1:37 P.M. revealed Resident #65 was out of her ordered Methadone 10 mg tablets. The pharmacy was called and stated the resident needed a new prescription. The nurse recorded that the oncoming nurse would be notified in the morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing progress note dated 08/12/25 at 10:00 A.M. revealed the Licensed Practical Nurse (LPN) #403 contacted the unnamed Certified Nurse Practitioner (CNP) due to the resident not having ordered Methadone available and communicated a new prescription was needed. The nurse further communicated that the resident had been out of the medication since Saturday 08/09/25. The CNP stated to utilize the resident’s as-needed Oxycodone if needed until the Methadone arrived from the pharmacy. A new prescription was sent to the pharmacy from CNP. LPN #403 verified the pharmacy received the prescription from CNP and the pharmacy stated the Methadone would be in that evening’s pharmacy delivery. Review of Resident #65's MAR for August 2025 confirmed this resident did already have an as-needed order for Oxycodone HCL 10 mg tablet which was to be given every 4 hours as needed for moderate to severe pain. This medication was already being administered prior to the Methadone not being available, and the MAR documented the as-needed Oxycodone was ineffective at times. During an interview on 08/12/25 at 9:00 A.M., Resident #65 stated she was very upset because she had been out of her pain medication for days and was experiencing pain. Resident #65 rated her pain a 10 on a one to ten scale. During an interview on 08/12/25 at 9:10 A.M., LPN #915 confirmed Resident #65 was out of her ordered Methadone and confirmed the resident had not received her scheduled doses since the morning of 08/08/25. 2. Review of the medical record for Resident #46 revealed an admission date of 01/22/25 with diagnoses including acquired absence of the left leg below the knee, displaced comminuted fracture of the shaft of the right tibia, and chronic pain syndrome. Review of the care plan dated 02/05/25 revealed Resident #46 had the potential for altered comfort related to decreased mobility, comorbidities, fracture of the right tibia, joint pain, and chronic pain. Interventions included attempting non-pharmacologic approaches before using medications, encouraging the resident to request pain medication before pain intensified, evaluating the effectiveness or need to adjust pain medications, monitoring pain every shift, and offering analgesics as ordered by the physician. Review of pain evaluation for cognitively intact individuals dated 04/29/25 revealed the resident reported past experiences of pain, with no diagnosis of opioid use disorder. Previous interventions included prescribed medications. An acceptable pain level was recorded at a four out of 10. The resident reported frequent pain, which did not interfere with sleep but did limit daily activities. Non-medication interventions used included relaxation techniques. Review of the MDS quarterly assessment dated [DATE] revealed Resident #46 was cognitively intact and received opioid medications for pain management. Record review revealed a physician order for Resident #46’s dated 08/01/25 for Oxycodone oral tablet 10 mg, one tablet by mouth every four hours for pain. Scheduled administration times were 12:00 A.M. , 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. Review of the controlled drug receipt/record/disposition form dated 08/10/25 revealed the last dose of Resident #46’s Oxycodone 10 mg was recorded as administered on 08/10/25 at 4:30 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #46’s progress notes dated 08/10/25 through 08/11/25 revealed multiple entries from staff documenting that the resident’s Oxycodone was not available and was awaiting delivery from the pharmacy. This included documentation on 08/10/25 at 8:21 A.M., 9:48 P.M., and 11:22 P.M., as well as on 08/11/25 at 5:05 A.M. On 08/11/25 at 12:30 P.M., the physician was notified the resident was out of her ordered Oxycodone. Review of Resident #46’s MAR from 08/10/25 at 8:00 A.M. through 08/11/25 at 12:00 P.M. revealed the resident’s Oxycodone was marked as not given or not available. On 08/11/25 at 8:00 A.M. and 12:00 P.M., pain levels were marked as not applicable. On 08/11/25 at 4:00 P.M., oxycodone was administered for pain rated at an eight out of 10. On 08/10/25 at 11:21 P.M. and on 08/11/25 at 5:05 A.M., Resident #46 was given doses of Acetaminophen (an over-the-counter mild