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	08/28/2024

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview, record review and policy review the facility failed to provide a written transfer notice when Resident #93 and Resident #103 were hospitalized . This affected two residents (#93 and #103) of two residents reviewed for hospitalization s. The facility census was 102. Findings include: 1. Review of Resident #93's medical record revealed an admitted [DATE] with diagnoses including hydrocephalus, traumatic hemorrhage of cerebrum, encephalopathy, chronic respiratory failure, unspecified severe protein-calorie malnutrition, dysphagia, anxiety, schizophrenia, other psychoactive substance abuse, legal blindness, and cognitive communication deficit. Review of Resident #93's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed his brief interview for mental status (BIMS) was not assessed. The resident was usually understood and sometimes understood others. Review of Resident #93's progress note dated 08/02/24 at 3:01 P.M. revealed the resident was noted to be lethargic with muscle twitching and was difficult to arouse. He was transferred to the hospital for treatment. Review of Resident #93's progress note dated 08/18/24 revealed the resident had a cognitive decline and his white blood cells were elevated. The facility obtained a new order to send him to the hospital for further evaluation. Review of Resident #93's medical record revealed no evidence he or his responsible party received a written notice of transfer for either hospitalization . Interview on 08/28/24 at 9:48 A.M. with the Director of Nursing (DON) revealed there was no written transfer notice for Resident #93 for the month of August. 41266 (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

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 08/28/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Newark		STREET ADDRESS, CITY, STATE, ZIP CODE 75 McMillen Drive Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Review of the closed medical record for Resident #103 revealed an admitted on 05/17/24 and a discharge date on 06/13/24. Medical diagnoses included displaced [NAME] fracture of left tibia, embolism and thrombosis of arteries of the lower extremities, severe protein-calorie malnutrition, anxiety disorder, and need for assistance with personal care. Review of Resident #103's clinical census revealed Resident #103 was hospitalized and discharged on [DATE]. Review of Resident #103's assessments revealed there was no evidence a written transfer notice had been completed for Resident #103's hospitalization on [DATE] from an outside appointment. Review of Resident #103's scanned documents revealed there was no evidence a written transfer notice had been provided to the resident or resident representative. Review of the progress notes dated 06/13/24 revealed Resident #103 was transferred to the hospital from an outside medical appointment and was admitted . Resident #103 did not return to the facility. There was no evidence a written transfer notice was provided or mailed to the resident or resident's representative. Interview on 08/26/24 at 4:13 P.M. with Social Services Director (SSD) #312 confirmed Resident #103 or the resident's representative were not provided with a written transfer notice because he was transferred to the hospital from an outside appointment. SSD #312 confirmed the resident had not requested to be transferred out of the facility. Review of the facility policy, Transfer or Discharge, Facility-Initiated, revised 10/2022, revealed the policy stated, Facility-initiated transfer or discharge means a transfer or discharge when the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. The resident and representative are notified in writing of the following information: the specific reason for the transfer or discharge, including the basis of the transfer or discharge, the effective date of the transfer or discharge, the specific location to which the resident is being transferred or discharged , an explanation of the resident's rights to appeal the transfer or discharge to the state, the name, address, and phone number of the Office of the State Long-Term Ombudsman, the name, address, email, and phone number of the state health department designated to handle appeals of transfers and discharge notices.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0625

Level of Harm - Potential for minimal harm

Residents Affected - Some

Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41266

Based on record review, staff interview, and facility policy review, the facility failed to provide a bed hold notice when two residents (Residents #93 and #103) were hospitalized . The deficient practice affected two residents (Residents #93 and #103) of two reviewed for hospitalization . The facility census was 102.

Findings Include:

1. Review of the closed medical record for Resident #103 revealed an admitted on 05/17/24 and a discharge date on 06/13/24. Medical diagnoses included displaced [NAME] fracture of left tibia, embolism and thrombosis of arteries of the lower extremities, severe protein-calorie malnutrition, anxiety disorder, and need for assistance with personal care.

Review of Resident #103's clinical census revealed Resident #103 was hospitalized and discharged on [DATE].

Review of Resident #103's scanned documents revealed there was no evidence a bed hold notice had been provided to the resident.

Review of the progress notes dated 06/13/24 revealed Resident #103 was transferred to the hospital from an outside medical appointment and was admitted . Resident #103 did not return to the facility. There was no evidence Resident #103 was provided with a bed hold notice.

Interview on 08/26/24 at 4:13 P.M. with Social Services Director (SSD) #312 confirmed Resident #103 was not provided with a bed hold notice because he was transferred to the hospital from an outside appointment. SSD #312 confirmed the resident had not requested to be transferred out of the facility.

43064

2. Review of Resident #93's medical record revealed an admitted [DATE] with diagnoses including hydrocephalus, traumatic hemorrhage of cerebrum, encephalopathy, chronic respiratory failure, unspecified severe protein-calorie malnutrition, dysphagia, anxiety, schizophrenia, other psychoactive substance abuse, legal blindness, and cognitive communication deficit.

Review of Resident #93's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed his brief interview of mental status was not assessed. The resident was usually understood and sometimes understood others.

Review of Resident #93's progress note dated 08/02/24 at 3:01 P.M. revealed the resident was noted to be lethargic with muscle twitching and was difficult to arouse. He was transferred to the hospital for treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #93's progress note dated 08/18/24 revealed the resident had a cognitive decline and his white blood cells were elevated. The facility obtained a new order to send him to the hospital for further evaluation. Review of Resident #93's medical record revealed no evidence he or his responsible party received a bed hold notice for either hospitalization . Interview on 08/28/24 at 9:48 A.M. with the Director of Nursing (DON) revealed there was no bed hold notice for Resident #93 for the month of August. Review of the facility policy, Transfer or Discharge, Facility-Initiated, revised 10/2022, revealed the policy stated, Facility-initiated transfer or discharge means a transfer or discharge when the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. The resident and his or her representative are notified in writing of the following information: The Notice of Facility Bed-Hold and policies.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 43064

Based on observation, interview and record review the facility failed to ensure comprehensive care plans were developed in the areas of diabetes, depression, anticoagulants, activities, and skin picking behaviors. This affected five residents (#2, #33, #56, #84, and #85) of thirty residents reviewed for care planning. The facility census was 102.

Findings include:

1. Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, encounter for orthopedic aftercare following surgical amputation, other chronic pain, type two diabetes mellitus, bipolar disorder, and fibromyalgia.

Review of Resident #56's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.

Review of Resident #56's physician orders dated 06/07/24 revealed an order for Insulin Glargine Subcutaneous (sq)Solution Pen-injector 100 units per milliliter (ml). Sixty units were to be injected (sq) at bedtime for diabetes. In addition, an order for Insulin Lispro subcutaneous solution 100 units per ml with dose to be injected as per sliding scale.

Review of Resident #56's plan of care revealed it did not address Resident #56's diabetes or insulin use.

Interview on 08/28/24 at 8:14 A.M. with the Director of Nursing (DON) verified Resident #56 did not have a care plan for diabetes or insulin and there should have been a care plan available.

2. Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses including chronic osteomyelitis, spina bifida, stage four pressure ulcer of the right buttock, paraplegia, anxiety disorder, hydronephrosis, and anemia.

Review of Resident #2's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.

Review of Resident #2's plan of care on 08/26/24 revealed it was absent for her activities preferences/activities.

Interview on 08/28/24 at 10:47 A.M. with MDS Coordinator #211 verified Resident #2 did not have plan of care for activities prior to 08/26/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #85's medical record revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, encephalopathy, dysphagia, major depressive disorder, cognitive social or emotional deficit, gastro-esophageal reflux disease without esophagitis, abnormal posture, and muscle weakness. Review of Resident #85's physician orders dated 04/12/24 revealed he had an order for Zoloft 25 milligrams (mg) take one tablet one time a day related to depression. Review of Resident #85's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. Resident #85 was on an antidepressant. Review of Resident #85's plan of care revealed his plan of care did not address depression or antidepressant use. Interview on 08/28/24 at 11:23 A.M. with MDS coordinator #211 verified Resident #85 did not have a care plan for depression or antidepressant use. 42015 4. Review of Resident #33's medical record revealed an admitted [DATE]. Diagnoses included end stage renal disease, paroxysmal atrial fibrillation, and dependence on renal dialysis. Review of Resident #33's physician orders for August 2024 revealed the resident was receiving apixaban (an anticoagulant medication that reduces clotting and thins the blood) oral tablet five milligrams by mouth twice a day for atrial fibrillation. Review of Resident #33's care plan dated 07/19/24 revealed the facility had not developed a care plan regarding the resident's use of her anticoagulant medication. Interview on 08/28/24 at 2:48 P.M. the facility's Director of Nursing confirmed the facility had not developed a care plan regarding Resident #22's use of an anticoagulant medication. 5. Review of Resident #84's medical record revealed an admitted [DATE]. Diagnoses included schizophrenia, anxiety disorder, pruritus (itching), and paresthesia of the skin. Observation on 08/25/24 at 10:47 A.M. revealed Resident #84 lying in bed. His bilateral arms and left leg were observed to have numerous open and closed scabbed areas, some noted to be as large as a dime. Some of the areas were noted to have a scant amount of blood surrounding the area. The resident was observed to be picking at his skin. The resident reported that he feels like he is always itching and picks at this arms and legs constantly due to the itching. Review of Resident #84's care plan revealed the facility had not developed a care plan related to the resident's skin issues or picking behavior. Interview on 08/27/24 at 11:16 A.M. the DON confirmed the facility had not developed a care plan related to Resident #84's skin issues or picking behaviors.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review, the facility failed to ensure Resident #406 was clean shaven, as preferred. This affected one resident (#406) of five residents reviewed for activities of daily living. The facility census was 102. Findings include: Review of Resident #406's medical record revealed an admitted [DATE] with diagnoses including chronic venous hypertension, chronic systolic heart failure, peripheral vascular disease, dysphagia and hypertension. Review of Resident #406's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. He required substantial or maximal assistance with personal hygiene. Further review of Resident #406's medical record revealed the last documented evidence of Resident #406 being shaved was with a bed bath on 08/19/24 when it was indicated CNA #234 shaved the resident. Observation on 08/25/24 at 2:59 P.M. and 08/27/24 at 9:08 A.M. revealed Resident #406 was unshaven with heavy stubble growth. Interview on 08/25/24 at 2:58 P.M. with Resident #406's family member revealed the resident liked to be clean shaven. They had asked a staff member to shave him the previous week and they did not think it had been done since then. Interview on 08/27/24 at 9:08 A.M. with Certified Nursing Assistant (CNA) #234 verified Resident #406 needed shaved. She reported she had shaved him when she showered him the previous week but was unsure if it had been done since then. Interview on 08/27/24 at 4:35 P.M. with the Director of Nursing (DON) revealed residents should be shaved with showers and when it was needed. This deficiency represents non-compliance investigated under Complaint Number OH00156649.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide activities to meet all resident's needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42015

