

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Newark		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, hospital record review, facility policy review, review of Centers for Disease Control (CDC) Stimulant Guide, and review of SAMHSA (Substance Abuse and Mental Health Services Administration) guidelines, the facility failed to ensure a resident with history of substance use received the appropriate care to manage his condition or attain the highest practicable mental and psychosocial well-being. This affected one resident (Resident #82) of three residents reviewed for neglect. Findings Include: Review of the medical record for Resident #82 revealed an admission date of [DATE]. The facility listed diagnoses as of [DATE] that included paraplegia, anxiety disorder, insomnia, depression, chronic pain syndrome, and peripheral vascular disease unspecified. The diagnosis list did not include substance use disorder or a drug abuse diagnosis. Review of hospital referral records dated [DATE] revealed Resident #82 had diagnosis of drug abuse, had reported current drug use of marijuana, methamphetamines and cocaine. The hospital report also stated Resident #82 had an order for naloxone (Narcan) (used for opioid overdoses). The hospital report noted Resident #82 had been paraplegic since an industrial accident in the late 1980's. Per the hospital report, Resident #82 was evicted from his apartment on [DATE] and had been living on the streets because he had a service dog that homeless shelters wouldn't allow. Review of the progress notes for Resident #82 from [DATE] revealed an incident in which Resident #82 had overnight visitors and reported himself to be so high. He was examined by nurses and found to have dilated pupils, abnormal mental status and was lethargic. He refused a search of his room. The CNP was notified and ordered his narcotic medications to be held and a drug test. The resident refused a drug test at that time but later consented. Results were unavailable at time of survey. Review of the outside counseling referral form dated [DATE] for Resident #82 completed by the facility social worker noted he was being referred for adjustment difficulties, anger problems, emotional outbursts and problem behaviors. History of or current substance use/abuse behaviors was not circled or indicated on the form in any way. Review of the care plan entry revised [DATE] revealed Resident #82 had an alteration in behavior and would have abusive attacks on staff and/or other residents. Interventions included: administer medications as ordered and monitor side effects; inform the Medical Director (MD)/Certified Nurse Practitioner (CNP) of worsening behavior; intervene as needed to protect the rights and safety of others, approach/speak in calm manner, divert attention, remove from situation and take to another location as needed. Review of the care plan entry for Resident #82, revised [DATE], revealed a focus that Resident #82 was at risk for episodes of anxiety due to a history of mood changes and anger outbursts. Interventions suggested included: address reasons for anxiety, social withdraw/crying, absence of family/friends; administer medications as ordered and monitor for side effects and effectiveness. A plan of care focus for Resident #82 revised on [DATE] indicated the resident had potential to demonstrate verbally abusive behaviors due to ineffective coping skills, mental/emotional illness and poor impulse control. Interventions included: analyze key times, places, circumstances, triggers and what de-escalates behaviors and document; assess the resident's coping skills and support system; assess the resident's understanding of the situation, allow time for the resident to express self and feelings to the situation; assess risks when the resident makes manipulative statements; evaluate for side effects of medications; monitor/document observed behaviors and attempted interventions in behavior log. Review of the care plan focus for Resident #82, revised [DATE], revealed that Resident #82 was assessed to have the potential for a mood problem displayed as anxiety or restlessness due to depression and anxiety. Suggested interventions included: assess/evaluate resident's behavior and cognition systematically and continually throughout the day and night as appropriate; discuss possibility of changes in mental status, agitation, confusion and restlessness with responsible party/family member; monitor for possibility of changes in mental status, agitation, confusion and restlessness; report to practitioner mood patterns of acute agitation, anxiety and/or restlessness; and to use the counseling source. Review of previous PHQ Questionnaire completed with Resident #82 on [DATE] revealed Resident #82 scored a 12 at that time, which indicated moderate depression. Review of the trauma evaluation completed on [DATE] for Resident #82 indicated trauma of forklift accident and triggers were nightmares. There was a 'no' selected for the question of whether the resident had any new trauma or issues related to old trauma. There was no other information on this documentation regarding Resident #82's behaviors or triggers that would lead him to seek maladaptive coping strategies such as substance use. Review of the annual Minimum Data Set (MDS) assessment</p>		