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

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Form Approved OMB
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 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	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 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** 33019 Based on medical record review, review of a facility Self-Reported Incident (SRI) and investigation, interviews with staff and residents, the facility failed to take reasonable precautions, including providing adequate supervision, to prevent a resident-to-resident altercation. This affected one resident (Resident #3) of three residents reviewed for abuse. The facility census was 72. Findings Include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of right humerus, asthma, diabetes mellitus, multiple fractures of ribs, fracture of right femur, heart disease, and history of cerebral infarction. The resident was moderately cognitively impaired and was dependent on staff for activities of daily living (ADLs) assistance. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 09 of 15, indicating moderately impaired cognition. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including hallucinations, history of malignant neoplasm of brain, thyroid, and larynx, disorientation, and shortness of breath. The resident was moderately cognitively impaired and was dependent on staff for activities of daily living (ADLs) assistance. Review of a psychiatry progress note, dated 08/13/24, revealed Resident #4 was admitted to the facility on [DATE]. Staff reports the resident continues on one-to-one monitoring and has ongoing behaviors. The resident has been paranoid and paces the unit. Numerous inpatient psychiatric facilities have been contacted for possible admission; however, all have denied admission related to his medical condition. The resident has concerns that others may be against him in the facility and reports feeling stressed. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 08/14/24 revealed Resident #4 had impaired cognitive process for daily decision making due to disorientation, personal history of malignant neoplasm of brain, hallucinations, and other symptoms and signs involving cognitive functions and awareness. Interventions included to provide a stable and supportive environment and to reorient and redirect as needed. Further review of the care plan revealed the resident had a potential for change in psychosocial well-being related to hallucinations and disorientation. Interventions included one-to-one, and staff caring for resident to be alert for possible changes in psychosocial status. Review of a hospital emergency admission application, dated 08/22/24, revealed Resident #4 had a history of combative and aggressive behaviors toward staff and has been unreceptive to redirection. Medications had been ineffective in helping to decrease his agitation/aggressiveness. The resident has a history if hallucinations and delusional thinking. There were concerns for safety of his peers and staff. The resident would benefit from inpatient hospitalization and stabilization due to these factors. Review of a nursing progress note, dated 10/09/24 at 6:43 A.M., revealed Resident #3 was yelling for help. The nurse went into the resident's room and the resident stated that a man covered in tattoos came into her room and removed a drawer from her dresser and threw it at her leg. The resident sated she told the man to stop but he did not. A broken drawer was observed lying on the floor near the bottom of the resident's bed. Resident #3's right lower extremity was observed to have a reddened area, and the resident complained of a pain level of seven on a (1-10) pain scale. A pain medication was administered. Resident #3 stated that the man scared her, and she felt unsafe. The resident identified the aggressor to be Resident #4. The Director of Nursing (DON), Administrator, and family members of both residents were notified. Review of a nursing progress note (authored by the DON), dated 10/09/24 at 7:00 A.M., revealed Resident #3 as resting quietly in bed with call light within reach. The resident was alert and pleasant and her mood was at baseline. The note indicated the resident denied feeling scared and afraid at this time and agreed to allow this nurse to place a stop sign across her doorway. There was no redness, bruising, or swelling noted to bilateral lower legs, and the resident denied pain. Review of a facility Self-Reported Incident (SRI), tracking number 252795, submission date of 10/09/24 and discovery date of 10/09/24, revealed the facility reported an allegation/suspicion of physical abuse with the initial source of the allegation being a resident victim. The SRI indicated on 10/09/24 Resident #3 was heard yelling help and when the nurse entered the resident's room, she alleged that a man covered in tattoos had come into her room and took a drawer from her dresser and threw it at her leg. The nurse observed a broken drawer on the floor and the resident had a new, red area on her right lower extremity. The resident stated she was scared and had pain in her leg. The nurse administered pain medication and assured the resident of her safety. Staff were interviewed and did not witness the incident but did observe Resident #4 wandering about the hallway. Residents were interviewed and voiced concern that perpetrator wanders and was not easily re-directed at times. Another resident down the hall heard the yell for help but was not sure what happened. Resident #4 could not recall the incident and was unable to communicate when asked questions. A stop sign was placed on Resident #3's door, Resident #4 was place on one-to-one observation and both families and physician were notified. The facility's conclusion following investigation revealed the allegation was unsubstantiated and abuse did not occur. The facility concluded that there was no willful intent and Resident #4 did not act deliberately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/24 at 2:02 P.M., with Resident #3 revealed a man came in her room and took that drawer out and dropped it on her bed and it hit her leg. The resident stated she had pain in her leg where the drawer first hit her leg, but it went away. The resident stated the incident scared her when it occurred, but they (staff) put something on my door to keep him out and I wasn't scared anymore. Interview on 10/24/24 at 3:10 P.M. with the Administrator confirmed Resident #4, while unsupervised and with ongoing behaviors including entering other resident rooms, entered Resident #3's room and threw a drawer at her while she was in her bed. The Administrator stated she reported the incident to the State agency, however, unsubstantiated the allegation of abuse because Resident #4 had no idea what he was doing at the time of the incident and because Resident #3 did not sustain an (significant) injury. This deficiency represents an incidental finding discovered during the course of this complaint investigation.

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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** 33019 Based on observation, record review, policy review, and interview, the facility failed to ensure ice water was provided to residents in their rooms, consistent with their preferences, to maintain hydration. This affected one (Resident #3) of three residents reviewed for hydration. The facility census was 72. Findings include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of right humerus, multiple fractures of ribs, fracture of right femur, asthma, diabetes mellitus, heart disease, and history of cerebral infarction. The resident was moderately cognitively impaired and was dependent on staff for activities of daily living (ADLs) assistance. Interview on 10/24/24 at 9:39 A.M. with Ombudsman #70 revealed she has received numerous complaints from residents regarding ice water not being provided to them in their rooms. Interview on 10/24/24 at 10:05 A.M. with Resident #7 revealed sometimes ice and water is not provided on a schedule. Resident #7 stated there have been some days when there was none passed until after lunch and on those days, she had to ask the staff for ice and water. Observation and interview on 10/24/24 at 2:02 P.M. with Resident #3 revealed ice water was not available on her bedside table or in her room. Resident #3 stated she would like to have ice water. Interview on 10/24/24 at 2:20 P.M. with the Assistant Director of Nursing (ADON)/former Director of Nursing (DON) revealed she had received concerns from some staff and residents of ice water not being provided to the residents consistently and sometimes not until 1:00 P.M. on some days. Review of the facility policy titled, Hydration/Fresh Water and Fluids, dated November 2018, revealed it is the policy of this facility to offer each resident fluids daily. State-tested Nursing Assistant (STNA)s will provide fresh ice water to residents each shift. Repeat fresh water delivery as needed throughout the shift and upon request for fresh water. This deficiency represents non-compliance investigated under Complaint Number OH00158883.