Based on observation, medical record review, interview, and review of scheduled activities, the facility failed to ensure residents were offered or assisted in attending activities and failed to provide activities as scheduled. This affected four (#14, #22, #406, #52) of five residents reviewed for participation in activities. The facility census was 102.

Findings include:

1. Review of the medical record for Resident #52 revealed an admitted [DATE], Diagnoses included moyamoya disease, hemiplegia, history of a cerebral infarction, and a left hand contractor.

Review of Resident #52's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely impaired, had a memory problem, untied a wheelchair, and had an upper extremity impairment.

Review of Resident #52's Care Plan dated 07/28/24 revealed the resident had impaired cognitive function related to confusion, poor safety awareness, and a cerebrovascular accident. Interventions included to encourage the resident to participate in daily decision making with daily activities and engage resident in simple, structured activities that avoid overly demanding tasks. The resident was also noted to be at risk for altered activity patterns related to difficulty following commands and impaired mobility. Interventions included to encourage the resident to participate in activity programs as an active participant and offer verbal, visual, and physical cues as needed. Involve the resident in simple and structured activities with cues and adaptations.

Review of Resident #52's Recreation and Activities assessment dated [DATE] revealed activity pursuits included animals/pets, beauty/barber shop, music, TV/radio. The assessment indicated the resident would like daily activities. Music is very important, being around animals and pets is very important, and it is very important to do things with groups and people.

Review of the activity calendar for August 2024 revealed group activities that included on 08/25/24 at 10:30 A.M. the facility participated in hymns, at 1:00 P.M. a movie matinee, and at 3:00 a sensory activity. On 08/26/24 at 10:00 A.M. morning hymns and at 2:00 P.M. storytelling. On 08/27/24 at 2:00 P.M. a movie drive in and 3:00 P.M. Tunes.

Observation of Resident #52 during the scheduled group activities revealed the resident to be sitting alone outside of the activity room, or in her room.

Interview on 08/26/24 at 4:40 P.M. State tested Nursing Assistant (STNA) #236 revealed Resident #52 does not participate in group activities. STNA #236 revealed the only activities the resident does is watching television when she is in bed and sometime the activity staff will play music for her. She reports that the resident requires full assistance for all activities of daily living.

Interview on 08/27/24 at 11:52 A.M. Activities Staff #203 revealed she has tried to assist Resident #52 with participating in activities in the past, but she doesn't seem to enjoy anything. She stated she is not currently participant in group activities or one-on-one activities. Activity Staff #203 reported at times they do play music for her, and she seems to like that.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/27/24 at 11:57 A.M. Activity Director #200 reported the only activities Resident #52 is provided is sometimes in the mornings she does her hair, snack time, and activity staff will play music for her out of a speaker. She stated she should be getting one-on-one activities but does not have any documentation indicating she has participated in or been offered activities for the month of August. 43064 2. Review of Resident #14's medical record revealed an admitted [DATE] with a readmitted [DATE]. Her diagnoses included displaced interochanteric fracture of left femur, sepsis, acute and chronic respiratory failure, chronic obstructive pulmonary disease, anxiety disorder, depression, and cognitive communication deficit. Review of Resident #14's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had severely impaired cognition. It was very important to listen to music, it was very important to have books, newspapers, and magazines to read, it was somewhat important to be around pets, somewhat important to do favorite activities. Review of Resident #14's medical record revealed an activities assessment had not been completed and she had no activities care plan. Review of Resident #14's medical record on 08/26/24 revealed no evidence Resident #14 had been invited to or had attended an activity. Interview on 08/25/24 at 2:59 P.M. with Resident #14's family revealed she did not think anyone came in to see the resident and she just watched television. Resident #14's family asked the resident who reported she liked music and she did not think anybody from activities had come to see her. Observation on 08/26/24 at 7:50 A.M., 9:06 A.M., 11:12 A.M., 2:13 P.M., 3:26 P.M., and 4:42 P.M. revealed Resident #14 in her room watching television. Interview on 08/27/24 at 12:45 P.M. and 4:27 P.M. with Activity Director #200 revealed residents who do not attend activities or those who stay in their rooms should be offered one on one activities. She verified she had no activity documentation for Resident #14, activities assessment, or care plan. She reported Resident #14 enjoyed spending time with her husband who resided in the facility. She indicated they refused other activities but verified this was not documented. 3. Review of Resident #406's medical record revealed an admitted [DATE] with diagnoses including chronic venous hypertension, chronic systolic heart failure, peripheral vascular disease, dysphagia and hypertension. Review of Resident #406's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #406's plan of care dated 08/13/24 revealed the resident had little or no activity involvement related to the residents wishes not to participate. He did, however, enjoy time with his wife. Interventions included inviting and encouraging his family members to attend activities to support participation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #406's activity assessment dated [DATE] revealed the resident found participation in religious services very important. He was interested in animals, arts and crafts, bingo, community outings, exercise, family and friend visits, gardening, movies, music, religious activities, socials, sports, TV and radio. He had no interest in attending activities. He needed encouragement but was willing to try. Interview on 08/25/24 at 2:59 P.M. with Resident #406's family revealed Resident #406 just laid in bed all day. Observation on 08/26/24 at 9:06 A.M. 11:08 A.M., 2:12 P.M., 3:26 P.M., and 4:41 P.M. revealed Resident #406 laying in bed in a dark room without entertainment. Interview on 08/27/24 at 12:45 P.M. and 4:27 P.M. with Activity Director #200 revealed residents who do not attend activities or those who stay in their rooms should be offered one on one activities. She verified she had no activity documentation for Resident #406. She reported Resident #406 enjoyed spending time with his wife who resided in the facility. She indicated they refused other activities but verified this was not documented. 4. Review of Resident #22's medical record revealed an admitted [DATE] with diagnoses including pneumonitis due to inhalation of food and vomit, sepsis due to streptococcus pneumoniae, dysphagia, type two diabetes mellitus, unspecified intellectual disabilities, peripheral vascular disease, anxiety disorder, epilepsy, unspecified dementia with anxiety, depression, and hypertension. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 had intact cognition. Review of Resident #22's plan of care dated 07/16/24 revealed the resident was dependent on staff for activities, cognitive stimulation, social interaction related to physical limitations, however, he was willing to defy the odds, he wanted to learn how to knit. Interventions included conversing with resident while providing care, one in one bedside or in-room visits and activities if unable to attend out of room activities, Resident #22 needs assistance with activities of daily living as required during the activities and thanking the resident for attendance. Review of Resident #22's activity assessment dated [DATE] revealed he found activity participation in religious services very important. Resident #22 liked animals, arts and crafts, barber shop, bingo, community outings, computer, cooking, cultural events, current events, exercise, family and friends' visits, gardening, movies, music, religious activities, socials, sports, TV, and radio. Resident #22 liked to participate in facility activities two to three times a week. Review of Resident #22's medical record revealed no evidence of activity participation. Observation on 08/25/24 at 9:13 AM, on 08/26/24 at 11:10 AM, 2:13 P.M., and 3:27 P.M., revealed the resident in his room with the TV on. Interview on 08/25/24 at 9:13 A.M. revealed Resident #22 was unable to answer questions. Observation on 08/27/24 at 9:02 A.M. and 10:13 A.M. revealed him in the lounge in silence (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/27/24 at 12:45 P.M. and 4:27 P.M. with Activity Director #200 revealed residents who do not attend activities or those who stay in their rooms should be offered one on one activities. She reported Resident #22 liked audiobooks and had a stack at the nurse's station. She verified there was no documented evidence he was receiving the audiobooks, and further verified that there was no activities documentation for the resident. Review of the policy 'Activity Programs' revealed the activities program was provided to support the well being of residents and to encourage independence and community interaction. Activities offered were to be based on the comprehensive resident centered assessment and resident preferences. All activities were to be documented in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on observation, interview, record review, and policy review the facility failed to ensure skin assessments and monitoring were completed. This affected two residents (#3 and #84) of three residents reviewed for skin conditions. The facility census was 102. Findings include: 1. Review of Resident #84's medical record revealed an admitted [DATE]. Diagnoses included schizophrenia, anxiety disorder, pruritus, and paresthesia of the skin. Observation on 08/25/24 at 10:47 A.M. revealed Resident #84 lying in bed. His bilateral arms and left leg were observed to have numerous open and closed scabbed areas some noted to be as large as a dime. Some of the areas were noted to have a scant amount of blood surrounding the areas. The resident was observed to be picking at his skin areas. The resident reported that he feels like he is always itching and picks at his arms and legs constantly due to the itching. Review of Resident #84's After Visit Dermatology Summery dated 08/20/24 revealed the facility should keep the sites to the resident's left leg and right arm clean, covered, and dry for one day. On the second day, remove the bandages and wash the site with mild soap and water pat dry and apply Vaseline ointment. The summery stated to continue triamcinolone 0.1% cream twice daily to excoriated areas. The facility had an order in place for the treatment. Review of Resident #84's Weekly Skin assessment dated [DATE] revealed the resident skin was intact. The assessment did not address the numerous open and closed skin lesions on the resident's bilateral arms and left leg. Continued review of the medical record revealed the facility did not have any evidence of skin or wound monitoring for the resident. Interview on 08/27/24 at 9:45 A.M. Licensed Practical Nurse (LPN) #301 reported she was responsible for wound monitoring in the facility. She confirmed the facility has not been monitoring Resident #84's skin issues. She reported since the resident was seeing dermatology each month, she assumed they would complete the wound monitoring. Interview on 08/27/24 at 11:16 A.M. the facility Director of Nursing verified Resident #84's skin issues should be monitored weekly and confirmed his skin assessment was inaccurately documented. Review of the undated facility policy, Skin Assessment revealed a full body skin assessment will be conducted by a licensed nurse upon admission and weekly thereafter. The documentation should include observations of the skin, type of wound, and a description of the wound including (measurements, color, type, drainage, odor, and pain). 41266 (continued on next page)

