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 03/05/2026
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to ensure the medication error rate did not exceed five percent (%). The facility had two medication errors of 34 opportunities for an error rate of 5.8%. This affected two Residents (#50 and #545) of three residents observed for medication administration. The facility census was 120 residents. Findings include:1.Review of the medical record for Resident #50 revealed an admission date of 08/20/19 with diagnoses to include but not limited to type two diabetes mellitus with hyperglycemia, muscle weakness, diastolic heart failure, chronic pancreatitis, toxic liver disease, cardiomyopathy, hyperlipidemia, hypertension, spinal stenosis, need for assistance with personal care, vascular disease, hypotension, gastro-esophageal reflux disease, and atrial fibrillation.Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #50 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. Further review of the quarterly MDS dated [DATE] revealed Resident #50 had no psychosis, no verbal or physical behaviors, and no rejection of care.Review of the care plan for Resident #50 dated 02/15/21 revealed a focus which stated resident has an impaired metabolic status related to diabetes and morbid obesity with interventions to include administer medications/insulins and treatments as indicated by physician orders.Review of an order for Resident #50 revealed Lantus subcutaneous solution 100 unit/milliliter (mL) (Insulin Glargine) inject 18 unit subcutaneously in the morning for diabetes mellitus type two.Observation on 03/03/26 at 8:58 A.M. of Licensed Practical Nurse (LPN) #268 administering Resident #50's morning medications revealed LPN #268 gave Resident #50 eye drops and oral medications but held the morning dose of Lantus. Interview on 03/03/26 at 5:06 P.M. with LPN #268 who verified she held Resident #50's morning dose of Lantus on 03/03/26 and stated Resident#50 did not refuse the Lantus injection. LPN #50 confirmed there are no parameters to hold the Lantus. LPN #268 stated she did not call the provider and Resident #50's blood sugar was 97 on the morning of 03/03/26.Review of the facility Administering Medications policy dated revised 04/2019 revealed if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having a potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's medical Director to discuss the concerns.2.Review of the medical record for Resident #545 revealed an admission date of 05/22/24 with diagnoses included but not limited to acute respiratory failure with hypoxia, depression, dementia, muscle weakness, hypertension, type two diabetes mellitus, bipolar disorder, anxiety disorders, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disorder, and chronic kidney disease stage three.Review of the annual MDS dated [DATE] for Resident #545 revealed a BIMS of 12 which indicated moderate cognitive impairment. Further review of the annual MDS dated [DATE] revealed Resident #545 had no psychosis, no verbal or physical behaviors, and no rejection of care.Review of the care plan dated 10/22/24 for Resident #545 revealed a focus which stated potential risk for hyper/hypoglycemia due to diagnosis of diabetes mellitus daily insulin with an intervention of administer medications as ordered.Review of an order for Resident #545 revealed Lantus SoloStar (continued on next page)

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

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Subcutaneous Solution Pen-Injector 100 unit/mL (Insulin Glargine) inject 10 unit subcutaneously in the morning related to type two diabetes mellitus without complications.Observation 03/03/26 at 7:44 A.M. of RN #310 administering medications for Resident #545. RN #310 removed the Lantus pen for Resident #545 from the medication drawer and placed a needle on the end of the pen. Then RN #310 dialed the Lantus pen to 10 units of insulin without priming the insulin pen. RN #310 administered the Lantus to Resident #545 in the lower left abdomen.Interview on 03/03/26 at 7:27 A.M. with RN #310 who stated she checked the Lantus insulin pen for air bubbles before she gave the insulin. RN #310 stated she did not know any other way of priming the Lantus pen.Review of the Lantus Solostar Pen instruction leaflet under step three states Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that the pen and needle work properly and removing air bubbles. Select a dose of two units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the needle cap and discard it. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way n. Check of insulin comes out of the needle tip. Check the dose window shows 0 following the safety test.This deficiency represents non-compliance investigated under Complaint Number 2722159.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent significant medication errors when staff did not administer insulin as ordered and did not prime insulin prior to administration. This affected two (Residents #50 and #545) of three residents reviewed for medication administration. The facility census was 120.1.Review of the medical record for Resident #50 revealed an admission date of 08/20/19 with diagnoses to include but not limited to type two diabetes mellitus with hyperglycemia, muscle weakness, diastolic heart failure, chronic pancreatitis, toxic liver disease, cardiomyopathy, hyperlipidemia, hypertension, spinal stenosis, need for assistance with personal care, vascular disease, hypotension, gastro-esophageal reflux disease, and atrial fibrillation.Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #50 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. Further review of the quarterly MDS dated [DATE] revealed Resident #50 had no psychosis, no verbal or physical behaviors, and no rejection of care.Review of the care plan for Resident #50 dated 02/15/21 revealed a focus which stated resident has an impaired metabolic status related to diabetes and morbid obesity with interventions to include administer medications/insulins and treatments as indicated by physician orders.Review of an order for Resident #50 revealed Lantus subcutaneous solution 100 unit/milliliter (mL) (Insulin Glargine) inject 18 unit subcutaneously in the morning for diabetes mellitus type two.Observation on 03/03/26 at 8:58 A.M. of Licensed Practical Nurse (LPN) #268 administering Resident #50's morning medications revealed LPN #268 gave Resident #50 eye drops and oral medications but held the morning dose of Lantus. Interview on 03/03/26 at 5:06 P.M. with LPN #268 who verified she held Resident #50's morning dose of Lantus on 03/03/26 and stated Resident#50 did not refuse the Lantus injection. LPN #50 confirmed there are no parameters to hold the Lantus. LPN #268 stated she did not call the provider and Resident #50's blood sugar was 97 on the morning of 03/03/26.Review of the facility Administering Medications policy dated revised 04/2019 revealed if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having a potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's medical Director to discuss the concerns.2.Review of the medical record for Resident #545 revealed an admission date of 05/22/24 with diagnoses included but not limited to acute respiratory failure with hypoxia, depression, dementia, muscle weakness, hypertension, type two diabetes mellitus, bipolar disorder, anxiety disorders, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disorder, and chronic kidney disease stage three.Review of the annual MDS dated [DATE] for Resident #545 revealed a BIMS of 12 which indicated moderate cognitive impairment. Further review of the annual MDS dated [DATE] revealed Resident #545 had no psychosis, no verbal or physical behaviors, and no rejection of care.Review of the care plan dated 10/22/24 for Resident #545 revealed a focus which stated potential risk for hyper/hypoglycemia due to diagnosis of diabetes mellitus daily insulin with an intervention of administer medications as ordered.Review of an order for Resident #545 revealed Lantus SoloStar Subcutaneous Solution Pen-Injector 100 unit/mL (Insulin Glargine) inject 10 unit subcutaneously in the morning related to type two diabetes mellitus without complications.Observation 03/03/26 at 7:44 A.M. of RN #310 administering medications for Resident #545. RN #310 removed the Lantus pen for Resident #545 from the medication drawer and placed a needle on the end of the pen. Then RN #310 dialed the Lantus pen to 10 units of insulin without priming the insulin pen. RN #310 administered the Lantus to Resident #545 in the lower left abdomen.Interview on 03/03/26 at 7:27 A.M. with RN #310 who stated she checked the Lantus insulin pen for air bubbles before she gave the insulin. RN #310 stated she did not know any other way of priming the Lantus pen.Review of the Lantus Solostar Pen instruction leaflet under step three states (continued on next page)

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Embassy of Newark	75 McMillen Drive Newark, OH 43055

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that the pen and needle work properly and removing air bubbles. Select a dose of two units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the needle cap and discard it. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way n. Check of insulin comes out of the needle tip. Check the dose window shows 0 following the safety test.This deficiency represents non-compliance investigated under Complaint Number 2722159.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure appropriate incontinence care was provided for one Resident # 910. This affected one (Resident #910) of the three residents reviewed for incontinence care. Additionally, the facility failed to ensure staff handled medication in a sanitary way. This affected one (Resident #205) of three residents observed for medication administration. The facility census was 120.Findings include:1.Review of the medical record for Resident #910 revealed an admission date of 12/24/25 with diagnoses to include, but not limited to cerebral infarction, hypertension, dementia, anorexia, abnormalities of gait and mobility, and urinary incontinence.Review of the admission Minimum Data Set (MDS) dated [DATE] for Resident #910 revealed a Brief Interview for Mental Status (BIMS) of six which indicated severe cognitive impairment. Resident #910 required supervision with