pain reliever) oral tablet 325 mg, two tablets by mouth every four hours as needed for pain. The pain scale was recorded as zero out of 10. Prior to this administration, Resident #46 did not receive any as-needed doses between 08/01/25 and 08/09/25. Review of a pain level summary from 08/09/25 through 08/11/25 revealed Resident #46 reported pain of a zero out of ten. On 08/11/25 at 1:12 P.M., the resident reported his pain at two out of 10, and at 4:18 P.M. reported pain of an eight out of 10. During an observation on 08/11/25 at 10:43 A.M., Resident #46 was observed lying supine in bed with his arms covering his head. He had his fists clenched with minimal movement. He gave short responses, stating he had not received his prescribed narcotic pain medication since 08/10/25 at 8:00 A.M. He rated his pain as “1000 out of 10” and described phantom limb pain in his left lower leg from a previous amputation. He confirmed LPN #402 was aware he was out of pain medication and was working with the Unit Manager to resolve the issue. Due to severe pain, he reported being unable to get out of bed and declined to continue the conversation. During an interview on 08/11/25 at 10:48 A.M., LPN #402 confirmed Resident #46 had no remaining doses of his ordered Oxycodone for his scheduled 8:00 A.M. and 12:00 P.M. administrations. LPN #402 acknowledged the resident’s severe pain and indicated he received his scheduled Lyrica (a nerve pain medication) for some pain relief. She attempted to pull a dose of Oxycodone from the back-up stock box, but the resident’s current prescription did not match the available stock. LPN #402 confirmed the Unit Manager was coordinating with the pharmacy and physician to obtain the correct order for the resident. During an observation on 08/11/25 at 12:01 P.M., Resident #46 remained lying still in bed in the fetal position, with a blanket completely covering his body. He reported ongoing and severe pain, rating it a 10 out of 10 and confirmed he had still not received his prescribed narcotic pain medication, nor had he heard of any additional updates. Review of the controlled drug receipt/record/disposition form for Resident #46, dated 08/11/25, showed Oxycodone tablets 10 milligrams, quantity of 60, was delivered to the facility. The order called for the medication to be administered every four hours as needed for pain. The first recorded dose administered from the new supply was given to Resident #46 on 08/11/25 at 4:00 P.M. Review of the pharmacy delivery slip dated 08/11/25 at 4:14 P.M. for Resident #46 confirmed delivery of oxycodone tablets 10 milligrams. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/14/25 at 10:10 A.M., Unit Manager #240 confirmed licensed nursing staff did not place a medication reorder on 08/10/25 to the pharmacy for Resident #46’s scheduled Oxycodone. Unit Manager #240 stated the first request occurred on Monday morning, 08/11/25, around 8:00 A.M., when she arrived on site and was notified the resident was out of his medication by LPN #402. She attempted to obtain an emergency order to pull from the back-up stock box from the physician, but by the time the order was received, the replacement medication had already arrived. She confirmed Resident #46 went approximately 36 hours without his prescribed pain medication and Resident #46 missed eight scheduled doses: 08/10/25 at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M., and 08/11/25 at 12:00 A.M., 4:00 A.M., 8:00 A.M., and 12:00 P.M. During an interview on 08/18/25 at 10:33 A.M., LPN #400 confirmed she was working with Resident #46 during the day shift on 08/10/25 when the resident was without his narcotic pain medication. She was informed by the night shift nurse that the facility had run out of Oxycodone and was awaiting delivery of the medication from the pharmacy. LPN #400 had not contacted the pharmacy to verify the refill request and had not received a delivery during her shift. During an interview on 08/21/25 at 11:38 A.M., Medical Director (MD) #900 confirmed an on-call physician was initially notified on 08/11/25 at approximately 12:00 A.M. via the facility’s non-urgent messaging system. As a result of the non-urgent alert, a voicemail was left, and the return call was not expected until the morning from an on-call physician. MD #900 was notified again on 08/11/25 at approximately 12:30 P.M. and was informed that Resident #46 had been without his prescribed pain medication and was experiencing increased pain. By that time, staff