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 08/28/2024

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #3 revealed an admitted on 04/05/24. Medical diagnoses included acute on chronic diastolic (congestive) heart failure, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris (chest pain), and type II diabetes mellitus with diabetic chronic kidney disease. Review of the Other payment assessment Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status assessment indicating the resident had intact cognition. Resident #3 required staff assistance to complete Activities of Daily Living (ADLs) ranging from supervision to extensive assistance. Resident #3 did not have any noted skin issues. Review of the physician orders dated August 2024 revealed Resident #3 had an order for aspirin oral tablet delayed release 81 milligrams (mg) daily dated 04/06/24. There was an additional order for apixaban (Eliquis) (an anticoagulant medication) 2.5 mg tablet daily dated 04/05/24. There was not an order to monitor any bruising to the top of Resident #3's left hand. Review of the progress notes dated from 08/01/24 through 08/28/24 revealed there was no indication the staff identified a large bruise to the top of Resident #3's left hand. Review of the weekly skin assessment dated [DATE] revealed Resident #3 had blisters to the tops of her bilateral feet. There was no indication of any bruising noted for Resident #3. Observation and interview on 08/26/24 at 11:02 A.M. with Resident #3 revealed the resident had a large purplish, blue bruise that covered the top of her left hand. The resident's hand and fingers were noted to be swollen. Resident #3 was able to move her hand and fingers and made a fist during the observation without any complaints of pain. Resident #3 was not sure how she acquired the bruise but stated, I probably bumped it on something. I bruise easily. Interview on 08/28/24 at 4:18 P.M. with Registered Nurse (RN) #308 revealed if a resident was found with a new bruise it should be reported to management, a skin alteration assessment should be completed to document the bruise, an origin of the bruise should be investigated and determined, and the physician and family should be notified of the new bruise. A physician's order to monitor the bruise until resolved should be initiated. RN #308 stated Resident #3 was on an anticoagulant medication and monitored for side effects of the medication, including bruising and bleeding. Observation and interview on 08/28/24 at 4:46 P.M. with RN #308 and Resident #3 in her room confirmed Resident #3 had a large bruise which covered the top of her left hand. RN #308 confirmed the bruise had not been previously documented for the resident, the bruise had not been noted on the skin assessment completed on 08/26/24, and the physician, management, or Resident #3's representative had not been notified of the bruise. There also was not a physician order to monitor the bruise to the top of Resident #3's left hand initiated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Skin Tears-Abrasions and Minor Breaks, Care of, undated, revealed the policy stated, the purpose of the procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin. Obtain a physician's order as needed and document physician notification as needed, review the resident's care plan, current orders, and diagnoses, check the treatment record, generate non-pressure form and complete. Complete in-house investigation of causation, document family notification, any problems or resident complaints, any complications, implement interventions, and document when a bruise is discovered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on observation, interview, and medical record review, the facility failed to ensure Resident #52 was given the opportunity to wear her recommended palm guard. This affected one resident (#52) of one residents reviewed for limited range of motion (ROM). The facility census was 102. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included moyamoya disease, hemiplegia, history of a cerebral infarction, and a left-hand contractor. Review of Resident #52's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had severely impaired cognition, had a memory problem, utilized a wheelchair, and had an upper extremity impairment. Review of Resident #52's Care Plan dated 07/28/24 revealed the resident had potential for pain related to a left-hand contracture. Interventions included a left-hand palm guard to be place on in morning and be taken off at night. The care plan also stated the resident has an activity of daily livings self-care performance deficit related to left sided hand contracture and limited range of motion (ROM) of the left upper extremity. Interventions included to apply splint as ordered. Review of Resident #52's Occupational Therapy (OT) Discharge Summery dated 04/12/24 revealed the resident received services from 03/20/24 through 04/12/24 with long term goals indicating patient will safely always wear a least restrictive splinting/orthotic device except bathing and exercise without skin irritation and redness and to develop/establish a wearing schedule. Care givers will be independent with genital Passive ROM to left upper extremity with recommendations for palm guard. Observations of Resident #52 on 08/26/24 from 9:10 A.M. through 4:00 P.M., on 08/27/24 from 09:18 A.M. through 4:40 P.M., revealed Resident #52 did not have her palm guard in place. Interview on 08/27/24 at 11:27 A.M. with Therapy Manager # 337 revealed Resident #52 discharged from OT on 04/12/24 with recommendations for a palm guard except for bathing and exercise. The facility staff received education regarding the best techniques for getting the palm guard on her which included putting it on her when she first got up and to complete passive range of motion while applying. The ROM was to be completed at the time of applying the palm guard. Therapy Manager #337 revealed as the resident got used to her palm guard, facility staff could add a foam piece into the palm guard which would allow for the resident to extend her fingers further from her palm. Interview on 08/27/24 at 11:49 A.M. State tested Nursing Assistant #236 reported she was responsible for Resident #52 on 08/26/24 and 08/27/24. She confirmed she had not been applying the residents palm guard to her left hand. She stated she has not been able to find it and would need to call down to laundry to see if they have it. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/24 at 3:03 P.M. with the Director of Nursing verified the facility did not place an order for Resident #52's palm guard after her therapy recommendation. She also verified the residents palm guard was not in place.