toileting hygiene and was occasionally incontinent with bladder and always incontinent of bowel.Review of the care plan dated 12/24/25 for Resident #910 revealed a focus which stated the resident has potential for impairment of skin integrity with an intervention of check and change approximately every two to three hours and as needed for incontinence.Observation on 03/03/26 at 10:07 A.M. of Certified Nursing Assistant (CNA) #164 and CNA #348 proving incontinence care for Resident #910. Licensed Practical Nurse (LPN) #209 was in Resident #910's room during the observation. CNA #164 went into Resident #910's room and washed his hands, then he put on gloves. While wearing gloves, CNA #910 opened bags of clean linen, then put a clean towel on Resident #910's bedside table. LPN #209 left Resident #910's room to retrieve wash basins for incontinence care. LPN #209 brought two wash basins which were not covered into Resident #910's room. CNA #164 took the basins from LPN #209, then put water in each one and placed it on the towel on Resident #910's bedside table. Then CNA #164 placed clean wash cloths into the wash basins. While wearing the same gloves, CNA #164 pulled Resident #910's bedside table closer to the bed and without changing gloves performed peri-care on Resident #910. After completing peri-care, CNA #164 removed his gloves and washed his hands, then CNA #164 put on new gloves, placed an incontinence brief on Resident #910 and pulled up her pants. Afterwards, CNA #164 removed his gloves and washed his hands.Interview on 03/03/26 at 10:36 A.M. with CNA #164 and LPN #209 revealed CNA #164 confirmed he washed his hands and put on gloves, then touched items such as the basins and bedside. CNA #164 confirmed he performed peri-care without removing the dirty gloves and washing his hands. LPN #209 verified CNA #164 did not change his gloves after touching multiple items before he performed peri-care for Resident #910.Review of the facility Handwashing/Hand Hygiene policy dated revised 08/2019 revealed all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Use an alcohol-based and rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents.Review of the facility Policies and Practices-Infection Control dated revised 10/2020 revealed this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and mange transmission of diseases and infections.2.Review of the medical record for Resident #205 revealed an admission date of 07/16/25 with diagnoses to include but not limited to spinal stenosis, anxiety disorder, mild cognitive impairment, need for assistance with personal care, muscle weakness, cognitive communication deficit, dysarthria and anarthria, asthma, dementia, hypertension, hyperlipidemia, and anemia osteoarthritis.Review of the quarterly MDS dated [DATE] for Resident #205 revealed a BIMS of eleven which indicated moderate cognitive impairment. Further review of the quarterly MDS dated [DATE] revealed Resident #205 had no psychosis, no verbal or physical behaviors, and no rejection of care.Review of the care plan dated 07/24/25 for Resident #205 revealed a focus which stated the resident has a slight impaired cognitive function/dementia with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	impaired communication due to BIMS of 13 and hearing impairment, uses hearing aids with an intervention to include administer medication as ordered.Review of an order for Resident #205 revealed Losartan Potassium oral tablet 50 milligrams (mg) give one tablet by mouth in the morning for hypertension.Observation on 03/03/26 at 7:27 A.M. of Registered Nurse (RN) # 310 preparing medications for Resident #205. The medications were in prefilled single containers within a bag which had all the medications listed on the outside of the bag. RN #310 removed the Losartan pill from its individual container by popping the back of the container. The Losartan pill fell out of its container onto the medication cart. RN #310 picked up the Losartan pill with her bare fingers and placed it in the medication cup with Resident #205's other oral medications. RN #310 then gave Resident #205 all the oral medications in the medication cup and Resident #205 swallowed them.Interview on 03/03/26 at 7:57 A.M. with RN #310 who verified she picked up Resident #205's Losartan with bare fingers and put it in the medication cup. RN #310 stated she should have put on a glove to pick up the pill.Review of the facility Administering Medications policy dated revised 04/2019 revealed staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of facility policies, the facility did not provide a safe, clean, and homelike environment by maintaining the building in good repair. This had the potential to affect all 120 residents living in the facility. The facility census was 120. Observation of the facility on 03/02/26 at 8:37A.M. to 9:39 A.M. revealed the following: -Observation of the 600-unit resident shower room revealed there was cracked tiles along the wall directly adjoining the floor. The cracked tiles were on the far wall from the desk area and around the toilet. There was a black and brown substance on eleven tiles to the left of the toilet and two cracked tiles, one cracked tile which was the