

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 32801 Based on review of submitted concerns to the state survey agency, interviews, and policy review the facility failed to ensure residents were treated with respect and dignity. This affected four residents (#3, #33, #41, and #49) of nine residents reviewed for respect and dignity. Findings included: Review of submitted concerns to the state survey agency, dated 07/16/24 to 09/03/24 revealed several concerns with staff not treating residents with respect and dignity. On 07/16/24 a submitted concern indicated staff had extremely cold manners, 08/02/24 aides had bad attitudes, very disrespectful towards residents, and talked about other residents to residents. On 08/05/24 a submitted concern revealed staff were yelling at residents and rough with care. On 08/22/24, a submitted concern revealed Licensed Practical Nurse (LPN) #145 was rude to residents and 09/03/24 LPN #145 told a male resident who fell Are you kidding me. I don't have time for this. I have a family emergency. Interview on 08/26/24 at 2:24 P.M., with Resident #3 revealed he has concerns with staff not treating him with respect and dignity. There was one staff member (Licensed Practical Nurse) #145 who was not permitted to come in his room. The LPN was very religious and had made racial remarks that were not appropriate. He has heard she had been in trouble before. Resident #3 also reported the Dietary Manager (DM) #192 has been disrespectful to residents when residents ask for alternative meals. Interview on 08/26/24 at 2:50 P.M., with Maintenance Director (MD) #160 confirmed he had recently received a letter from an anonymous visitor who reported staff didn't treat them with respect and dignity. Interview on 8/26/24 at 3:14 P.M., with the Administrator revealed she was not aware of any incidents that occurred with DM #192; however, the staff member left a note resigning immediately on Friday. Interview on 08/26/24 at 4:23 P.M., with anonymous health care worker #207 revealed she was visiting a resident recently and as she was walking down the hall behind two staff members; she had overheard them talking poorly about Resident #41. Resident #41 had reported to the health care worker that Licensed Practical Nurse (LPN) #145 had been rude to her and made her come to the door to get her medication when she was on isolation for COVID because the nurse didn't want to come in the room or apply the protective equipment. (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

FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365770	If continuation sheet Page 1 of 34
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/24 at 5:06 P.M., with Resident #41 and the Director of Nursing (DON) revealed the Resident reported LPN #145 was rude and has made her come to the door to get her medication on a few occasions due to the nurse didn't want to come in her room when she had COVID a couple weeks ago. The resident also reported other staff members had been disrespectful and tell her to quit feeling sorry for yourself. Interview on 08/29/24 at 9:14 A.M., with Resident #33 revealed the previous Dietary Manger (DM)#192 was one of the meanest persons he had encountered at the facility. On Friday he had voiced concerns to the DM #192 about the poor food quality and she got mad and slammed the door in his face. The incident was witnessed by a male staff member. Interview on 08/29/24 at 11:05 A.M., with Resident #49 revealed the staff don't treat her with respect and dignity. The staff call her Little (proper name) referring to a staff member who talks to herself and she finds that very offensive and it is upsetting to her. Review of the facility's policy titled Customer Services (undated) revealed every person in the facility deserves to be treated with respect and dignity at all times. Always treat our residents as you would be want to treat you. Call each person by their name or a nick name only if they request it. Speak to the residents respectfully. Be as gentle as possible. Always speak the truth respectfully, do not show annoyance or frustration. Every resident should feel important and special. This deficiency represents non-compliance investigated under Complaint Numbers OH00157045, OH00156496, and OH00156413.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of timecards, review of the facility investigation, review of self-reported incidents (SRI), interviews, and policy review the facility failed to ensure resident narcotics were not misappropriated. This affected two residents (#42 and #51) of three records reviewed. Findings included: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including anxiety, insomnia, dementia, depression, and senile degeneration of the brain. Review of Resident #51's orders dated ,d+[DATE] revealed the resident was ordered Ativan 0.5 milligrams (mg) every four hours for anxiety/agitation. There was an additional order to administer an additional 0.5 mg at bedtime with the other 0.5 mg scheduled Ativan. Review of Licensed Practical Nurse (LPN) #198's timecard revealed on [DATE] the LPN clocked in at 2:36 P. M. and clocked out at 2:00 A.M. on [DATE]. Review of Resident #51's Ativan 0.5 mg control drug receipt form dated [DATE] revealed on [DATE] Licensed Practical Nurse (LPN) #198 had signed out one Ativan 0.5 mg at 0330 (3:30 A.M.) (one and half hours after clocking out) on [DATE]. Review of Resident #51's Medication Administration Record (MAR) dated ,d+[DATE] revealed Resident #51's Ativan 0.5 mg was scheduled at midnight, 4:00 A.M., 8:00 A.M., Noon, 4:00 P.M. and two 0.5 mg at 8:00 P.M. There was no evidence LPN #198 had signed out the Ativan 0.5 mg at 4:00 A.M. on [DATE]. On [DATE] LPN #208 had signed off the 4:00 A.M. dose and entered a progress note. Review of Resident #51's progress notes dated [DATE] at 3:13 A.M. revealed a notation that Ativan 0.5 mg was given by the previous nurse. Interview on [DATE] at 12:57 P.M. and [DATE] at 11:19 A.M. with Registered Nurse (RN) #206 and the Director of Nursing (DON) revealed a nurse, who no longer works for the facility, had reported that if LPN #198 wanted to be helpful he needed to start signing off the MAR when he administered medications. The DON reported she was not aware the LPN was administering narcotics and not signing them off the MAR. The DON reported when the facility had their annual survey in [DATE] the facility was cited for inaccurate medical records due to LPN #198 not signing off medication administration records when administering medications and she thought it was the same issue. The DON reported the nurse (LPN #208) that worked on [DATE] no longer works at the facility and LPN #198 had expired last week and there was no way to complete an investigation at this time to determine why LPN #198 signed out the Ativan at 3:30 A.M. when he clocked out at 2:00 A.M. on [DATE]. The DON reported the facility did not do an investigation because they were not aware the issue was narcotic related. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] from 3:00 P.M. to 5:00 P.M., with Anonymous Licensed Staff Member #210 and #211 revealed there had been times they had followed LPN #198, and he would have administered scheduled and as needed narcotics and would not sign off the MAR. The nurse reported for example just this month he had signed out Resident #51's Ativan and he wasn't even in the building. He had left after midnight, and he signed out he administered Resident #51's Ativan around 3:00 A.M. The concerns were reported to the DON. The staff reported when LPN #198 didn't sign off the MAR they wrote a progress note stating the medication was administered by the previous nurse. 2. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including radiculopathy, cervical disc degeneration, low back pain, and need for assistance with personal care. Review of Resident #42's orders dated ,d+[DATE] revealed Oxycodone 10 milligrams (mg) three times daily for pain. Review of Resident #42's MAR dated ,d+[DATE] revealed the resident's Oxycodone was scheduled at 3:00 A.M., 11:00 A.M., and 7:00 P.M. Review of an anonymous complaint dated [DATE] revealed there were concerns that LPN #198 was working under the influence of drugs because he was always sitting at the nurse's station nodding off and he was found in rooms with his pants down and fighting the air. Some of the aides have pictures of him eating at the nurse's station with eyes closed or sitting there nodding off. There were concerns with resident medication being misappropriated. Review of the facility's Self Reported Incidents (SRI) dated [DATE] to [DATE] revealed no evidence the facility had reported an incident of misappropriation. Interview on [DATE] at 1:17 P.M. with Consulting Pharmacist #203 revealed the facility had reported nine missing Oxycodone at the beginning of the month ([DATE]). The Pharmacist reported she could not recall the resident name or details, however, would have the pharmacy email the information to the surveyor, however the information was never received. Interview on [DATE] at 3:14 P.M. with the Administrator and DON revealed there was an incident this month when Resident #42 had approximately nine Oxycodone 10 milligram (mg) that were missing. The facility did not report the missing narcotics due to the resident didn't miss a dose and the facility paid to replace the medication. The Administrator reported the facility started an investigation but was not able to determine what happened to the medication. The Oxycodone blister pack and the control sheets were both missing. Review of the facility investigation revealed there was a typed statement signed by the DON dated [DATE] that indicated LPN #198 had removed an empty narcotic sheet from the Northwest cart and documented (-1) on the narcotic log and placed the completed narcotic card of Resident #42 in the medical records box and tore the name off the top of the actual narcotic card and placed it in the shred box. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second statement was handwritten by LPN #145 dated [DATE] that indicated when she asked LPN #198 if they needed to count (narcotics), he reported no he had already counted with LPN #169 and LPN #145 took the keys for A.M. medication pass. After completing A.M. medication pass, the narcotic count was completed and was correct and LPN #145 exited the building due to, she only picked up to help with morning med pass. The third statement was handwritten by LPN #169 dated [DATE] revealed the day before on [DATE] she was joking with Resident #42 about his new card of Oxycodone 10 mg were pink, however told him he had about , d+[DATE] pack of the white one to finish first before starting the new ones. On [DATE] LPN #169 had taken the keys from LPN #145 due to LPN #145 came in from 6:30 A.M. to 9:00 A.M. to help pass medications. When she was administering medication, she noticed the resident only had the pink Oxycodone. The LPN continued med pass and then took her concern to LPN #121. The staff realized the card and sheet were both missing. Concerns were reported to the DON and Administrator. Review of the controlled medication shift change log dated [DATE] to [DATE] revealed on [DATE] the 6:00 A. M. shift LPN #198 was the off going nurse and the on-coming nurse was LPN #169. The 6:00 P.M. off-going nurse was LPN #169 and on-coming nurse was LPN #198. On [DATE] 6:00 A.M. shift the off-going nurse was LPN #198 and on-coming nurse was LPN #145. At 8:45 A.M. LPN #145 was the off-going nurse, and the on-coming nurse was LPN #169. There was no documented evidence a count sheet was removed for Resident #42. The DON educated all licensed staff on [DATE] on the narcotic process. All narcotic sheets on Northwest were reviewed and no discrepancy noted. Seven residents were interviewed to ensure they were receiving medication as ordered. No concerns documented. LPN #198 received a final disciplinary on [DATE] for not following policy and procedure at shift change to ensure proper communication with all nurses. Audits were completed on four residents weekly for four weeks with no discrepancies noted. There was no evidence the other three medication carts were audited to ensure accuracy due to LPN #198 and LPN #169 had access to the other carts in the past few days. (There were concerns with Resident #51's medication (see example 1) which the resident resided on a different unit and LPN #198 was involved as well). Interview on [DATE] at 3:30 P.M., with LPN #169 revealed there had been concern with LPN #198 and he had been spiraling out of control the last ,d+[DATE] weeks. The LPN reported the only reason she caught that Resident #42's Oxycodone was missing was because the new package was pink, which was a different color than the ones the resident was currently taking, and she was joking with the resident on [DATE] about the color. The resident still had about a half of card of the white ones left on [DATE]. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:05 A.M., with Resident #49 revealed she has had concerns with three staff members working under the influence. One of the nurses no longer worked at the facility, one just expired, and one was still working but it was a rumor she had heard and had not actually seen for herself. Resident #49 reported LPN #198 would rock back and forth with his eyes closed at the nursing station like he was on something, not because he was tired. Interview on [DATE] at 3:34 P.M. with RN #206, Director of Nursing (DON) and RN #149 confirmed the facility was not able to determine the exact amount of Oxycodone missing due to the control sheet and blister packet were both missing. The facility calculated the missing amount by determining the amount of Oxycodone sent on [DATE] (60 tablets) and subtracted the amount administered each day from [DATE] to [DATE] which would have been 51 tablets. The facility then subtracted 51 from the 60 sent on [DATE] to determine nine tablets were missing. RN #206 confirmed there was a big breakdown in the reconciliation system. Staff were not having two nurses sign in or out the control sheets, LPN #198 didn't sign out the control sheet for Resident #42 per his statement, LPN #145 signed she verified count with LPN #198 on [DATE] when her statement indicated she didn't count with LPN #198, and staff were not counting sheets correctly. On [DATE] the facility had completed an audit from [DATE] to [DATE] with the pharmacy delivery invoice to ensure all medication were accounted for. There was no discrepancy except for Resident #42. The facility didn't report the incident to the state agency and could not determine what happened to the Oxycodone. The facility only interviewed the three nurses because they were the only three that had access to the cart on [DATE] and [DATE]. LPN #198 received a final disciplinary notice due to he told LPN #145 he already did count with LPN #169 when he did not. Review of the facility policy titled Abuse (dated [DATE]) revealed it was the facility policy to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation, and misappropriation of resident's property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or one without a resident's consent. The facility should reported all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies with specified timeframes: Immediately, but no later than two hours after the allegation was made, if the events that cause the allegation involved abuse or result in serious bodily injury or no later than 24 hours if the event that causes the allegation do not involve abuse and do not result in serious bodily injury. Reporting to the state nurse aide registry of licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is unfit for services. The administrator will follow up with government agencies, during business hours, to confirm the initial report received, and to report result of the investigation when final within five working days of the incident, as required by state agencies. Review of the facility's policy titled Control Substance (dated [DATE]) revealed narcotics were to be counted at the beginning and end of each shift by the on-coming nurse and authorized by the off-going nurse. Any discrepancies would be reported the DON immediately for further action. This deficiency represents non-compliance investigated under Complaint Number OH00156496.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of timecards, review of the facility investigation, review of self-reported incidents (SRI), interviews, and policy review the facility failed to ensure misappropriation of resident narcotics was reported to the state survey agency within the required timeframe. This affected two residents (#42 and #51) of three records reviewed. Findings included: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including anxiety, insomnia, dementia, depression, and senile degeneration of the brain. Review of Resident #51's orders dated ,d+[DATE] revealed the resident was ordered Ativan 0.5 milligrams (mg) every four hours for anxiety/agitation. There was an additional order to administer an additional 0.5 mg at bedtime with the other 0.5 mg scheduled Ativan. Review of Licensed Practical Nurse (LPN) #198's timecard revealed on [DATE] the LPN clocked in at 2:36 P. M. and clocked out at 2:00 A.M. on [DATE]. Review of Resident #51's Ativan 0.5 mg control drug receipt form dated [DATE] revealed on [DATE] Licensed Practical Nurse (LPN) #198 had signed out one Ativan 0.5 mg at 0330 (3:30 A.M.) (one and half hours after clocking out) on [DATE]. Review of Resident #51's Medication Administration Record (MAR) dated ,d+[DATE] revealed Resident #51's Ativan 0.5 mg was scheduled at midnight, 4:00 A.M., 8:00 A.M., Noon, 4:00 P.M. and two 0.5 mg at 8:00 P.M. There was no evidence LPN #198 had signed out the Ativan 0.5 mg at 4:00 A.M. on [DATE]. On [DATE] LPN #208 had signed off the 4:00 A.M. dose and entered a progress note. Review of Resident #51's progress notes dated [DATE] at 3:13 A.M. revealed a notation that Ativan 0.5 mg was given by the previous nurse. Interview on [DATE] at 12:57 P.M. and [DATE] at 11:19 A.M. with Registered Nurse (RN) #206 and the Director of Nursing (DON) revealed a nurse, who no longer works for the facility, had reported that if LPN #198 wanted to be helpful he needed to start signing off the MAR when he administered medications. The DON reported she was not aware the LPN was administering narcotics and not signing them off the MAR. The DON reported when the facility had their annual survey in [DATE] the facility was cited for inaccurate medical records due to LPN #198 not signing off medication administration records when administering medications and she thought it was the same issue. The DON reported the nurse (LPN #208) that worked on [DATE] no longer works at the facility and LPN #198 had expired last week and there was no way to complete an investigation at this time to determine why LPN #198 signed out the Ativan at 3:30 A.M. when he clocked out at 2:00 A.M. on [DATE]. The DON reported the facility did not do an investigation because they were not aware the issue was narcotic related. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] from 3:00 P.M. to 5:00 P.M., with Anonymous Licensed Staff Member #210 and #211 revealed there had been times they had followed LPN #198, and he would have administered scheduled and as needed narcotics and would not sign off the MAR. The nurse reported for example just this month he had signed out Resident #51's Ativan and he wasn't even in the building. He had left after midnight, and he signed out he administered Resident #51's Ativan around 3:00 A.M. The concerns were reported to the DON. The staff reported when LPN #198 didn't sign off the MAR they wrote a progress note stating the medication was administered by the previous nurse. 2. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including radiculopathy, cervical disc degeneration, low back pain, and need for assistance with personal care. Review of Resident #42's orders dated ,d+[DATE] revealed Oxycodone 10 milligrams (mg) three times daily for pain. Review of Resident #42's MAR dated ,d+[DATE] revealed the resident's Oxycodone was scheduled at 3:00 A.M., 11:00 A.M., and 7:00 P.M. Review of an anonymous complaint dated [DATE] revealed there were concerns that LPN #198 was working under the influence of drugs because he was always sitting at the nurse's station nodding off and he was found in rooms with his pants down and fighting the air. Some of the aides have pictures of him eating at the nurse's station with eyes closed or sitting there nodding off. There were concerns with resident medication being misappropriated. Review of the facility's Self Reported Incidents (SRI) dated [DATE] to [DATE] revealed no evidence the facility had reported an incident of misappropriation. Interview on [DATE] at 1:17 P.M. with Consulting Pharmacist #203 revealed the facility had reported nine missing Oxycodone at the beginning of the month ([DATE]). The Pharmacist reported she could not recall the resident name or details, however, would have the pharmacy email the information to the surveyor, however the information was never received. Interview on [DATE] at 3:14 P.M. with the Administrator and DON revealed there was an incident this month when Resident #42 had approximately nine Oxycodone 10 milligram (mg) that were missing. The facility did not report the missing narcotics due to the resident didn't miss a dose and the facility paid to replace the medication. The Administrator reported the facility started an investigation but was not able to determine what happened to the medication. The Oxycodone blister pack and the control sheets were both missing. Review of the facility investigation revealed there was a typed statement signed by the DON dated [DATE] that indicated LPN #198 had removed an empty narcotic sheet from the Northwest cart and documented (-1) on the narcotic log and placed the completed narcotic card of Resident #42 in the medical records box and tore the name off the top of the actual narcotic card and placed it in the shred box. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second statement was handwritten by LPN #145 dated [DATE] that indicated when she asked LPN #198 if they needed to count (narcotics), he reported no he had already counted with LPN #169 and LPN #145 took the keys for A.M. medication pass. After completing A.M. medication pass, the narcotic count was completed and was correct and LPN #145 exited the building due to, she only picked up to help with morning med pass. The third statement was handwritten by LPN #169 dated [DATE] revealed the day before on [DATE] she was joking with Resident #42 about his new card of Oxycodone 10 mg were pink, however told him he had about , d+[DATE] pack of the white one to finish first before starting the new ones. On [DATE] LPN #169 had taken the keys from LPN #145 due to LPN #145 came in from 6:30 A.M. to 9:00 A.M. to help pass medications. When she was administering medication, she noticed the resident only had the pink Oxycodone. The LPN continued med pass and then took her concern to LPN #121. The staff realized the card and sheet were both missing. Concerns were reported to the DON and Administrator. Review of the controlled medication shift change log dated [DATE] to [DATE] revealed on [DATE] the 6:00 A. M. shift LPN #198 was the off going nurse and the on-coming nurse was LPN #169. The 6:00 P.M. off-going nurse was LPN #169 and on-coming nurse was LPN #198. On [DATE] 6:00 A.M. shift the off-going nurse was LPN #198 and on-coming nurse was LPN #145. At 8:45 A.M. LPN #145 was the off-going nurse, and the on-coming nurse was LPN #169. There was no documented evidence a count sheet was removed for Resident #42. The DON educated all licensed staff on [DATE] on the narcotic process. All narcotic sheets on Northwest were reviewed and no discrepancy noted. Seven residents were interviewed to ensure they were receiving medication as ordered. No concerns documented. LPN #198 received a final disciplinary on [DATE] for not following policy and procedure at shift change to ensure proper communication with all nurses. Audits were completed on four residents weekly for four weeks with no discrepancies noted. There was no evidence the other three medication carts were audited to ensure accuracy due to LPN #198 and LPN #169 had access to the other carts in the past few days. (There were concerns with Resident #51's medication (see example 1) which the resident resided on a different unit and LPN #198 was involved as well). Interview on [DATE] at 3:30 P.M., with LPN #169 revealed there had been concern with LPN #198 and he had been spiraling out of control the last ,d+[DATE] weeks. The LPN reported the only reason she caught that Resident #42's Oxycodone was missing was because the new package was pink, which was a different color than the ones the resident was currently taking, and she was joking with the resident on [DATE] about the color. The resident still had about a half of card of the white ones left on [DATE]. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:05 A.M., with Resident #49 revealed she has had concerns with three staff members working under the influence. One of the nurses no longer worked at the facility, one just expired, and one was still working but it was a rumor she had heard and had not actually seen for herself. Resident #49 reported LPN #198 would rock back and forth with his eyes closed at the nursing station like he was on something, not because he was tired. Interview on [DATE] at 3:34 P.M. with RN #206, Director of Nursing (DON) and RN #149 confirmed the facility was not able to determine the exact amount of Oxycodone missing due to the control sheet and blister packet were both missing. The facility calculated the missing amount by determining the amount of Oxycodone sent on [DATE] (60 tablets) and subtracted the amount administered each day from [DATE] to [DATE] which would have been 51 tablets. The facility then subtracted 51 from the 60 sent on [DATE] to determine nine tablets were missing. RN #206 confirmed there was a big breakdown in the reconciliation system. Staff were not having two nurses sign in or out the control sheets, LPN #198 didn't sign out the control sheet for Resident #42 per his statement, LPN #145 signed she verified count with LPN #198 on [DATE] when her statement indicated she didn't count with LPN #198, and staff were not counting sheets correctly. On [DATE] the facility had completed an audit from [DATE] to [DATE] with the pharmacy delivery invoice to ensure all medication were accounted for. There was no discrepancy except for Resident #42. The facility didn't report the incident to the state agency and could not determine what happened to the Oxycodone. The facility only interviewed the three nurses because they were the only three that had access to the cart on [DATE] and [DATE]. LPN #198 received a final disciplinary notice due to he told LPN #145 he already did count with LPN #169 when he did not. Review of the facility policy titled Abuse (dated [DATE]) revealed it was the facility policy to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation, and misappropriation of resident's property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or one without a resident's consent. The facility should reported all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies with specified timeframes: Immediately, but no later than two hours after the allegation was made, if the events that cause the allegation involved abuse or result in serious bodily injury or no later than 24 hours if the event that causes the allegation do not involve abuse and do not result in serious bodily injury. Reporting to the state nurse aide registry of licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is unfit for services. The administrator will follow up with government agencies, during business hours, to confirm the initial report received, and to report result of the investigation when final within five working days of the incident, as required by state agencies. Review of the facility's policy titled Control Substance (dated [DATE]) revealed narcotics were to be counted at the beginning and end of each shift by the on-coming nurse and authorized by the off-going nurse. Any discrepancies would be reported the DON immediately for further action. This deficiency represents non-compliance investigated under Complaint Number OH00156496.		