had already begun coordinating with the on-call physician and pharmacy to obtain a new prescription and arrange for delivery. MD #900 acknowledged that Resident #46 should not have gone without scheduled pain medication for such an extended period. MD #900 confirmed nursing staff often wait until medications are completely depleted before requesting refills, which prevents physicians and pharmacies from acting proactively. MD #900 stated that, ideally, refill requests should be submitted several days in advance to avoid any lapse in medication availability. Review of the facility policy titled, Pain-Clinical Protocol, dated March 2018 revealed, the physician and staff will identify individuals who have pain or who are at risk of having pain. The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. This deficiency represents noncompliance investigated under Complaint Number 1263770 (OH00165823).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. Based on medical record review, controlled substance log review, staff interview, and facility policy review, the facility failed to ensure residents were free from significant medication errors related to controlled medications. This affected six residents (#1, #3, #36, #62, #93, and #108) of seven residents reviewed for medication administration. The facility census was 105. Findings include: 1. Review of the medical record for Resident #1 revealed an initial admission date of 10/06/21 with a re-entry date of 03/09/25. Diagnoses included stage three chronic kidney disease, chronic obstructive pulmonary disease, and peripheral vascular disease. Review of Resident #1's physician order dated 03/09/25 revealed an order for Oxycodone (narcotic pain medication) 5 milligram (mg) tablet, give two tablets by mouth every eight hours for pain. Review of the Controlled Drug Receipt/Record/Disposition form revealed on 08/12/25, Resident #1 received the scheduled pain medication at 5:16 A.M. and again at 9:00 P.M. Resident #1's 2:00 P.M. dose had not been administered or signed out on the log. On 08/16/25, Resident #1 was noted to receive the scheduled pain medication at 6:00 A.M. and again at 2:30 P.M. but had not received the 9:00 P.M. dose. Interview on 8/18/2025 at 10:00 A.M. with Licensed Practical Nurse (LPN) #403 confirmed Resident #1 was scheduled to receive Oxycodone every eight hours or three times a day and on a few of the noted days, the resident only received this medication twice. 2. Review of the medical record for Resident #36 revealed an admission date of 11/25/22. Diagnoses included cervical disc disorder, generalized anxiety, and mucopurulent chronic bronchitis. Review of Resident #36's physician order dated 12/13/23 revealed an order for Norco (a narcotic pain medication containing a combination of Hydrocodone and acetaminophen) oral tablet 5-325 mg, give one tablet by mouth three times a day for pain. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #36's Norco medication revealed on 08/12/25, this medication was recorded as being administered at 10:22 A.M., 2:26 P.M., 4:00 P. M., and 9:57 P.M. Interview on 08/18/25 at 10:00 A.M. with LPN #403 confirmed Resident #36 was supposed to receive the scheduled pain medication three times a day and received it four times on 08/12/25. 3. Review of the medical record for Resident #62 revealed an initial admission date of 08/07/24 and a re-entry date of 10/05/24. Diagnoses included alcoholic cirrhosis of the liver, osteoarthritis of the left hip, and hypertension. Review of Resident #62's physician order dated 06/25/25 revealed an order for Oxycodone HCL 5 mg tablet, give one tablet my mouth in the morning for moderate to severe pain. Review of the Controlled Drug Receipt/Record/Disposition form revealed Resident #62's scheduled pain medication was administered twice on 07/23/25, at 9:50 A.M. and at 8:35 P.M. This pain medication was also administered twice on 07/27/25 at 8:00 A.M. and again at 8:30 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 08/18/25 at 10:00 A.M. with LPN #403 confirmed Resident #62 was supposed to get his scheduled pain medication one time a day in the morning and actually received two doses of this medication on 07/23/25 and 07/27/25. 4. Review of the medical record for Resident #93 revealed an initial admission date of 01/18/24 and a re-entry date of 06/04/25. Diagnosis included chronic obstructive pulmonary disease, chronic kidney disease, and respiratory failure. Review of Resident #93's physician order dated 06/04/25 revealed an order for Oxycodone HCL 20 mg tablet, give one tablet my mouth every 6 hours for chronic pain. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #93's pain medication revealed this medication was administered five times on 08/10/25 at 5:10 A.M., 8:00 A.M. 10:10 A.M, 12:00 P.M. and 6:00 P.M. On 08/12/25, only three doses were administered instead of the scheduled four at 5:30 A.M., 4:00 P.M. and 11:00 P.M. Continued review revealed Resident #93 only received three doses of this medication again on 08/14/25, at 12:11 P.M., 5:25 P.M. and 11:00 P.M. On 08/17/25, Resident #93 was noted to only receive three doses of this medication at 6:23 A.M., 2:08 P.M. and 11:17 P.M. Interview on 08/18/25 at 10:00 A.M. with LPN #403 confirmed Resident #93 received one dose too many on 08/10/25 and one dose less than what was ordered on 08/12/25, 08/14/25, and again on 08/17/25. 5. Review of the medical record for Resident #108 revealed an admission date of 08/04/25. Diagnoses included dementia, bipolar disorder, anxiety disorder, and insomnia. Review of Resident #108's physician order dated 08/04/25 revealed an order for Lorazepam (a controlled anti-anxiety medication) 1 mg tablet, give one tablet by mouth every eight hours for anxiety. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #108 revealed this medication was administered only two times on 08/09/25 at 5:22 A.M. and at 10:10 P.M. instead of three times that day. Interview on 08/18/2025 at 10:00 A.M. with LPN #403 confirmed a medication that was scheduled to be administered every eight hours would equal out to three times a day and that Resident #108 did not receive the correct amount of medication on 08/09/25. 6. Review of the medical record for Resident #3 revealed an admission date of 07/25/22 with diagnoses of chronic pulmonary edema, chronic obstructive pulmonary disease, acute diastolic heart failure, chronic respiratory failure with hypoxia, metabolic encephalopathy, chronic pain syndrome, rheumatoid arthritis, and a personal history of diabetic foot ulcer. Review of the care plan dated 01/19/24 revealed Resident #3 was at risk for pain related to chronic pain syndrome, rheumatoid arthritis, and comorbidities. Interventions include administering analgesia as per orders, anticipating need for pain relief, calling for assistance when in pain, evaluating the effectiveness of pain interventions, and monitoring for side effects pertaining to pain medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #3's physician orders revealed an order dated 03/09/25 revealed Oxycodone HCl extended-release (ER) tablet 10 mg, give one tablet by mouth two times a day related to chronic pain syndrome. Continued review revealed an additional physician order dated 03/12/25 for Oxycodone HCl oral tablet 10 mg, give one tablet by mouth every six hours for pain. Review of Resident #3's Minimum Data Set (MDS) 3.0 annual assessment completed 07/13/25 revealed the resident was cognitively intact, received opioid medications, and had a scheduled pain medication regimen. Review of Resident #3's Medication Administration Record (MAR) from 07/01/25 through 07/31/25 revealed OxyContin (narcotic pain medication) 10 mg was scheduled to be administered at 7:00 A.M. and 7:00 P.M., and on 07/29/25 the medication was marked as given. Additionally, Oxycodone 10 mg was scheduled for administration on 07/29/25 at 5:00 A.M., 11:00 A.M., 5:00 P.M., and 11:00 P.M. On 07/29/25, an extra administration of Oxycodone 10 mg was not documented. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #3 dated 07/23/25 through 07/30/25 revealed on 07/29/25 at 10:00 A.M. and again at 12:00 P.M., the resident was administered Oxycodone 10 mg tablets. The form recorded five administrations of Oxycodone 10 mg tablets were given on 07/29/25, where the resident was scheduled to receive four doses per day. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #3 dated 07/25/25 through 08/08/25 for Resident #3 revealed only one dose of OxyContin on 07/29/25 at 11:50 P.M. was logged and was noted as administered late. The form did not include indication that the scheduled 7:00 A.M. dose was administered on 07/29/25. Review of Resident #3's progress notes dated 07/29/25 revealed no documentation pertaining to a medication error. Additionally, there was no notification of physician notification of the error. Review of a medication error without harm report dated 08/18/25 revealed Resident #3 was noted to have received Oxycodone 10 mg on 07/29/25 at 10:00 A.M. instead of the scheduled OxyContin. An agency nurse was noted to have signed off the medication in the narcotic book. Resident #3 had no adverse effects. The report noted an unnamed Nurse Practitioner was notified. The medication error was recorded as being discussed with the resident. Interview on 08/13/25 at 11:39 A.M. with Resident #3 revealed concerns pertaining to the medication error. The resident stated an error had occurred a couple of weeks ago and that during the incident, she could not stay awake and believed she was overdosed on her pain medication. Interview on 08/18/25 at 1:18 P.M. with the Regional Director of Clinical Services (RDCS) #901 confirmed two doses of Oxycodone were given on 07/29/25 at 10:00 A.M. and 12:00 P.M. RDCS #901 confirmed the extra administration of Oxycodone was not documented on the MAR and prior to the surveyor's request for additional information, management was unaware of the documented medication error; therefore, an incident report was not completed on the day of the incident or around the event. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 08/19/25 at 5:24 P.M. with Licensed Practical Nurse (LPN) #404 confirmed she worked with Resident #3 on 07/29/25. She denied knowledge of any medication error that day. However, she confirmed, based on the signature on the Controlled Drug Receipt/Record/Disposition form the resident's Oxycodone, that she administered the medication. LPN #404 denied notifying the physician, stating she was unaware that a medication error had occurred. Review of the policy Accidents and Incidents - Investigating and Reporting dated 07/2017 revealed all accidents or incidents involving residents occurring on facility premises shall be investigated and reported to the administrator, additionally the nurse supervisor/charge nurse/supervisor shall promptly initiate and document investigation of the accident or incident. Review of the policy Controlled Substances revealed access to controlled medications remain locked at all times, and access is recorded. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on the premises. Upon administration, the nurse administering the medication is responsible for recording the name of the resident receiving the medication, the name, strength, and dose of the medication, time of administration, quantity remaining, and a signature of the nurse administering the medication. This deficiency represents noncompliance investigated under Complaint Number 1263770 (OH00165823).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospice records, staff interview, and facility policy review, the facility failed to ensure hospice records were available for review to allow for effective collaboration between the facility and the hospice provider. This affected one resident (#43) of one resident reviewed for hospice care. The facility census was 105. Findings include:Review of the medical record for Resident #43 revealed an initial admission date of 04/05/25 and a re-entry date of 07/27/24. Diagnoses included vascular dementia, cerebral atherosclerosis, disorders of the bone density and structure, and hypertension. Review of Resident #43's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09 out of 15 indicating severely impaired cognition for daily decision-making abilities. Interview on 08/19/25 at 12:49 P.M. with a hospice staff member revealed Resident #43 was planned to received Certified Nursing Assistant (CNA) services three times per week, nursing care weekly, and a social services visit monthly. All staff who visit Resident #43 are to fill out a summary of the care provided after returning to the office and this will either be faxed or emailed over to the facility. Interview with 08/19/25 10:00 A.M. with Registered Nurse (RN) #243 revealed hospice notes are located at the nurse's station in a binder. Observation of the binder revealed only a sign in log was located in this binder. No hospice notes or care notes were available. RN #243 stated that she believed the unit manager may have Resident #43's hospice notes in her office. A request was made on 08/19/25 for Resident #43's hospice notes for review which was not provided until later that same day. Each received document was noted to be printed on 08/19/25, which was the day the notes were requested. Interview with Licensed Practical Nurse (LPN) #215 confirmed the documents were not available at the facility upon request and Hospice had to be contacted so the documents could be forwarded to the facility. Review of the facility policy titled, Hospice Program, dated 07/2017 revealed the facility would designate a staff member to ensure that the long-term care facility communicates with the hospice medical director, the residents attending physician and other practitioners participating in the provision of care to the resident as needed. This deficiency represents noncompliance investigated under Complaint Number 1263770 (OH00165823).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Newark	75 McMillen Drive Newark, OH 43055