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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** 42015 Based on observations, interview, medical record review, and facility investigation review the facility failed to maintain adequate supervision to ensure Resident #78 did not leave the facility's secured unit and complete a thorough investigation into her unsupervised departure from the secured unit. The facility also failed to ensure a safe environment for Resident #29. This affected two (Resident #29 and Resident #78) of seven residents reviewed for accidents. The facility census was 102. Findings include: 1. Review of the medical record for Resident #78 revealed an admitted [DATE]. Diagnoses include cerebral infarction, nontraumatic intracerebral hemorrhage, and dementia. Review of Resident #78's Annual Minimum Data Set (MDS) dated [DATE] revealed the resident had a severe cognitive impairment. The resident could independently ambulate. Review of Resident #72's care plan dated 6/27/2024 revealed the resident is at high risk for elopement related to dementia. The care plan was initiated on 11/10/2022. Interventions included discuss with resident/family risks of elopement/wandering. If resident is missing from facility, follow elopement protocol, notify the medical director (MD) and family immediately. If resident is wandering in potentially unsafe area or situation, redirect to safer area. Observe/ record/ report to MD risk factors for potential elopement. Resident has a diagnosis of dementia that requires secured observation. The resident exhibits one or more of the following criteria for placement on the secure dementia/behavior unit. Interventions included invite resident and encourage her to participate in activities of choice, with direct supervision, the resident may attend facility activities that are outside the secured unit, the resident may participate in physician ordered leave of absence with the direct supervision of responsible family member/friend, the resident to be reviewed on a quarterly basis as to the continued appropriateness and benefit from placement on a secured unit, staff to provide adequate nutrition and hydration to resident by offering snacks on a regular basis, and take the resident on walks or allow resident to walk ad lib in the enclosed unit or enclosed areas outside when weather permits. Review of Resident #78's Behavioral Health Evaluation dated 07/11/24 revealed the resident had delusions (misconceptions or beliefs that are firmly held, contrary to reality), a history of wanting to pack things up to leave, history of exit seeking, and a lack of safety awareness. The resident's representative was aware of current care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #78's Nursing Progress note dated 06/21/2024 at 9:35 P.M. LPN #296 reported, Resident cannot be located on unit two by nurse aides. Nurse aide walks by room [ROOM NUMBER] and feels hot air coming from this room. As nurse aide enters room, she notices the rooms window is pulled all the way open and there is a small black box sitting below the window. Nurse aide calls and alerts this nurse. This nurse walks to unit four where this nurse located resident in question. Resident seen sitting in a chair by the courtyard door. This nurse asks unit three and four staff if they brought resident to unit four in which everyone replied to no. This nurse approaches resident and asks her how she got to unit four. Resident states told you I was smoking regardless. This nurse notified the DON (Director of Nursing). Resident's daughter was called, however no answer at this time. Review of Resident #78's Nursing Progress note dated 06/22/2024 at 5:42 A.M. LPN #296 reported, Resident stating to other staff that she had climbed out the window and laughing about the matter. Resident has been in her bedroom since 10:00 P.M. with no further incidents currently. Review of the facility investigation dated 06/22/24 revealed a statement from the facility's DON stating she was notified of the event, a witness statement from Maintenance Director stating the window was fixed and he assessed all windows on the secured unit to ensure they were in proper condition, punch details form 06/21/24, and a sheet with staff initials showing where 15-minute checks were completed. The investigation did not include witness statements from staff working, a timeline indicating when the resident was last seen and at what time she was found, and skin assessment, staff education on the elopement policy, information on whether the resident received her 8:00 P.M. smoke break, or additional interventions that were put in place after the resident left supervision. Review of the Staffing schedule for unit two (secured unit) on 06/21/24 revealed the facility had two STNAs and one Nurse for 25 residents. Interview on 08/28/24 at 11:36 A.M. the Administrator revealed on 06/21/24 Resident #78 was able to open a bedroom window on the memory care unit due to a loose screw that was intended to stop the window from opening more than a few inches and climbed out into the facility locked courtyard. She stated the resident was found on unit four after she walked through the courtyard and entered back into the facility. She did not have any smoking materials on her. One of the maintenance workers fixed the window the next morning. All windows were assessed, and no other issues were noted. Interview on 08/28/24 at 11:37 A.M. the DON reported it was her expectation that Resident #78 should be visually checked on every 30 minutes and if expressing elopement behaviors, she would expect staff to increase checks on her. The DON reports the last document check on the resident was 8:51 P.M., when she received her medication and stated that she was discovered around 9:30 P.M. Interview on 8/28/24 at 3:34 P.M. STNA #228 reported she was working the secured unit on 06/21/24. She reports she arrived at 8:00 P.M. At this time, she visualized Resident #78 wearing a housecoat and slippers. She reports she is unsure whether the resident received her 8:00 P.M. Smoke break or not. The STNA reported she was in and out of the unit assisting another STNA off the unit. STNA #263 reported to her that she could not find Resident #78. A head count was completed and after about 15 minutes the Resident was found to have crawled out of a window and reentered the building onto another unit. STNA #228 reported she felt staffing was appropriate that night. She always revealed that she was never interviewed or required to summit a witness statement regarding the incident. (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 08/28/24 at 3:57 P.M. LPN #296 reported on 06/21/24 she was working the secured unit with two STNAs. Resident #78 became upset because the staff were running late providing the smoke breaks. Around 9:00 P.M. she was made aware that the resident could not be found. LPN #296 reported she went to other units in search and was able to find her on unit four. She reported she was able to get out of the facility through a malfunctioning window and walked through the courtyard and back into the building. She visually assessed the resident as she was walking but did not complete a skin assessment to determine if she had a skin injury from climbing out the window. The resident was then placed on 15-minute checks until 2:00 P.M. the next day. Interview on 08/28/24 at 3:52 P.M. the Administrator confirmed the facility had not completed a thorough investigation into Resident #78 leaving the secured unit, did not conduct interviews with facility staff working the unit, did not develop a timeline indicating how long she was gone, did not complete a skin assessment upon her return, and did not implement new interventions related to her leaving the secured unit. Review of the facility policy, Elopement Prevention, dated 12/01/23 revealed it is the facility's policy to ensure that a resident's environment remains as free from accident hazards as is possible while lining in the facility. 47569 2. An observation on 08/25/24 at 2:04 P.M. revealed Resident #29's room being cluttered with personal belongings piled on the bed, floor and on multiple tables. There was an electrical power strip located on the top of a table with multiple electrical cords plugged into the strip. Siting in front of the power strip was a regular multi-cup coffee maker with a half filled glass pot of coffee. The coffee maker was not turned on at the time. An observation on 08/26/24 at 10:15 A.M. revealed Resident #29's room continued to have the regular multi-cup coffee maker sitting on the table in front of the electrical power strip with multiple power cords attached. The coffee pot was full of coffee and was warm to touch. The coffee maker was turned off at the time. A review of the medical record for Resident #29 revealed admitted [DATE] with diagnoses including cancer of the head, face, and neck, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, and heart failure. Resident #29 was independent with activities of daily living (ADL) tasks, requiring limited assistance from staff, and required the use of an electric wheelchair for mobility. Resident #29 had intact cognition with a score of 15 out of 15 on the Brief Interview of Mental Status (BIMS) dated 07/06/24. An interview on 08/26/24 at 10:25 A.M. with Resident #29 revealed Resident #29 will make coffee in the room using the present coffee pot for independent use by Resident #29. An interview on 08/28/24 at 10:45 A.M. with the Administrator confirmed Resident #29 was known to use a multi-cup coffee maker in the room. The Administrator stated the facility has attempted to encourage Resident #29 to keep the coffee maker at the nurse desk instead of the room. At the time of the interview, the coffee maker had been removed from resident #29's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Electrical Safety for Residents dated 01/01/11 revealed. The residents will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review revealed the facility failed to provide timely treatment for Resident #85's urinary tract infection (UTI). This affected one resident (#85) of four residents reviewed for UTI's. The facility census was 102. Findings include: Review of Resident #85's medical record revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, encephalopathy, dysphagia, major depressive disorder, cognitive social or emotional deficit, and gastro-esophageal reflux disease without esophagitis. Review of Resident #85's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. He had a urinary catheter. Review of Resident #85's progress note dated 07/27/24 revealed Resident #85 had Clostridium difficile (C. Diff) and a new order was placed for Vancomycin 125 milligrams (mg) four times a day for five days. Review of Resident #85's physician order dated 07/29/24 to 07/30/24 revealed an order for repeat urinary analysis with culture and sensitivity. Review of Resident #85's lab results collected and reported on 07/30/24 revealed Resident #85's urine was abnormal in the areas of pH, protein, blood, leukocytes, and white blood cells. Review of Resident #85's progress note dated 07/30/24 revealed urinalysis results were received and there were no new orders. Review of Resident #85's progress note dated 08/01/24 revealed there was a new order for labs. Review of Resident #85's progress note dated 08/02/24 revealed the lab results were received and there were no new orders. Review of Resident #85's lab results finalized 08/03/24 revealed his culture from 07/30/24 had been reported multiple times. The preliminary report on 07/31/24 indicated the urine was contaminated. The preliminary report on 08/01/24 revealed the presence of Proteus mirabilis, Staphylococcus aureus, and Enterococcus faecalis. The preliminary report on 08/02/24 indicated the presence of Proteus mirabilis, Staphylococcus aureus, and Enterococcus faecalis. The verified findings on 08/03/24 indicated the presence of Proteus mirabilis, Methicillin-Resistant Staphylococcus aureus, and Enterococcus faecalis. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #85's progress note dated 08/04/24 revealed the urinary analysis results were received with culture sensitivity. The nurse notified that a C Diff culture needed to be obtained prior to treatment of urinary analysis. The physician was aware and a new order to recheck for C Diff was obtained. Review of Resident #85's physician order dated 08/05/24 to 08/06/24 revealed an order for C Diff culture. Review of Resident #85's physician order dated 08/06/24 to 08/08/24 revealed an order to obtain a stool sample and send to the laboratory to check for C Diff. Review of Resident #85's progress notes dated 08/05/24 and 08/06/24 revealed nothing related to checking for C Diff or Resident #85's UTI. Review of Resident #85's progress note dated 08/07/24 revealed the resident had a formed bowel movement at that time. Review of Resident #85's progress notes dated 08/08/24 revealed nothing related to checking for C Diff or Resident #85's UTI. Review of Resident #85's progress note dated 08/09/24 revealed a new order was placed to obtain a urinary analysis with culture and sensitivity for a recheck of the urine. Review of Resident #85's physician order dated 08/09/24 to 08/11/24 revealed an order for a urinary analysis with culture and sensitivity. Review of Resident #85's progress note dated 08/10/24 revealed the urine was obtained and pending pick up. Review of Resident #85's progress note dated 08/12/24 revealed urinalysis results were received, and the certified nurse practitioner (CNP) was notified. There were no new orders. Review of Resident #85's progress note by CNP #327 dated 08/14/24 revealed the resident was being seen for follow up to UTI. The CNP indicated a course of Ciprofloxacin was ordered through 08/19/24 according to culture and sensitivity results. Review of Resident #85's physician order dated 08/14/24 to 08/19/24 revealed an order for Ciprofloxacin oral tablet 500 mg one tablet twice a day. Interview on 08/28/24 at 11:35 A.M. with Licensed Practical Nurse #301 and #293 verified the physician indicated on 08/03/24 he wanted Resident #85 checked for C Diff prior to treatment of UTI. They additionally verified the only progress note addressing C Diff between 08/04/24 and 08/13/24 was the progress note on 08/07/24 indicating a formed stool. The LPN's reported the resident had only formed stools during that time, so they called the physician and he said to end the attempt for the stool sample and to get a new urinary analysis as it had been several days since his last one at that point. They verified none of this was indicated in Resident #85's progress notes. Additionally, LPN #301 and #293 verified his second urinary analysis results came in on 08/12/24 and treatment did not start until 08/14/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review the facility failed to care plan and implement interventions for Resident #86's autism and failed to monitor and effectively treat his anxiety. This affected one resident (#86) of three reviewed for mood and behaviors. The facility census was 102. Findings include: Review of Resident #86's medical record revealed an admitted [DATE] with diagnoses including autistic disorder, dysphagia, chronic pain syndrome, anxiety disorder, depressive disorder, Barrett's esophagus, gastroparesis, and diaphragmatic hernia. Review of Resident #86's plan of care dated 03/28/23 revealed the potential for adverse side effects of psychotropic drug use related to antianxiety medication. Interventions included documenting the side effects of medication, notifying the physician of any mental status changes that occur, observing and documenting any abnormal behavior or moods, and observing and reporting any signs of drug related complications. Review of the Preadmission Screening and Resident Review (PASRR) Identification screen dated 03/07/23 revealed it was completed by the hospital. Resident #86's autism diagnosis was documented but his anxiety was not indicated. Review of Resident #86's plan of care revealed it was his autism diagnosis, refusals of care, and other behaviors were not addressed. Review of Resident #86's physician order dated 03/15/23 revealed the resident was okay to utilize facility ancillary services including a psychiatrist or psychologist. Review of Resident #86's physician order dated 11/09/23 revealed an order to monitor for signs of anxiety and indicate interventions completed. Review of Resident #86's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition and had not exhibited behaviors during the look back period. Review of Resident #86's physician order dated 06/20/24 revealed an order to document any symptoms related to autistic behavior. Review of Resident #86's physician note dated 06/26/24 revealed the resident had anxiety, 'as needed' Xanax was to continue as the resident was clinically stable. For his autism the physician recommended continuing supportive care and working on possible discharge to group home. Review of Resident #86's Certified Nurse Practitioner (CNP) note dated 07/30/24 revealed the resident was seen for follow up of autism. The CNP recommended continuing supportive care and working on possible discharge to group home. In relation to his anxiety the physician recommended continuing as needed Xanax. (continued on next page)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's physician order dated 08/09/24 to 09/08/24 revealed an order for Xanax oral tablet 0.5 mg one tablet every eight hours as needed for anxiety for thirty days. Review of Resident #86's Medication Administration Record (MAR) from 08/09/24 to 08/26/24 revealed resident #86 was given 'as needed' Xanax twice on 08/09/24, once on 08/11/24, once on 08/12/24, once on 08/15/24, once on 08/16/24, once on 08/17/24, twice on 08/18/24, once on 08/20/24, twice on 08/21/24, once on 08/22/24, twice on 08/23/24, once on 08/24/24, once on 08/25/24, and once on 08/26/24. It was indicated that resident had symptoms related to autism on 08/01/24, 08/04/24, 08/07/24, 08/08/24, 08/10/24, and 08/11/24. Review of Resident #86's behavior monitoring from 08/01/24 to 08/26/24 revealed no behaviors were documented. Review of Resident #86's progress notes from 08/09/24 to 08/26/4 revealed on 08/21/24 it was indicated the resident had increased anxiety. There was no further indication of why he received Xanax or if any nonpharmacological interventions were attempted. Additionally, there was no indication of any behaviors including when it was indicated he had symptoms related to autism on the MAR. Review of Resident #86's medical record from 03/27/24 to 08/25/24 revealed no evidence he had seen a psychologist or psychiatrist. Interview on 08/25/24 at 2:29 P.M. with Certified Nursing Assistant (CNA) #241 revealed Resident #86 had severe autism and would hide under the blanket when people attempted to speak to him. Observation on 08/25/24 at 2:29 P.M. and on 08/27/24 at 11:35 A.M. with Resident #86 revealed he was hidden under his blanket and did not respond to questioning. The room smelled like body odor. Interview on 08/27/24 at 11:19 A.M. with the Director of Nursing (DON) verified there was no administration documentation for the 'as needed' Xanax. There was no description of his behaviors or causes of anxiety. The DON further verified they did not have a care plan for his autism, behaviors, or chronic refusals of care. Interview on 08/27/24 at 11:24 A.M. with CNA #226 revealed she had Resident #86 for her assignment. She reported she had barely seen or spoken to the resident. Resident #86 hid under the blanket when she came in and she was unsure if he ever left his room. She reported he only spoke to certain staff, but she was unsure why. She reported he was very light sensitive and refused most care. She reported other staff told her he was independent in toileting with most activities of daily living, and she assumed he was because she never smelled incontinence. However, CNA #226 reported the resident would not let her look at him or check him. She verified his room smelled unclean, she reported he often refused any assistance with showering or hygiene. She reported only one person (CNA #260) was able to get him to shower. She reported she was unaware of any techniques to work with people with autism and had not received any training. Interview on 08/27/24 at 11:29 A.M. with Licensed Practical Nurse (LPN) #290 revealed Resident #86 expected his Xanax daily. He was very anxious, but she thought it was general anxiety rather than something specific. She thought his anxiety was related to his autism but was not very family with autism. She reported he refused to talk to most people and refused care. She reported one aide (CNA #260) was able to get the resident to shower. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/24 at 3:06 P.M. with Social Service Director (SSD) #312 revealed Resident #86 saw a therapeutic behavior specialist but not a psychologist or psychiatrist. He reported there were no notes for these meetings. Reported the goal has been for the resident to go back to the community but the resident did not seem to be motivated. Reported it was hit or miss if he would talk with staff, but CNA #260 was usually able to get him shower. Reported sometimes the resident responded to him and sometimes he did not. Reported the staff had not received training for autism and he was unsure who would be able to do that. SSD #312 verified the PASARR was completed prior to his admission and did not address his anxiety. Interview on 08/27/24 at 3:34 P.M. with Therapeutic Behavior Specialist (TBS) #336 and SSD #312 revealed TBS #336 had been working with the resident on getting him out of his room. The resident loves animals so if he wants to see them, he needs to come out of the room or at least go to the doorway. He wants to leave the facility, so TBS #336 is pushing him to work on his goals and have discussed the consequences of him not moving towards the goals. Both staff indicated when Resident #56 is stressed, does not want to talk to people, or does not want to hear what he was being told he would make himself throw up. The staff members agreed his anxiety played a role in some of his behaviors. SSD #312 indicated he did not think a psychiatrist or psychologist had been considered to address Resident #56's anxiety. Interview on 08/28/24 at 10:03 A.M. with SSD #312 revealed he had no discharge plans for Resident #56. He did not feel a group home was appropriate for the resident at this time. Interview on 08/27/24 at 3:04 P.M. with CNA #260 revealed she had a lot of friends with autistic children so she spoke to them about techniques that might work with Resident #86. She then spent time working on those techniques with him. Reported due to his light sensitivity she was usually only able to get him to shower by leaving one small light on, blocking it with the shower curtains, and allowing him to wear his sunglasses. Review of the policy Psychotropic Medication Use' dated July 2022. revealed antipsychotics, antidepressants, antianxiety medications, and hypnotics were subject to monitoring and review requirements specific to psychotropic medications. Psychotropic medication management included: Indications for use, dose, duration, adequate monitoring, and preventing, identifying, and responding to adverse consequences. Non-pharmacological approaches should be used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. This deficiency represents non-compliance investigated under Complaint Number OH00156649.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and review of medical records the facility failed to ensure #56 who was on anticoagulants were monitored for side effects of the medication and had care plans in place for the anticoagulant. This affected one resident (#56) of five residents reviewed for unnecessary medications. The facility census was 102. Findings include: Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, encounter for orthopedic aftercare following surgical amputation, other chronic pain, type two diabetes mellitus, bipolar disorder, and fibromyalgia. Review of Resident #56's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #56's physician order dated 06/07/24 revealed an order for Apixaban (an anticoagulant) oral tablet five milligrams twice a day. Review of Resident #56's physician's orders revealed no order related to monitoring for anticoagulant side effects. Review of Resident #56's medical record revealed no evidence the facility was monitoring Resident #56 for anticoagulant side effects. Review of Resident #56's plan of care revealed it did not address anticoagulants. Interview on 08/28/24 at 8:14 A.M. and 2:28 P.M. with the Director of Nursing (DON) verified Resident #56 did not have a care plan for anticoagulants. Additionally, the DON verified the facility did not have anticoagulant side effect monitoring, she reported staff was just to follow the resident's care plan. 42015