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of timecards, review of the facility investigation, review of self-reported incidents (SRI), interviews, and policy review the facility failed to ensure misappropriation of resident narcotics was thoroughly investigated. This affected two residents (#42 and #51) of three records reviewed. Findings included: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including anxiety, insomnia, dementia, depression, and senile degeneration of the brain. Review of Resident #51's orders dated ,d+[DATE] revealed the resident was ordered Ativan 0.5 milligrams (mg) every four hours for anxiety/agitation. There was an additional order to administer an additional 0.5 mg at bedtime with the other 0.5 mg scheduled Ativan. Review of Licensed Practical Nurse (LPN) #198's timecard revealed on [DATE] the LPN clocked in at 2:36 P. M. and clocked out at 2:00 A.M. on [DATE]. Review of Resident #51's Ativan 0.5 mg control drug receipt form dated [DATE] revealed on [DATE] Licensed Practical Nurse (LPN) #198 had signed out one Ativan 0.5 mg at 0330 (3:30 A.M.) (one and half hours after clocking out) on [DATE]. Review of Resident #51's Medication Administration Record (MAR) dated ,d+[DATE] revealed Resident #51's Ativan 0.5 mg was scheduled at midnight, 4:00 A.M., 8:00 A.M., Noon, 4:00 P.M. and two 0.5 mg at 8:00 P.M. There was no evidence LPN #198 had signed out the Ativan 0.5 mg at 4:00 A.M. on [DATE]. On [DATE] LPN #208 had signed off the 4:00 A.M. dose and entered a progress note. Review of Resident #51's progress notes dated [DATE] at 3:13 A.M. revealed a notation that Ativan 0.5 mg was given by the previous nurse. Interview on [DATE] at 12:57 P.M. and [DATE] at 11:19 A.M. with Registered Nurse (RN) #206 and the Director of Nursing (DON) revealed a nurse, who no longer works for the facility, had reported that if LPN #198 wanted to be helpful he needed to start signing off the MAR when he administered medications. The DON reported she was not aware the LPN was administering narcotics and not signing them off the MAR. The DON reported when the facility had their annual survey in [DATE] the facility was cited for inaccurate medical records due to LPN #198 not signing off medication administration records when administering medications and she thought it was the same issue. The DON reported the nurse (LPN #208) that worked on [DATE] no longer works at the facility and LPN #198 had expired last week and there was no way to complete an investigation at this time to determine why LPN #198 signed out the Ativan at 3:30 A.M. when he clocked out at 2:00 A.M. on [DATE]. The DON reported the facility did not do an investigation because they were not aware the issue was narcotic related. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] from 3:00 P.M. to 5:00 P.M., with Anonymous Licensed Staff Member #210 and #211 revealed there had been times they had followed LPN #198, and he would have administered scheduled and as needed narcotics and would not sign off the MAR. The nurse reported for example just this month he had signed out Resident #51's Ativan and he wasn't even in the building. He had left after midnight, and he signed out he administered Resident #51's Ativan around 3:00 A.M. The concerns were reported to the DON. The staff reported when LPN #198 didn't sign off the MAR they wrote a progress note stating the medication was administered by the previous nurse. 2. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including radiculopathy, cervical disc degeneration, low back pain, and need for assistance with personal care. Review of Resident #42's orders dated ,d+[DATE] revealed Oxycodone 10 milligrams (mg) three times daily for pain. Review of Resident #42's MAR dated ,d+[DATE] revealed the resident's Oxycodone was scheduled at 3:00 A.M., 11:00 A.M., and 7:00 P.M. Review of an anonymous complaint dated [DATE] revealed there were concerns that LPN #198 was working under the influence of drugs because he was always sitting at the nurse's station nodding off and he was found in rooms with his pants down and fighting the air. Some of the aides have pictures of him eating at the nurse's station with eyes closed or sitting there nodding off. There were concerns with resident medication being misappropriated. Review of the facility's Self Reported Incidents (SRI) dated [DATE] to [DATE] revealed no evidence the facility had reported an incident of misappropriation. Interview on [DATE] at 1:17 P.M. with Consulting Pharmacist #203 revealed the facility had reported nine missing Oxycodone at the beginning of the month ([DATE]). The Pharmacist reported she could not recall the resident name or details, however, would have the pharmacy email the information to the surveyor, however the information was never received. Interview on [DATE] at 3:14 P.M. with the Administrator and DON revealed there was an incident this month when Resident #42 had approximately nine Oxycodone 10 milligram (mg) that were missing. The facility did not report the missing narcotics due to the resident didn't miss a dose and the facility paid to replace the medication. The Administrator reported the facility started an investigation but was not able to determine what happened to the medication. The Oxycodone blister pack and the control sheets were both missing. Review of the facility investigation revealed there was a typed statement signed by the DON dated [DATE] that indicated LPN #198 had removed an empty narcotic sheet from the Northwest cart and documented (-1) on the narcotic log and placed the completed narcotic card of Resident #42 in the medical records box and tore the name off the top of the actual narcotic card and placed it in the shred box. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second statement was handwritten by LPN #145 dated [DATE] that indicated when she asked LPN #198 if they needed to count (narcotics), he reported no he had already counted with LPN #169 and LPN #145 took the keys for A.M. medication pass. After completing A.M. medication pass, the narcotic count was completed and was correct and LPN #145 exited the building due to, she only picked up to help with morning med pass. The third statement was handwritten by LPN #169 dated [DATE] revealed the day before on [DATE] she was joking with Resident #42 about his new card of Oxycodone 10 mg were pink, however told him he had about , d+[DATE] pack of the white one to finish first before starting the new ones. On [DATE] LPN #169 had taken the keys from LPN #145 due to LPN #145 came in from 6:30 A.M. to 9:00 A.M. to help pass medications. When she was administering medication, she noticed the resident only had the pink Oxycodone. The LPN continued med pass and then took her concern to LPN #121. The staff realized the card and sheet were both missing. Concerns were reported to the DON and Administrator. Review of the controlled medication shift change log dated [DATE] to [DATE] revealed on [DATE] the 6:00 A. M. shift LPN #198 was the off going nurse and the on-coming nurse was LPN #169. The 6:00 P.M. off-going nurse was LPN #169 and on-coming nurse was LPN #198. On [DATE] 6:00 A.M. shift the off-going nurse was LPN #198 and on-coming nurse was LPN #145. At 8:45 A.M. LPN #145 was the off-going nurse, and the on-coming nurse was LPN #169. There was no documented evidence a count sheet was removed for Resident #42. The DON educated all licensed staff on [DATE] on the narcotic process. All narcotic sheets on Northwest were reviewed and no discrepancy noted. Seven residents were interviewed to ensure they were receiving medication as ordered. No concerns documented. LPN #198 received a final disciplinary on [DATE] for not following policy and procedure at shift change to ensure proper communication with all nurses. Audits were completed on four residents weekly for four weeks with no discrepancies noted. There was no evidence the other three medication carts were audited to ensure accuracy due to LPN #198 and LPN #169 had access to the other carts in the past few days. (There were concerns with Resident #51's medication (see example 1) which the resident resided on a different unit and LPN #198 was involved as well). Interview on [DATE] at 3:30 P.M., with LPN #169 revealed there had been concern with LPN #198 and he had been spiraling out of control the last ,d+[DATE] weeks. The LPN reported the only reason she caught that Resident #42's Oxycodone was missing was because the new package was pink, which was a different color than the ones the resident was currently taking, and she was joking with the resident on [DATE] about the color. The resident still had about a half of card of the white ones left on [DATE]. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:05 A.M., with Resident #49 revealed she has had concerns with three staff members working under the influence. One of the nurses no longer worked at the facility, one just expired, and one was still working but it was a rumor she had heard and had not actually seen for herself. Resident #49 reported LPN #198 would rock back and forth with his eyes closed at the nursing station like he was on something, not because he was tired. Interview on [DATE] at 3:34 P.M. with RN #206, Director of Nursing (DON) and RN #149 confirmed the facility was not able to determine the exact amount of Oxycodone missing due to the control sheet and blister packet were both missing. The facility calculated the missing amount by determining the amount of Oxycodone sent on [DATE] (60 tablets) and subtracted the amount administered each day from [DATE] to [DATE] which would have been 51 tablets. The facility then subtracted 51 from the 60 sent on [DATE] to determine nine tablets were missing. RN #206 confirmed there was a big breakdown in the reconciliation system. Staff were not having two nurses sign in or out the control sheets, LPN #198 didn't sign out the control sheet for Resident #42 per his statement, LPN #145 signed she verified count with LPN #198 on [DATE] when her statement indicated she didn't count with LPN #198, and staff were not counting sheets correctly. On [DATE] the facility had completed an audit from [DATE] to [DATE] with the pharmacy delivery invoice to ensure all medication were accounted for. There was no discrepancy except for Resident #42. The facility didn't report the incident to the state agency and could not determine what happened to the Oxycodone. The facility only interviewed the three nurses because they were the only three that had access to the cart on [DATE] and [DATE]. LPN #198 received a final disciplinary notice due to he told LPN #145 he already did count with LPN #169 when he did not. Review of the facility policy titled Abuse (dated [DATE]) revealed it was the facility policy to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation, and misappropriation of resident's property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or one without a resident's consent. The facility should reported all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies with specified timeframes: Immediately, but no later than two hours after the allegation was made, if the events that cause the allegation involved abuse or result in serious bodily injury or no later than 24 hours if the event that causes the allegation do not involve abuse and do not result in serious bodily injury. Reporting to the state nurse aide registry of licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is unfit for services. The administrator will follow up with government agencies, during business hours, to confirm the initial report received, and to report result of the investigation when final within five working days of the incident, as required by state agencies. Review of the facility's policy titled Control Substance (dated [DATE]) revealed narcotics were to be counted at the beginning and end of each shift by the on-coming nurse and authorized by the off-going nurse. Any discrepancies would be reported the DON immediately for further action. This deficiency represents non-compliance investigated under Complaint Number OH00156496.		

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed medical record review, staff interview, and policy review the facility failed to ensure all required information upon transfer was communicated and/or documented in the resident's medical record. This affected one resident (#74) of three residents reviewed for transfer and discharge. Findings include: Closed record review revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. Review of Resident #74's progress note dated 08/22/24 revealed the resident was transferred to the emergency room . Review of Resident #74's Psych 360 note dated 08/22/24 revealed the resident's behaviors have continued to escalate. The resident was sent to the emergency room and returned to the facility. The facility called requesting a pink slip to send him to another emergency room . Offered to find bed placement, however per the facility, transport was currently at the facility and waiting on a pink slip to transport him. Due to the facility's wishes and the resident's unsafe behavior with the risk of harm to others, a pink slip was emailed to the Administrator. Review of Resident #74's application for emergency mental health admitted d 08/22/24 revealed the resident had a history of combative, aggressive, delusional thinking, and hallucination behaviors. There were concerns for safety with his peers and staff. The resident would benefit from in patient hospitalization to stabilize these factors. Review of Resident #74's discharge Minimum Data Set, dated dated [DATE] revealed the resident's active diagnoses including hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. The resident was anticipated to return to the facility. Review of Resident #74's closed medical record on 08/26/24 revealed no documented evidence the required information was communicated to the receiving health care facility/provider. Interview on 08/29/24 at 4:32 P.M., with the Administrator confirmed there was no documented evidence the facility provided the required information to the receiving health care facility/provider for Resident #74's transfer to the emergency room . Review of the facility's policy and procedure titled Transfer and Discharge (dated 08/22/22) revealed the facility's policy was to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The facility would evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs. (continued on next page)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: Contact information of the practitioner who was responsible for the care of the resident, resident representative information, resident status, advance directives, diagnoses, allergies, medications including when last received, most recent relevant labs, test, and immunizations, all special instructions, the resident comprehensive plan of care, and any additional information outline in the transfer agreement with the acute care provider. The original transfer form would be sent with the resident and a copy placed in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00156733.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32801 Based on closed medical record review, staff interview, and policy review the facility failed to ensure the resident and resident representative received a transfer notice as soon as practicable prior to being transferred to the hospital. This affected one resident (#74) of three residents reviewed for transfer and discharge. Findings include: Closed record review revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. Review of Resident #74's progress note dated 08/22/24 revealed the resident was transferred to the emergency room . Review of Resident #74's Psych 360 note dated 08/22/24 revealed the resident's behaviors have continued to escalate. The resident was sent to the emergency room and returned to the facility. The facility called requesting a pink slip to send him to another emergency room . Offered to find bed placement, however per the facility, transport was currently at the facility and waiting on pink slip to transport him. Due to the facility's wishes and the resident's unsafe behavior with the risk of harm to others a pink slip was emailed to the Administrator. Review of Resident #74's application for emergency mental health admitted d 08/22/24 revealed the resident had a history of combative, aggressive, delusional thinking, and hallucination behaviors. There were concerns for safety with his peers and staff. The resident would benefit from in patient hospitalization to stabilize these factors. Review of Resident #74's discharge Minimum Data Set (dated 08/22/24) revealed the resident's active diagnoses included hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. The resident was anticipated to return to the facility. Review of Resident #74's closed medical record on 08/26/24 revealed no evidence the resident or resident representative received a transfer notice when the resident was transferred on 08/22/24. Interview on 08/29/24 at 4:32 P.M., with the Administrator confirmed there was no documented evidence the facility completed a transfer notice, or the resident or resident representative received a transfer notice. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled Transfer and Discharge (dated 08/22/22) revealed the facility's policy to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The facility would evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs. The facility's transfer/discharge notice would be provided to the resident and the resident representative in a language and manner in which they can understand. The notice would include all of the following at the time it is provided: The specific reason and basis for transfer or discharge, effective date of transfer or discharge, specific location, an explanation of the right to appeal, contact information of the State entity which receives such appeal hearing request, information on how to obtain a appeal form and assistance on completing the form, Ombudsman information, and contact information for state agency responsible for protection and advocacy of resident with mental health illness. The notice must be provided to the resident, resident's representative if appropriate, and the ombudsman as soon as practicable before the transfer or discharge. This deficiency represents non-compliance investigated under Complaint Number OH00156733.		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32801 Based on closed medical record review, staff interview, and policy review the facility failed to ensure the resident and resident representative received a bed hold notice when the resident was transferred. This affected one resident (#74) of three residents reviewed for transfer and discharge. Findings include: Closed record review revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. Review of Resident #74's progress note dated 08/22/24 revealed the resident was transferred to the emergency room . Review of Resident #74's Psych 360 note dated 08/22/24 revealed the resident's behaviors have continued to escalate. The resident was sent to the emergency room and returned to the facility. The facility called requesting a pink slip to send him to another emergency room . Offered to find bed placement, however per the facility, transport was currently at the facility and waiting on pink slip to transport him. Due to the facility's wishes and the resident's unsafe behavior with the risk of harm to others a pink slip was emailed to the Administrator. Review of Resident #74's application for emergency mental health admitted d 08/22/24 revealed the resident had a history of combative, aggressive, delusional thinking, and hallucination behaviors. There were concerns for safety with his peers and staff. The resident would benefit from in patient hospitalization to stabilize these factors. Review of Resident #74's discharge Minimum Data Set, dated dated [DATE] revealed the resident's active diagnoses including hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. The resident was anticipated to return to the facility. Review of Resident #74's closed medical record on 08/26/24 revealed no evidence the resident or resident representative received the bed hold policy when the resident was transferred on 08/22/24. Interview on 08/29/24 at 4:32 P.M., with the Administrator confirmed there was no documented evidence the resident or resident representative received the bed hold notice. The Administrator had the facility reach out to Resident #74's sister and she wanted his bed held but the Administrator reported she would follow up with the sister again to ensure she knows she would be responsible to pay for the bed hold. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled Bed Hold Notice Upon Transfer (dated 06/01/24) revealed at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident and/or representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. In the event of an emergency transfers of a resident, the facility would provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. The facility would keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file. This deficiency represents non-compliance investigated under Complaint Number OH00156733.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed medical record review, review of information submitted to the state survey agency, staff interview, and policy review the facility failed to ensure a resident's Pre-Admission Screening and Resident Review (PASARR) documents accurately reflected the resident's diagnoses. This affected one resident (#74) of three residents reviewed for PASARR assessment. Findings include: Closed record review revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. Review of a neurology note dated 07/31/24 (prior to admission) revealed the resident had intermittent hallucinations and was still having bizarre behaviors. Review of Resident #74's PASARR dated 08/08/24 indicated the resident had no serious mental illness. Review of Resident #74's progress note dated 08/10/24 revealed the resident was agitated and entered an empty room at the end of the hall and removed a wooden bar from the closet and busted out both windows in the room. Staff attempted to deescalate the resident, but it further agitated the resident. The resident was hitting staff with a closed fist. The staff called 911 and the resident's sister. The resident was transferred to the local emergency room . Review of anonymous information submitted to the state survey agency dated 08/12/24 revealed the facility didn't secure proper PASARR and documentation needed to ensure the facility was able to provide care to Resident #74. The facility put the safety and security of all their residents in danger. Review of Resident #74's application for emergency mental health admitted d 08/22/24 revealed the resident had a history of combative, aggressive, delusional thinking, and hallucination behaviors. There were concerns for safety with his peers and staff. The resident would benefit from in patient hospitalization to stabilize these factors. Review of Resident #74's discharge Minimum Data Set, dated dated dated [DATE] revealed the resident's active diagnoses included hallucinations, disorientation, and other symptoms and signs involving cognitive functions and awareness. The resident was admitted from home/community. Interview on 08/29/24 at 4:32 P.M., with the Administrator confirmed Resident #74's PASARR was inaccurate and did not reflect the resident's admission diagnosis of hallucinations. The resident was pink slipped on 08/22/24 to inpatient mental health hospital. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled Resident Assessment-Coordination with PASARR Program (dated 2021) revealed the facility coordinates assessment with the PASARR program to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. This deficiency represents non-compliance investigated under Complaint Number OH00156733.		

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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** 32801 Based on observation, interview, and policy review the facility failed to ensure fall interventions were implemented for a resident at risk of falls. This affected one resident (#51) of three residents reviewed for falls. Findings included: Record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses included history of falls, history of healed traumatic fracture, and muscle weakness. Review of Resident #51's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had two or more falls with no injuries since the last admission/entry, reentry, or prior assessment. Review of Resident #51's fall plan of care initiated 12/04/21 and revised on 03/19/24 revealed the resident required a soft call light, ensure call light was in reach at all times, low bed, and a full mattress on the floor beside the bed. Review of Resident #51's activity of daily living (ADL) plan of care initiated on 05/12/21 and revised on 03/19/24 revealed to call light in reach when in bed. Observation on 09/03/24 at 8:26 A.M. revealed Resident #51's was lying in bed. The resident's bed was in the high position and the full mattress was not on the floor beside the bed. The full mattress was leaned up against the furniture at the end of the resident bed. The surveyor activated the resident's call light. Two staff members walked by Resident #51's room and didn't respond. State tested Nurse's Aide (STNA) #135 returned shortly and confirmed the call light outside the room was not lighting up to alert staff the call light was activated. The STNA reported she was the float STNA today and she just came over to help assist the resident with breakfast and didn't really know what the resident's fall intervention were. The STNA then placed the full mattress on the floor, lowered the bed, and reported she would let the staff know about the call light malfunction. Interview on 09/03/24 at 3:45 P.M., with the Director of Nursing (DON), Registered Nurse (RN) #206, and RN #149 revealed Resident #51's call light was immediately fixed and staff education was started regarding fall interventions. The DON reported the resident had not sustained a fall in the last three months and confirmed the resident's plan of care indicated the resident's bed would be in low position and a full mattress would be placed on the floor beside the bed. Review of the facility policy and procedure titled Fall Prevention Program (dated 06/01/24) revealed each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards would be evaluated when developing the resident's comprehensive plan of care. Intervention would be monitored for effectiveness. This deficiency represents non-compliance investigated under Complaint Number OH00157045.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32801 Based on review of information submitted to the state survey agency, interview, resident council minutes review, review of the concern log, and policy review the facility failed to ensure adequate staffing to answer call lights timely and provide care timely. This had the potential to affect all 69 residents residing in the facility. Findings include: Interview on 08/26/24 at 12:26 P.M. with anonymous staff member #300 revealed the facility was understaffed. The anonymous staff member reported it was difficult to provide incontinence care and answer call lights timely when there was only one aide per hall and by the time she completed the first rounds half of her day was gone. Interview on 08/26/24 at 2:24 P.M. with Resident #3 revealed the facility was understaffed. The resident reported there was only one aide for each unit. The resident reported one aide was not enough for his unit and the facility kept adding residents but not adding staff to care for them. He had to beg for a bed bath daily. It took staff an hour or so to answer call lights. Interview on 08/27/24 at 8:22 A.M., with Resident #65 revealed the facility was understaffed and provided no effort to get her out of bed and if they did they put her in a wheelchair and left her up for hours. She had to wait two to four hours on night shift for someone to answer her call lights because there was only one aide for North (two units) and one for South (two units). She had voiced concerns, but no one ever listened. She told the Director of Nursing (DON) to come in one night and see for herself. The resident reported she was incontinent of urine and the staff don't check on her. She has to ring to let them know she needs changed. The staffing on the weekends is worse. If you need changed around mealtime you might as well forget it because they won't do it, and she has to lay for two hours wet. Interview on 08/27/24 at 5:06 P.M., with Resident #41 (with the DON present) revealed there was not enough staff to meet her needs. She has had to wait an hour for someone to answer her call light. The other night she had to go to the bathroom and staff told her to urinate on herself and they would be back to clean her up. The resident reported she had laid on the floor after a fall recently for 45 minutes to an hour before staff heard her screaming. The resident reported she understands she isn't the only resident in the building, but she still needs assistance. Interview on 08/27/24 at 10:30 A.M., with Resident #24 revealed staff was thin. It takes anywhere from 15-30 minutes for staff to answer the call lights. Interview on 08/29/24 at 11:05 A.M., with Resident #49 revealed there was not enough staff. The resident reported it takes staff one to two hours to answer her call light and it's hard to find staff. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/29/24 at 11:48 A.M., with Medical Care Provider (MCP) #207 revealed when she had visited a client yesterday (08/28/24) she had turned on the call light while she was there to check the response time due to the client had been reporting she had been waiting for an hour for staff to respond to her call light. The MCP reported she had waited 20 minutes and staff still had not responded when she left. The MCP reported early this month her client had wet socks from spilling water on them and she had asked staff for some clean socks and staff never did get them, so she went to the client's room and obtained the socks and changed them herself. Review of information submitted to the state survey agency in the form of complaints dated 08/02/24 to 08/22/24 revealed concerns related to staff not answering call lights timely (up to an hour wait), staff answering call lights and not returning as promised, not providing incontinence care timely, and not assisting residents timely upon request. Review of the facility concern log revealed on 08/17/24 Resident #69's niece had voiced concerns the resident had not been dressed and was incontinent. The staff provided incontinence care and clean linens and clothes. The staff had placed the incontinent linens on the floor. The niece demanded that management be called. The nurse was instructed to provide education to staff on not placing soiled linen/pads on the floor and instructed staff to clean the room. There was no evidence the concern of incontinence care not provided timely or not being dressed was addressed. Review of Resident Council Minutes dated 08/07/24 revealed call light response times were slower on the weekends. Fifteen (15) of 15 residents who attended the resident council meeting voiced concerns. The facility's response was to initiate call light audits for the weekend. The facility did three call light audits on Saturday 08/10/24 (2:00 P.M., 2:15 P.M., and 3:30 P.M.), three call light audits on Sunday 08/11/24 (9:00 A.M., 10:20 A.M., and 10:25 A.M.), two on 08/24/24 (10:00 A.M. and 11:28 A.M.) and one on 08/25/24 (1:55 A.M.). All the call light audits were conducted on one shift. Review of the facility's policy titled Call Light: Accessibility and Timely Response (dated 04/01/22) revealed all staff members who see or hear an activated call light are responsible for responding. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives. Review of the facility's policy titled Customer Service (undated) revealed call lights should be answered as soon as possible and the issue resolved. Everyone answers call lights. If you tell a resident, you will be back in a few minutes go back as promised. If you are not able to do so, notify another staff person to complete the needed task. You lose credibility when you promise to return and don't. Don't tell a resident not to use the call light no matter how many times they use it. This deficiency represents non-compliance investigated under Complaint Number OH00156535, OH00156496, and OH00156413.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of daily nurse staff posting, review of staffing schedule, review of time sheets, review of the facility assessment, policy review, and interview the facility failed to provide a registered nurse (RN) for at least eight consecutive hours daily on 08/04/24. This had the potential to affect all 69 residents residing in the building. Findings included: Review of the facility's daily staff posting dated 08/04/24 revealed the census was 64. There was no RN or RN hours for dayshift or night shift noted. There was 3.75 Licensed Practical Nurses (LPN) for 44 hours on dayshift and 2.75 LPN for 32 hours on nightshift. Review of the staffing schedule dated 08/04/24 revealed no evidence a RN was scheduled. Review of time sheets dated 08/04/24 revealed no evidence a RN had worked on 08/04/24. Interview on 09/03/24 at 3:45 P.M., with the Director of Nursing (DON) confirmed there was no evidence a RN had worked eight consecutive hours on 08/04/24. The DON reported she had come into the facility on [DATE] to investigate an allegation of missing narcotics, however she never clocked in and could not say she was at the facility for eight hours that day. Review of the facility policy and procedure titled Staffing (dated 10/2017) revealed the facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Review of the Facility assessment dated [DATE] and revised 08/29/24 revealed the facility would have one to four RN's daily. The federal regulation requires that a facility must provide 3.48 hours per resident day (HPRD) of direct care with 0.55 HPRD from RN's. This deficiency represents non-compliance investigated under Complaint Number OH00156535, OH00156496, and OH00156413.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32801 Based on review of narcotic control sheets, interview, and policy review the facility failed to ensure staff followed the systems in place for managing narcotic medications to assist in the prevention of narcotic diversion. This had the potential to affect all 69 residents residing in the facility. Finding included: Review of the Northwest controlled medication form dated 07/30/24 to 08/07/24 revealed no evidence a second nurse witnessed/signed when a narcotic medication count sheet was added or removed from the inventory. Interview on 08/27/24 at 12:57 P.M., with Registered Nurse (RN) #206 and the Director of Nursing (DON) confirmed nurses were not ensuring a second nurse was witnessing when narcotic count sheets were added or removed from the narcotic inventory. The facility recently had nine oxycodone missing. The resident's blister card and control sheet were both removed and not documented on the control sheets per staff. The staff reported the only reason the missing medication was discovered was the nurse that had worked the prior day noticed the resident's new blister pack of oxycodone was pink and she had joked with the resident about the change in color. The following day during administration the same nurse noted the previous card she used the day prior was missing and there was several pills left in the card yesterday and should have not been used. Review of the facility's policy titled Control Substance (dated 06/21/17) revealed narcotics were be counted at the beginning and end of each shift by the on-coming nurse and authorized by the off-going nurse. Any discrepancies would be reported the DON immediately for further action. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156496.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, observation, and interview the facility failed to ensure a resident received their diet as ordered. This affected one resident (#41) of three records reviewed. Findings included: Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including Parkinson's, dysphagia, and gastro-esophageal reflux disease. Review of Resident #41's nursing note dated 08/26/24 revealed the resident returned from the hospital with new orders for six small mechanical soft meals daily and aspiration precautions due to the resident had failed a swallowing evaluation. Review of Resident #41's orders dated 08/26/24 revealed the resident's diet order was changed to six small mechanical soft texture meals daily. Interview and observation on 08/28/24 at 11:41 A.M., of Resident #41 with Registered Nurse (RN) #206 revealed the resident had only received one meal thus far today and it was breakfast. Observation of the resident's meal ticket from breakfast revealed no evidence of the new order for six small meals daily. The resident confirmed she had not been receiving six small meals. RN #206 confirmed the resident had new orders written on 08/26/24 for six small meals. Interview on 08/28/24 at 11:46 A.M., with [NAME] #151 confirmed she was not aware the resident was ordered six small meals daily and confirmed the order was not on the resident's meal ticket. [NAME] #151 confirmed she only sent one meal to the resident thus far today and it was breakfast. This deficiency represents non-compliance investigated under Complaint Number OH00156496.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32801 Based on review of photos, review of daily food temperature logs, interview, observation, and policy review the facility failed ensure food was palatable. This had the potential to affect all 69 residents residing in the building. Finding includes: 1. Observation on 09/03/24 at 12:31 P.M., of lunch tray line revealed the mechanical soft chicken patty on the steam table temperature was 117.8 degrees Fahrenheit (F) and the pureed chicken patty on the steam table was 115.1 degrees Fahrenheit. At the time of the observation, interview with the Dietary Manager (DM) #212 from a sister facility reported the food should be held at 135 degrees F on the steam table. The DM #212 reported the knobs were missing on the steam table and she didn't know what temperature the steam table was set on. During the observation, [NAME] # 151 made a mechanical soft meal tray for Resident #53 from the steam table without re-heating the mechanical soft chicken patty after the surveyor confirmed the chicken didn't reach holding temperature. The surveyor intervened prior to the dietary aide delivering the meal tray to the resident in the dining room. DM #212 reported staff should have removed the food items that didn't meet temperatures and re-heated them prior to serving. 