fifth tile up the wall next to the inoperable shower which had equipment in it and rust on the facet handles. The shower room sink was leaking water and did not turn off. The shower nearest to the door had black and brown substances in the grout nearest the floor and cracked tiles adjoining the floor. There was cracked flooring at the door to enter the shower room. There was a hole in the floor of the hallway near the recreation room by the 600-unit nurse station. -In the hallway floor between room [ROOM NUMBER] and room [ROOM NUMBER] there was a round metal plumbing cover as big as the bottom of a one half gallon milk jug raised one inch above the rest of the flooring in the middle of the hallway. The 400-unit shower floor had a black substance on all four sides of the shower between the wall and the floor and around under the sink. The wall in the 400-unit shower room had the paint pulled off the wall by the sharps box, both the wooden cabinets in the 400-unit shower room had water damage to the bottoms with damage going up the wood cabinets about twelve inches and breaking off near the floor with wood dust and chips lying in the floor. -The 300-unit shower room had a black substance all around the showers between the floor and the wall in both showers, cracks in the tiles in the showers, cracks in the tiles near the door entrance. -On the memory care unit, the wall nearest the 300-unit behind the television had black streaks and parts of the drywall were chipped, the drywall was chipped at the corner near the double doors, and the trim was separating from the wall. The trim under the air conditioner in the common area with the small television was separated from the wall. There was paint chipping off the corner wall near the single external door and piano. There was paint off the drywall on the nurse's desk wall on all three sides facing into the common area. There was a black substance along the floor corners near the kitchenette on the memory care unit and trim was coming off the wall near the kitchenette. On the memory care unit, rooms 230, 229, 228, 227, 226, 225, 224, 223, 221, 220, 119, 117, 116, 115, 114, 113, 112, 109 had door frames which were separated from wall near the floor. On the memory care unit, the shower room had cracked tiles around the toilet and a black substance around the tile under the sink and under the window. -In the 700-unit shower room, the wall corner on the right of the door frame had two- and one-half tiles broken and a black substance in the shower floor and around the toilet. -The carpet in all six nurse stations had black areas where the carpet had worn down to the floor underneath. Interview on 03/02/26 at 9:22 A.M. with Housekeeper #207 who stated a lot of the housekeepers (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	think they shouldn't have to clean the floors, because the floor technician should do it. Housekeeper #207 stated there had been issues with the floor machine and it was not working currently. Interview on 03/02/26 at 3:38 P.M. with Housekeeping Supervisor #425 who stated the common areas, the nurses' stations, and each resident's room on the unit is cleaned daily. The Housekeeping Supervisor stated the floor machine is broken right now. Interview on 03/02/26 at 2:39 P.M. to 3:21 P.M. with Maintenance #530 who verified and confirmed the 600-unit resident shower room which had cracked tiles along the wall directly adjoining the floor. The cracked tiles were on the far wall from the desk area and around the toilet. There was a black and brown substance on eleven tiles to the left of the toilet and two cracked tiles, one cracked tile which was the fifth tile up the wall next to the inoperable shower which had equipment in it and rust on the facet handles. The shower room sink was leaking water and did not turn off. The shower nearest to the door had black and brown substances in the grout nearest the floor and cracked tiles adjoining the floor. There was cracked flooring at the door to enter the shower room. There was a hole in the floor of the hallway near the recreation room by the 600-unit nurse station. Observation of 03/04/26 at 8:35 A.M. on the memory care unit common area of the two love seats with multi-colored circles and two chairs with multi-colored circles have black stains on the arms of the chairs and black stains throughout the seat cushions. Licensed Practical Nurse (LPN) #281 verified the black stains at the time of the observation stated the two love seats with multi-colored circles and two chairs with multi-colored circles had been on the memory care for at least five years with these stains and the stains were getting worse. Review of the facility policy, Maintenance Service, dated revised 12/2009 revealed maintenance shall be provided to all areas of the buildings, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner. Functions of the maintenance personnel include, but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, maintaining the building in good repair, maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order, and providing routinely scheduled maintenance service. This deficiency represents non-compliance found under Complaint Numbers 2712669 and 2722594.