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review revealed the facility failed to monitor behaviors for Residents' #22, #56, and #306 who were receiving psychotropic medications. This affected three residents (#22, #56, and #306) of five reviewed for unnecessary medications. The facility census was 102. Findings include: 1. Review of Resident #22's medical record revealed an admitted [DATE] with diagnoses including pneumonitis due to inhalation of food and vomit, dysphagia, type two diabetes mellitus, unspecified intellectual disabilities, peripheral vascular disease, anxiety disorder, epilepsy, unspecified dementia with anxiety, depression, and hypertension. Review of Resident #22's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 had intact cognition. Review of Resident #22's plan of care dated 08/01/24 revealed he used psychotropic medications related to disease process. Interventions included administering medications as ordered, discussing with physician and family need for use of medication, educating risks and benefits of psychoactive medications, monitoring for target behavior symptoms. and monitoring side effects and adverse reactions of psychoactive medications. Review of Resident #22's plan of care dated 08/01/24 revealed he was at risk for episodes of anxiety related to diagnoses. Interventions included addressing reasons for anxiety, social withdrawal, crying, administering medications as ordered, encouraging attendance of scheduled activities, remove excess stimulation as able, and spending time talking with resident. Review of Resident #22's plan of care dated 08/01/24 revealed Resident #22 had a diagnosis of depression. Interventions included administering medications as ordered, attempting non-pharmacological interventions, encouraging and praising resident for displaying effort, encourage activities of interest, encouraging verbalization of feelings and fears, psychological consult as needed, and monitoring for increased side effects if psychotropic medications have been increased or decreased. Review of Resident #22's physician orders dated 07/01/24 to 08/06/24 and beginning again on 08/09/24 revealed an order for Buspirone (antianxiety medication) tablet 15 milligrams (mg) one tablet three times a day. Review of Resident #22's physician orders dated 07/02/24 to 08/06/24 and beginning again on 08/08/24 revealed an order for Escitalopram Oxalate (antidepressant) 20 mg one time a day for depression. Review of Resident #22's physician order dated 08/09/24 revealed an order for Risperdal (antipsychotic) tablet four mg at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's physician order dated 08/25/24 revealed an order to monitor for antipsychotic side effects. Review of Resident #22's physician order dated 08/25/24 revealed an order to monitor for behaviors related to antipsychotics. Review of Resident #22's physician order dated 08/25/24 revealed an order to monitor for antianxiety side effects. Review of Resident #22's physician order dated 08/25/24 revealed an order to monitor for behaviors related to antianxiety medications. Review of Resident #22's physician order dated 08/25/24 revealed an order to monitor for antidepressant side effects. Review of Resident #22's physician order dated 08/25/24 revealed an order to monitor for behaviors related to antidepressants. Review of Resident #22's medical record revealed no further evidence of behavior monitoring. Interview on 08/27/24 at 4:35 P.M. and 08/28/24 at 7:38 A.M. with the Director of Nursing (DON) verified they put in orders on 08/25/24 for behavior monitoring and monitoring of side effects as there was none done before that. 2. Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, encounter for orthopedic aftercare following surgical amputation, other chronic pain, type two diabetes mellitus, bipolar disorder, and fibromyalgia. Review of Resident #56's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #56's plan of care dated 06/07/24 revealed the resident used psychotropic medications related to disease process including bipolar, depression, and anxiety. Interventions included administering medications as ordered and monitoring side effects and adverse reactions of psychoactive medications. Review of Resident #56's physician order dated 06/07/24 revealed an order for Quetiapine Fumarate (antipsychotic) 400 mg one tablet at bedtime. Review of Resident #56's physician order dated 06/07/24 revealed an order for buspirone (antianxiety medication) oral tablet 10 mg three times a day. Review of Resident #56's physician order dated 06/08/24 revealed an order for 100 mg one tablet in the morning. Review of Resident #56's physician order dated 06/08/24 revealed an order for Citalopram Hydrobromide 40 mg one tablet by mouth related to depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #56's physician order dated 06/16/24 revealed an order for Ativan (antianxiety) one mg one tablet in the morning. Review of Resident #56's physician order dated 08/25/24 revealed an order to monitor for antipsychotic side effects. Review of Resident #56's physician order dated 08/25/24 revealed an order to monitor for behaviors related to antipsychotics. Review of Resident #56's physician order dated 08/25/24 revealed an order to monitor for antianxiety side effects. Review of Resident #56's physician order dated 08/25/24 revealed an order to monitor for behaviors related to antianxiety medications. Review of Resident #56's physician order dated 08/25/24 revealed an order to monitor for antidepressant side effects. Review of Resident #56's physician order dated 08/25/24 revealed an order to monitor for behaviors related to antidepressants. Review of Resident #56's medical record revealed no evidence of behavior monitoring prior to 08/25/24. Interview on 08/27/24 at 4:35 P.M. and 08/28/24 at 7:38 A.M. with the Director of Nursing (DON) verified they put in orders on 08/25/24 for behavior monitoring and monitoring of side effects. as there was none done before that. Review of the policy Psychotropic Medication Use' dated July 2022. revealed antipsychotics, antidepressants, antianxiety medications, and hypnotics were subject to monitoring and review requirements specific to psychotropic medications. Psychotropic medication management included: Indications for use, dose, duration, adequate monitoring, and preventing, identifying, and responding to adverse consequences. Non-pharmacological approaches should be used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 47569 3. Multiple observations through out the day on 08/25/24, 08/26/24, and 08/27/24 revealed Resident #306 pacing the hallway and common area of the Memory Unit. Resident #306 would either be crying or anxiously asking staff or peers what was going on in the area, or asking to go home. The staff attempted to redirect Resident #306 with either activities of coloring, offering a snack, or encouraging Resident #306 to lay down in bed to rest. A review of the medical record for Resident #306 revealed admitted [DATE] for a five day hospice respite stay with diagnoses including senile degeneration of the brain, unspecified dementia, and anxiety. Resident #306 required assistance from staff for activities of daily living (ADL) tasks including personal hygiene care, was independent with ambulation and eating, and required verbal cues for finding room and reminders of being at the facility related to having severely impaired cognition. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician orders for Resident #306 dated 08/23/24 to 08/28/24 revealed an order dated 8/25/2024 Antianxiety 1. Picking at skin 2. Withdrawn 3. Restlessness INTERVENTION CODES A. Redirect B. 1 on 1 C. Refer to nurse's note D. Activity E. Return to Room F. Toilet G. Give Food H. Give Fluids I. Change Position J. Backrub K. Other, every shift, an order dated 8/25/2024 Antipsychotic 1. Withdrawn 2. Restlessness 3. Hallucinations INTERVENTION CODES A. Redirect B. 1 on 1 C. Refer to nurse's note D. Activity E. Return to Room F. Toilet G. Give Food H. Give Fluids I. Change Position J. Backrub K. Other every shift, and an order dated 8/25/2024 Antidepressant 1. Crying 2. Withdrawn 3. Restlessness INTERVENTION CODES A. Redirect B. 1 on 1 C. Refer to nurse's note D. Activity E. Return to Room F. Toilet G. Give Food H. Give Fluids I. Change Position J. Backrub K. Other, every shift. A review of Resident #306's behavior documentation in the Medication Administration Record dated 08/23/24 to 08/28/24 revealed the behavior documentation was marked with only a check mark and the nurse initials only one time per day. There was not any specific behaviors or non-pharmacological interventions documented or marked to reflect Resident #306's behavior of pacing, roaming, crying and anxious behaviors that had been observed. There was not any specific interventions which had been tried or encouraged to assist Resident #306 with the observed behaviors. A review of Resident #306's care plan dated 08/25/24 revealed Resident #306 had the potential for elopement from the facility and had dementia and psychosocial disorder, and was moderate to high risk for an elopement and currently wanders, is disoriented to place and impaired safety awareness with interventions including encourage participation in activities and give clear explanations of all care to be provided. An interview on 08/27/24 at 4:35 P.M. with the Director of Nursing Services (DNS) confirmed the [NAME] of specific behaviors and non-pharmacological interventions for Resident #306. The DNS stated the facility had started an audit on behavior monitoring on 08/25/24 and initiated monitoring in orders for several residents who did not have implemented previously. Review of the facility's policy titled, Behavioral Monitoring dated 06/01/24 revealed, If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function. This deficiency represents non-compliance investigated under Complaint Number OH00156649.