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure Resident #75's wound and living space were free from pests. This affected one resident (#75) of six residents sampled for wounds. The facility census was 105. Findings include: Review of Resident #75's medical record revealed an admission date of 01/31/05 and diagnoses including malignant neoplasm of head and face, squamous cell carcinoma, autistic disorder, diabetes, anxiety disorder, peripheral vascular disease, hypertension, acquired absence of right leg below the knee, and non-pressure chronic ulcer of other part of left lower leg with other specified severity. Review of Resident #75's Minimum Data Set (MDS) significant change in status assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13 indicating the resident was cognitively intact and had no recorded behaviors. Further review revealed Resident #75 required set up assistance for eating and was dependent on staff for all other activities of daily living. Resident #75 was assessed to be always incontinent of bladder, frequently incontinent of bowel, and was receiving hospice services. Resident #75 was recorded as having an unhealed diabetic ulcer. Review of Resident #75's progress notes revealed a note dated 07/17/25 at 11:33 P.M. written by Licensed Practical Nurse (LPN) Unit Manager #215 indicating she was notified of a new wound and upon assessment, debris was noted in the wound bed of the left foot. Observation on 08/11/25 at 10:40 A.M. revealed flies were observed in Resident #75's room and in the hallway outside of Resident #75's room. Observation on 08/14/25 at 11:00 A.M. revealed flies were observed in Resident #75's room on the bed. In an interview on 08/18/25 at 12:36 P.M., LPN Unit Manager #215 stated Resident #75 had chronic cellulitis of her lower left leg and foot and was being treated with an antibiotic (medication used to treat infection) and a diuretic (medication used to help decrease swelling) prior to the wound on her left foot opening on 07/17/25. A follow-up interview at 12:47 P.M. revealed LPN Unit Manager #215 stated there were also some maggots present in Resident #75's wound bed when she first observed the wound on 07/17/25. However, LPN Unit Manager #215 stated the next day Resident #75's wound bed was clean. In an interview on 08/18/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #146 revealed Resident #75's wound was found on 07/17/25 when she and CNA #125 were providing care, and the wound was observed to have some maggots in it. CNA #146 and CNA #125 reported the new area immediately to the nurse. CNA #146 stated she had not seen any other wounds with maggots in them. In an interview on 08/18/25 at 3:17 P.M., LPN #403 stated that she completed a treatment to Resident #75's left lower leg on 7/17/25 on day shift and she did not see any new area on the foot at that time. LPN #403 stated that she changed the dressing while the resident was lying in bed, and had to pick up Resident #35's leg to do the dressing and had a good view of the bottom of her foot.In an interview on 08/19/25 at 9:00 A.M., CNA #125 stated that when the open area was found on Resident #75's left foot it had a few maggots in it. CNA #125 stated she had not seen any other wounds with maggots in them. CNA #125 stated Resident #75 often had flies in her room because she would hoard food and trash and the staff had to go in and clean her room. Observation on 08/19/25 at 12:12 P.M. revealed Resident #75's dressing change was completed by LPN Unit Managers #215 and #240. The dressing to Resident #75's plantar surface wound of the left foot was completed. The wound bed was observed and appeared clean with no debris present in the wound. However, flies were noted in the room during the dressing change and the presence of the flies were confirmed by LPN Unit Managers #215 and #240. This deficiency represents noncompliance investigated under Complaint Numbers 2582471 and 2568937.