2. Review of the daily food temperature logs dated 09/01/24 to 09/03/24 revealed on 09/01/24 the facility did not obtain food temperatures for all three meals. On 09/02/24 the facility did not obtain food temperatures for dinner meal and 09/03/24 food temperatures were not obtained for lunch. The temperature log indicated all food temperatures should be taken before tray line starts. It was the responsibility of the cook to be sure that all temperatures were taken at each meal. Interview on 09/03/24 at 12:30 P.M. with [NAME] #151 and DM #212 confirmed on 09/01/24 no food temperatures were recorded for all three meals, 09/02/24 the dinner temperatures were not recorded, and today 09/03/24 the lunch temperatures were not recorded. [NAME] #151 confirmed she did not write the temperatures down for today because she was running behind. The cook reported she took the temperatures of the food when she removed the food from the oven but did not check the holding temps in the steam table before she started meal services. Review of the facility policy titled Record of Food Temperatures (dated 07/01/24) revealed it was the facility's policy to record food temperatures daily to ensure food was at the proper serving temperature before trays were assembled. Hot food would be held at 135 degrees Fahrenheit or greater. Measure and record the temperatures for each food product and record the temperature log. If food temperatures fall into an unsafe range, immediately follow procedures for reheating previously cooked food. No food would be served that doesn't meet the food code standard temperatures. 3. Observation of a photo dated 08/03/24 revealed the resident was served raw porkchops. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/27/24 at 3:00 P.M., with the Administrator confirmed on 08/03/24 there were four residents that actually ingested the raw porkchops. Staff had pulled all the pork and offered resident alternative meals. A nurse bought pizza for her unit as well. The ovens were audited, and the thermometers were calibrated. The Corporate Dietician provided staff with education. Interview on 08/26/24 at 12:26 P.M., with State tested Nurse's Aide (STNA) #123 confirmed residents voice food concerns frequently. Interview on 08/26/24 at 2:24 P.M. and 08/28/24 at 9:43 A.M., with Resident #3 confirmed he received the raw porkchop on 08/03/24 and also had picture to confirm the porkchops were raw. The resident reported the food was terrible and he had Walmart delivered food items he can keep in his room for backup. Interview on 08/27/24 at 8:22 A.M., with Resident #65 confirmed the food was usually cold. Interview on 08/28/24 at 9:56 A.M., with Resident #6 confirmed the food was sometimes really bad. Interview on 08/28/24 at 10:02 A.M., with Resident #8 confirmed the food was iffy. Interview on 08/28/24 at 3:30 P.M., with Licensed Practical Nurse (LPN) #169 confirmed residents had received raw meat recently and she had received several food concerns from residents. Interview on 08/28/24 at 3:39 P.M., with LPN #134 revealed there was several residents that have door dash deliver food due to the facility food quality. Interview on 08/29/24 at 9:44 A.M., with Resident #33 revealed the food was terrible. He orders door dash almost every day. His roommate had been losing weight due to the poor quality of food and they started him on supplements to help prevent further weight loss. Resident #33 reported he tried speaking to the Dietary Manager and she slammed the door in his face and quit on Friday. Interview on 08/29/24 at 10:31 A.M. with Resident #40 confirmed the food was not good. The resident reported her food was usually burnt. Interview on 08/29/24 at 11:05 A.M., with Resident #49 confirmed she received raw pork recently. This deficiency represents non-compliance investigated under Complaint Number OH00157223, OH00156535 and OH00156496.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, observation, and interview the facility failed to ensure a resident received fluids as ordered. This affected one resident (#41) of three records reviewed. Findings included: Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including Parkinson, dysphagia, and gastro-esophageal reflux disease. Review of Resident #41's nursing note dated 08/26/24 revealed the resident returned from the hospital with new orders for nectar thickened liquids and aspiration precautions due to the resident had failed a swallowing evaluation. Review of Resident #41's orders dated 08/26/24 revealed the resident's diet order was changed to nectar thickened liquids. Observation on 08/28/24 at 5:31 P.M. of Resident #41's dinner meal revealed the resident had a red juice on her meal tray that was thin consistency. The resident had no other fluids on her tray except the red juice. The resident's meal ticket was handwritten with the resident's name, mechanical soft, and nectar written on the paper. Interview and observation on 08/28/24 at 5:31 P.M. of Resident #41's dinner meal with the Director of Nursing (DON) confirmed the resident's handwritten meal ticket and orders indicated the resident was ordered nectar thickened liquids and the resident's red juice on her meal tray was thin consistency and not nectar thick. The DON removed the red juice from the meal tray and requested nectar thickened juice for the resident. This deficiency represents non-compliance investigated under Complaint Number OH00157045 and OH00156496.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, observation, interview, and policy review the facility failed to ensure resident medical records including medication administration records and narcotic administration records were complete and accurate. This affected three residents (#31, #37, and #42) of 28 residents residing on Northwest. Findings included: 1. Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome and presence of a neurostimulator. Observation on 09/03/24 at 1:02 P.M. of Northwest medication cart revealed Resident #37 had a blister package of 51 Oxycodone (15 milligram (mg) tablets). Review of Resident #37's controlled drug receipt form revealed the resident had 52 Oxycodone (15 mg) remaining. 2. Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including knee pain, diabetes, and lymphedema. Observation on 09/03/24 at 1:02 P.M. of Northwest medication cart revealed Resident #31 had a blister package of 15 Oxycodone (5 mg) and an empty blister package of Ativan (0.5 mg). Review of Resident #31's controlled drug receipt form revealed the Resident had 16 Oxycodone (5 mg) tablets and one Ativan left. 3. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including radiculopathy, cervical disc degeneration, low back pain, and need for assistance with personal care. Observation on 09/03/24 at 1:02 P.M. of Northwest medication cart revealed Resident #42 had a blister package of 36 Oxycodone (10 mg left). Review of Resident #42's controlled drug receipt form revealed the Resident had 37 Oxycodone (10 mg) left. During the observation Registered Nurse (RN) #129 reported she had administered Resident #42's Oxycodone at 12:00 P.M. and forgot to sign it out in the narcotic book and signed it out before copies were received. The RN confirmed she had administered Resident #31 and #37's medication earlier today and also forgot to sign the narcotics out of the narcotic book. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/03/24 at 1:10 P.M. with RN #206 confirmed RN #129 should have signed the narcotics out at the time of administration. The RN reported she had pulled up the administration records for the three residents to ensure what time the residents received their medications. Resident #37 had received his Oxycodone 15 mg at 11:00 A.M., Resident #31 received her Oxycodone 5 mg and Ativan 0.5 mg at 7:58 A.M. , this morning, and Resident #42 received his Oxycodone at 11:12 A.M., not noon as the RN documented during the observation. Review of the facility's policy titled Medication Administration (dated 08/22/22) revealed to sign the Medication Administration Record (MAR) after administration. If a medication was controlled substance, sign narcotic book. Correct any discrepancies and report to the nurse manger. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156496.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, interview, and policy review the facility failed to ensure a resident's call light was functional at the resident's bedside. This affected one resident (#51) of three residents reviewed for falls. Findings included: Record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses included history of falls, history of healed traumatic fracture, and muscle weakness. Review of Resident #51's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had two or more falls with no injuries since the last admission/entry, reentry, or prior assessment. Review of Resident #51's fall plan of care initiated 12/04/21 and revised on 03/19/24 revealed the resident required a soft call light and to ensure call light was in reach at all times. Review of Resident #51's activity of daily living (ADL) plan of care initiated on 05/12/21 and revised on 03/19/24 revealed to have call light in reach when in bed. Observation on 09/03/24 at 8:26 A.M. revealed the surveyor activated the resident's call light. Two staff members walked by Resident #51's room and didn't respond. State tested Nurse's Aide (STNA) #135 returned shortly and confirmed the call light outside the room was not lighting up to alert staff the call light was activated. The STNA reported she was the float STNA today and she just came over to help assist the resident with breakfast. Review of the facility policy titled Call Lights: Accessibility and Timely Response (dated 04/01/22) revealed the purpose of the policy was to assure the facility was adequately equipped with a call light at each resident's bedside to allow residents to call for assistance. Each resident would be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156496.		