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview, manufacturer guidelines, and facility policy review the facility failed to remove expired medications and securely store multi-use insulin vials. This deficient practice had the potential to affect any resident requesting flu vaccination, any new admission requiring tuberculosis (TB) testing, and affected one resident (Resident #84) out of four residents reviewed during medication administration. The facility census was 102. Findings Include: a) An observation on 08/26/24 at 10:09 A.M. revealed in Unit one's medication storage refrigerator an opened multi-use vial of Tubersol (tuberculosis (TB)) solution with out an opened date on either the vial or the packaging box. The TB solution had an expiration date of 04/2007 and had been dispensed from the pharmacy on 02/24/24. Interview on 08/26/24 at 10:09 A.M. with Licensed Practical Nurse (LPN) #290 confirmed the opened multi-use TB solution vial without an opened date. LPN #290 stated once the vial was opened it could only be used for 30 days and then was to be disposed. Review of the manufacturer guidelines for Tubersol TB solution dated 10/01/21 revealed, A vial of Tubersol which has been entered and in use for 30 days should be discarded. Do not use after expiration date. Review of the facility's policy titled, Medication Labeling and Storage Policy dated 2001 revealed, Multi-dose vials that have been opened or accessed are dated and discarded within 28-days unless the manufacturer specifies a shorter or longer date for the open vial. b) An observation on 08/26/24 at 10:09 A.M. revealed an opened box of five pre-filled syringes of Fluzone high dose (HD) Pre-Filled Syringes 2023-2024 flu vaccines. There were five out of ten syringes pre-filled with 0.7 milliliters of flu vaccine. The expiration date for the box of flu vaccines was 06/2024 and the box of fly=u vaccines had been dispensed from the pharmacy on 09/12/23. Interview on 08/26/24 at 10:09 A.M. with LPN #290 confirmed the box of five pre-filled syringes containing flu vaccine were out of date with the expiration date 06/2024. LPN #290 stated those syringes should be removed from the refrigerator and disposed of since it it pasted the expiration date to be used. Review of the manufacturer guidelines for Fluzone HD flu vaccine revealed, Do not use after the expiration date shown on the label. Review of the facility's policy titled, Medication Labeling and Storage Policy dated 2001 revealed, If the facility has discontinued, outdated or deteriorated medications or biological's, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) An observation on 08/27/24 at 7:40 A.M. with LPN #290 completing the morning medication administration for Unit One revealed two multi-use vials of insulin sitting on top of the medication cart, one vial of Lantus Insulin and one vial of Novolog Insulin for Resident #89 had been entered and insulin drawn up for administration by LPN #290. Resident #89 had a new order for a multivitamin which was not available in the medication cart. LPN #290 locked the medication cart and proceeded to the medication storage room located at the end of the Unit One hallway, leaving the two vials of insulin sitting on the top of the medication cart. Upon return to the medication cart from retrieving the bottle of multivitamin tablets, LPN #290 realized the two vials of insulin had been left on top of the cart unsecured. LPN #290 placed the two vials back into the respective packaging boxes and returned to the top drawer of the medication cart. A review of the medical record for Resident #89 revealed admitted [DATE] with diagnoses including type two diabetes mellitus, depression, schizophrenia, and bipolar disorder. Further review revealed physician orders for a sliding scale for Novolog insulin as needed based on the obtained blood glucose readings and Lantus Insulin administering 10 units every morning. An interview on 08/27/24 at 7:52 A.M. with LPN #290 confirmed the two opened vials of insulin, one of Novolog Insulin and one of Lantus Insulin were left unsecured and unattended on top of the medication cart while LPN #290 went to the medication storage room at the end of Unit One hallway. LPN #290 stated, those vials should have been put away before I went down to the medication room. Review of the facility policy titled, Medication Administration Policy dated 04/2019 revealed, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. It may be kept in the doorway of the resident's room, with the open drawers facing inward and all other sides closed. No medications are kept on the top of the cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41266 Based on observations, staff and resident interviews, review of lunch meal tickets, review of the dietary spreadsheet, review of the menu, review of the emergency food menu, and facility policy review, the facility failed to ensure two residents (Residents #22 and #33) received all the foods as ordered according to their meal tickets and the facility failed to ensure there was an emergency food stock in a designated area of the facility. The deficient practices affected two residents (Residents #22 and #33) and had the potential to affect all of the residents who resided at the facility, except Resident #93 who had an ordered nothing by mouth (NPO) diet. The facility census was 102. Findings Include: Review of the daily menu for the lunch meal on Tuesday, 08/27/24, revealed the planned meal was barbecue cheeseburgers on a bun with lettuce, tomato, and a pickle spear, confetti coleslaw, French fries with ketchup, and an oatmeal raisin cookie. Review of the dietary spreadsheet for the lunch meal on Tuesday, 08/27/24, revealed for a resident on an ordered renal diet, the resident should receive a 1/2 cup of garden pasta salad instead of French fries and a resident on an ordered dysphagia pureed diet should receive a #10 scoop of pureed marinated mixed vegetable salad. Review of the list of residents with ordered diets revealed Resident #22 had an ordered regular dysphagia pureed diet with nectar thickened liquids. Resident #33 had an ordered carbohydrate controlled renal diet. Review of the lunch meal ticket for Resident #22 revealed the resident requested a pureed barbecue cheeseburger for a bun, barbecue sauce, a pureed hamburger bun, a 1/2 cup of mashed potatoes, a #10 scoop of pureed marinated mixed vegetable salad, a #16 scoop of pureed sugar cookie, and four ounces (oz) of nectar thickened cranberry juice. Review of the lunch meal ticket for Resident #33 revealed the resident requested a hamburger on a bun with a lettuce slice and one packet of mayonnaise, 1/2 cup of garden pasta salad, 1/2 cup of confetti coleslaw, one sugar cookie, and eight oz of lemonade. Observation on 08/27/24 at 12:00 P.M. revealed [NAME] #400 placed Resident #22's main dish with pureed barbecue cheeseburger, pureed hamburger bun, and mashed potatoes with one covered side dish on Resident #22's meal tray. There was no pureed marinated vegetable mix salad placed on the resident's tray. There was no thickened cranberry juice placed on the resident's tray. At 12:08 P.M., [NAME] #400 placed Resident #33's main dish of a hamburger on a bun, a side dish of lettuce, and a side dish of confetti coleslaw. There was not any pasta salad placed on Resident #33's meal tray. Interview and observation on 08/27/24 at 12:01 P.M. with [NAME] #400 confirmed upon lifting the lid to the side dish was confetti coleslaw on Resident #22's meal tray. (continued on next page)

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 08/27/24 at 12:09 P.M. with [NAME] #400 confirmed upon lifting the lid to the side dishes revealed confetti coleslaw and a slice of lettuce were on Resident #33's meal tray. Observation and interview on 08/27/24 at 12:39 P.M. with Resident #22 and Certified Nurse Aide (CNA) #212 of the resident's lunch meal tray confirmed Resident #22 did not receive pureed marinated vegetable mix or thickened cranberry juice with his lunch meal. Resident #22 stated he would like to have both the marinated vegetable mix and cranberry juice. CNA #212 stated he would follow up with the kitchen to request the additional items for the resident. Observation and interview on 08/27/24 at 12:45 P.M. with Resident #33 confirmed she did not receive any pasta salad with her lunch meal. Resident #33 stated she would like to have pasta salad with her meal. Interview on 08/27/24 at 1:08 P.M. with Dietary Manager (DM) #401 confirmed Resident #33 did not receive pasta salad with her meal as requested. Review of the facility policy, Meal Distribution, revised 02/2023, revealed the policy stated, all meals will be assembled in accordance with the individualized diet order, plan of care, and preferences. 43064 2. Review of the emergency menu guide for no electricity, no gas, revealed all food items for the menu were ready to serve at room temperature. For Day 1 the menu included juice, cheerios, crackers, peanut butter, jelly, reconstituted milk (three times), beef stew, carrots, peaches, cookies, water, punch, ravioli with sauce, green beans, and chocolate pudding. For Day 2 the menu included juice, corn flakes, crackers, corned beef hash, reconstituted milk (three times), canned chicken with mayonnaise, green beans, applesauce, punch, sloppy joe, peas, lemon pudding, and cookies. For Day 2 the menu included juice, cheerios, crackers, peanut butter, jelly reconstituted milk (three times), tuna with mayonnaise, sliced potatoes with Italian dressing, beets, pears, cookies, punch, chili con carne, green beans, and vanilla pudding. Observation of the kitchen on 08/25/24 at 1:26 P.M. revealed the facility had no emergency food set aside. Review of the dry storage room revealed in their regular storage they did not have any beef stew, canned carrots, ravioli, canned green beans, canned chicken, sloppy joe, canned peas, sliced potatoes, beets, or chili con carne. Additionally, the facility did not have sufficient reconstituted milk. Interview on 08/25/24 at 2:12 P.M. with Dietary manager #401 verified the facility did not have emergency food set aside. He reported they kept a cart saved in their Cysco's system to order if needed for emergencies. He additionally verified they did not have the canned food's mentioned on the emergency menu onsite. Review of the policy 'Emergency Supplies Planning for Dietary Department' undated, revealed the facility was to plan for the dietary consideration of a crisis or disaster situation that may require facility evacuation or long-term sheltering in place without the support of outside resources. The facility was to maintain food and water to last for at least three days in a specific location.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41266 Based on observations, staff interview, and facility policy review, the facility failed to ensure pureed foods were prepared to an appropriate texture, requiring surveyor intervention. The deficient practice had the potential to affect four residents (Residents #8, 22, 46, and 60) who had an ordered pureed diet. The facility census was 102. Findings Include: Observation on 08/27/24 at 10:23 A.M. of the preparation of pureed foods with [NAME] #201 revealed the cook placed six barbecue hamburgers into the blender and started blending. At 10:36 A.M., [NAME] #201 stopped the blender and poured the pureed barbecue hamburgers into a silver serving dish. [NAME] #201 tasted the pureed food item and confirmed she felt it was an appropriate at serve to the residents. There was no other staff present at the time of the observation to taste the pureed food. At 10:38 A.M., this surveyor tasted the pureed barbecue hamburgers and found there were dime size bits of gristle or fat in the food. Interview on 08/27/24 at 10:39 A.M. with [NAME] #201 confirmed the pureed barbecue hamburgers were not an appropriate texture and still had bits of gristle or fat in it that required chewing before swallowing safely. After surveyor intervention, [NAME] #201 placed the pureed barbecue hamburgers back into the blender and continued blending until smooth. Review of the facility policy, Dysphagia Puree How To, undated, revealed the policy stated, continue grinding until product achieves a pudding, mousse-like, consistency.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 41266 Based on review of the arbitration agreement and staff interview, the facility failed to ensure the arbitration agreement notified residents of their right to rescind the agreement within 30 days. The deficient practice affected 51 residents (Residents #2, 6, 10, 11, 14, 16, 21, 22, 29, 31, 34, 35, 42, 43, 44, 47, 48, 50, 51, 56, 58, 64, 66, 67, 69, 70, 71, 72, 73 74, 77, 78, 79, 81, 82, 83, 84, 86, 87, 88, 89, 91, 92, 97, 98, 100, 101, 405, 406, 407, and 409) who agreed to enter into the arbitration agreement. The facility census was 102. Findings Include: Review of the facility Arbitration Agreement, Agreement to Resolve Legal Disputes through Binding Arbitration, undated, revealed the agreement did not inform residents of their right to rescind the agreement within 30 days of signing the agreement. Interview on 08/27/24 at 5:02 P.M. with the Admissions Director (AD) #205 confirmed the agreement did not include the above information. AD #205 stated the facility's corporate office developed the agreement for the facility and she was not aware the agreement did not include all of the required information. A facility policy related to arbitration agreements was requested at the time of the survey but the facility did not have a policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview, record review and facility policy review the facility failed to ensure proper hand hygiene was conducted during meal service, and failed to ensure Enhanced Barrier Precautions (EBP) were implemented. This deficient practice had the potential to affect residents residing on the Memory Unit and had affected two residents (Resident #62 and #406) out two residents reviewed for EBP implementation. The facility census was 102. Findings Include: An observation on 08/26/24 at 8:18 A.M. during breakfast meal service on the Memory Unit revealed State tested Nursing Assistants (STNAs) #224 and #244 serving the meal trays to residents sitting in the dining room on the memory unit. Observation of STNA #244 adjusting clothing several times after bending over the table to assist the resident with food preparation and then returning to the food tray cart and removing another meal tray from the cart and serving the tray to the resident. STNA #244 was not observed sanitizing or washing hands after readjusting clothing and before touching another food tray. STNA #224 and #244 completed the breakfast meal service without washing or sanitizing hands throughout the meal service. Interview on 08/26/24 at 8:22 A.M. with STNA #224 revealed the staff had been instructed by the administration to only wash hands before and after meal tray service. Interview on 08/26/24 at 8:25 A.M. with STNA #244 confirmed during the breakfast meal service, STNA #244 had readjusted clothing several times and continued to serve food trays to the residents. STNA #244 confirmed neither hand washing or hand sanitization had been conducted following the readjustment of clothing. Interview on 08/26/24 at 8:30 A.M. with the Director of Nursing Services (DNS) confirmed the staff is to wash hands before prior to beginning meal service, any time staff touches clothing, face, or a resident, after every third tray is served and at the end of the meal service. The DNS stated the staff may sanitize hands between each tray being served. Review of the facility's policy titled, Handwashing/Hand Hygiene Policy dated 10/2023 revealed, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 42015 2. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses include diabetic foot ulcer, spinal stenosis and diabetes mellitus type two. Observations on 08/25/24 at 11:00 A.M. and 08/26/24 at 2:29 P.M. revealed the resiant did not have EBP sign on the door or available Personal Protective Equipment (PPE) close to the residents door. Interview on 08/25/24 at 11:00 A.M. Resident #62 reported she has a diabetic foot ulcer that the facility was treating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's Quarterly MDS assessment dated [DATE] revealed the resiant had intact cognition and a diabetic foot ulcer. Review of Resiant #62's Weekly Non-Pressure Skin Report dated 08/26/24 revealed the resident had a left heel diabetic ulcer. Treatment included to cleanse the wound with Dakin's solution dwell for 15-30 minutes and pat dry with gauze. Then apply Tetracyte to the wound bed, followed by iodofoam. Cover the wound with absorbent pad dressing and wrap with rolled gauze. The wound measured 5.49 centimeters (cm) length by 4. 68 cm width and x 0.1 cm deep. The wound was first discovered on 06/21/24. Review of Resiant #62's physician's orders from 06/21/24 through 08/26/24 revealed the facility had not placed the resident on EBP. Interview on 08/27/24 at 9:06 A.M. The facility DON verified they facility did not have an order in place stating that Resident #62 should be in EBP due to her foot ulcer. Review of the facility policy, Enhanced Barrier Precautions dated 03/20/24 revealed EBP refers to the use of gown and gloves for use during high-contact resident care activities for resident known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical device). The policy stated clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions required PPE and high contact resident care activities that require the use of gowns and gloves. An order for for EBP will be obtained for residents with wounds (chronic wounds such as diabetic foot ulcers). 43064 3. Review of Resident #406's medical record revealed an admitted [DATE] with diagnoses including chronic venous hypertension, chronic systolic heart failure, peripheral vascular disease, dysphagia and hypertension. Review of Resident #406's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #406's physician order dated 08/09/24 to 08/26/24 revealed Resident #406 did not have an order for Enhanced Barrier Precautions (EBP). Review of Resident #406's admission nursing evaluation dated 08/09/24 revealed he had a skin concern to his right lower leg measuring 2.0 centimeters (cm) by 2.0 cm by 0.1 cm. Review of Resident #406's skin report dated 08/19/24 revealed he had a non-pressure chronic ulcer to his leg. Review of Resident #406's skin report dated 08/26/24 revealed he had a non-pressure chronic ulcer to his leg. Observation on 08/25/24 at 2:59 P.M. and on 08/26/24 at 9:06 A.M. and 4:41 P.M. of Resident #406's room revealed EBP were not in place. There were no signs posted on or in his room. Observation on 08/27/24 at 9:01 A.M. revealed EBP were still not in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/24 at 9:01 A.M. with Licensed Practical Nurse (LPN) #293 verified EBP were not in place for Resident #406 but she was unsure if they were needed. Interview on 08/27/24 at 9:06 A.M. with the Director of Nursing (DON) verified if a resident had a chronic wound, they should be on EBP. Review of the policy 'Enhanced barrier precautions' dated 03/20/24, revealed clear signage was to be posted on the door or wall outside of the resident room indicating the type of precautions, the required personal protective equipment, and the high-contact resident care activities that require the use of gowns and gloves. An order for EBP was to be obtained for residents with chronic wounds, indwelling medical devices, or infections.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47569 Based on observation, record review, interview, and facility policy review the facility failed to maintain a safe, functional home like environment. This deficient practice affected one resident (Resident #29) out of four residents reviewed for environment. Findings Include: An observation on 08/25/24 at 2:10 P.M. revealed in Resident #29's room the rubber toe plate covering at the bottom of the wall under the sink was loose and falling off the wall revealing moderate sized hole approximately three feet long extending from the end of the wall to the corner of the two walls. The hole was approximately two inches wide and was deep enough for the dry wall material and the wall support boards to be exposed. The rubber toe plate covering was also falling off the shorter wall to the right of the sink exposing the dry wall material behind the rubber toe plate covering. A review of the medical record for Resident #29 revealed admitted [DATE] with diagnoses including cancer of the head, face, and neck, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, and heart failure. Resident #29 was independent with activities of daily living (ADL) tasks, requiring limited assistance from staff, and required the use of an electric wheelchair for mobility. Resident #29 had intact cognition with a score of 15 out of 15 on the Brief Interview of Mental Status (BIMS) dated 07/06/24. An interview on 08/25/24 at 2:30 P.M. with Resident #29 revealed Resident #29 was not aware of the damaged wall underneath the sink in the room. An interview on 08/28/24 at 10:45 A.M. with the Administrator confirmed the damaged wall with dry wall and wall support boards exposed under the sink in Resident #29's room. The Administrator stated Resident #29's electrical wheelchair probably caused the damage to the wall from pulling up under the sink and running the foot rest into the wall. A review of the facility policy titled, Homelike Environment, revealed Residents are provided with a safe, clean, comfortable and homelike environment.