STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. Building B. Wing	11/22/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of concern log and report, interview, and policy review the facility failed to ensure a resident was treated with respect and dignity. This affected one (Resident #4) of three residents reviewed for respect and dignity. Findings included: Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including but not limited to lymphedema, diabetes, neuropathy, depression, anxiety, and insomnia. Review of the facility's concern log and report dated 10/31/24 revealed Resident #4 reported to the Ombudsman that Agency Certified Nursing Assistant (CNA) #545 was engaging in a political view conversation and the resident had asked him to stop the conversation during care. The CNA had also stretched the resident's leg too far during care. The Assistant Director of Nursing (ADON) #153 spoke to CNA #545 and he recalled having a conversation months ago about politics but be thought they were just having fun because how blown up it all was now. The ADON educated the CNA not to provide care or engage with the resident and to assign another staff to his room assignment and education was provided to the CNA on 10/31/24 and 11/01/24 to avoid offensive conversations particularly religion/politics. There was no evidence the concern regarding the resident's leg being stretched was addressed. Review of Resident #4's progress notes dated 09/07/24 to 11/07/24 revealed no evidence of any incident involving Resident #4's and CNA #545 was documented. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/05/24 at 7:07 A.M., 11/06/24 at 7:42 A.M., and 11/13/24 at 7:30 A.M., with Resident #4 revealed an Agency CNA (CNA #545) did not treat him with respect and dignity recently and the facility permits the Agency CNA to work. The resident reported CNA #545 was providing care to him and was making comments about his music and saying the singers were witches, Satan, and belonged to cults. He made inappropriate comments about a singer. Then he started on him about voting for (a said presidential candidate). Resident #4 reported he kept telling CNA #545 he didn't want to discuss politics, and the staff member kept on and on and asking him if he was (a said presidential candidate) and told him he better not vote for (a said presidential candidate). CNA #545 then pulled his leg up to wash under it which was a very uncomfortable position for the resident and caused him pain the rest of the day. He has never had anyone left his leg to wash under it. Staff usually have him roll to his side to wash the back side of his body. The resident had reported his concerns to the Ombudsman and the ADON came and spoke to him. He told the ADON he preferred that CNA #545 not provide care to him anymore and the ADON kept asking if the facility hired CNA #545 full time, would he permit the CNA to provide care to him. The resident reported the ADON kept asking him the same question and he kept telling her No, he didn't want the CNA to provide care to him. Resident #4 reported he felt CNA #545 had mentally abused him related to the politics and music comments and physically abused him for raising his leg in a position that caused him increased pain. The facility didn't address his concern regarding the CNA lifting his leg. The ADON was just concerned about what would happen if they hired the CNA full-time, according to Resident #4. Interview on 11/05/24 at 8:25 A.M. with the Ombudsman revealed Resident #4 was upset and had reported concerns to her regarding CNA #545 discussing politics and music views. She had reported the concern to the Administrator and was told the Agency CNA would not be returning to the facility. Interview on 11/12/24 at 4:23 P.M., via email with the Director of Nursing (DON) revealed Resident #4 reported his concern to the ombudsman on 10/31/24 indicating issues with CNA #545 were not acute. The resident was assessed on 10/30/24 by the ADON and wound doctor and verbalized zero complaints of pain/discomfort at that time. The CNA provided a statement and education was provided on 11/01/24 and assignment changes per request. The ADON reassessed the resident on 11/06/24 with the wound doctor. An allegation of abuse was reported on 11/06/24 and a self-reported investigation (SRI) submitted, and investigation begun. Interview on 11/18/24 at 8:42 A.M., with the DON revealed the facility had completed the Abuse investigation and determined the allegation was not abuse. The Resident had perceived it as a respect and dignity issue. Review of the facility's policy titled Customer Service undated revealed every person in the facility deserves to be always treated with respect and dignity. No matter Who they were before they were here, once they come through our door, they are our resident or guest, and every staff person will treat them with respect. Always treat our residents as you would want them to treat you. Know each person's preference about care and ask them how they would like it done. Treat each person as an adult no matter what their cognitive function level is. All residents are entitled to self-choice-speak to the resident respectfully, explaining care as needed and giving the resident the chance to respond and to refuse. Be as gentle as possible-a resident may have pain, pain on movement, stiffness, fragile skin, etc. that was not apparent to you. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Resident Rights dated 06/01/24 revealed the resident had a right to be treated with respect and dignity. This deficiency represents non-compliance investigated under Master Complaint Number OH00159408 and Complaint Number OH00159399

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of the facility concern log, review of a facility soft file, interviews, and policy review the facility failed to ensure timely and appropriate efforts were implemented to achieve resolution regarding Ombudsman, resident representatives, and/or resident concerns. This had the potential to affect all 72 residents residing in the facility. Finding included: 1. Review of the facility's soft file related to the Ombudsman's concerns revealed on 09/05/24 at 3:00 P.M., the Ombudsman had visited, and she was here two weeks ago and had the same issues she had this day. Today's concerns include a resident was still not getting bologna sandwiches at bedtime, grilled cheese sandwiches and potatoes were burnt, call lights not being answered timely (worse on weekends), residents not getting what they asked for with meals, food over cooked, always available items not always available, and sheets not being changed on shower days. There was no documented evidence who attended the meeting. A meeting was held on 10/15/24 that included handwritten notes that Agency staff were not setting up meal trays, residents not getting milk, concern with changing linens, and call lights. There was no documented evidence who attended the meeting. An additional handwritten note with the Ombudsman's concerns dated 10/31/24 revealed they would like to meet the Director of Nursing (DON). There were concerns with Resident #68 that included receiving assistance with meal trays, not getting supplements, and barrier cream not always available. On Saturday (date not provided) residents didn't have new cups of ice water. Staff told residents they didn't have cups. No fruity pebbles, burnt food, linens not changed on shower days, call lights take 1/2 to one hour to be answered, issues with Direct TV channels, Resident #4 was uncomfortable about talking about politics with a staff member. It was not documented who attended the meeting. Interview on 11/05/24 at 8:25 A.M., with the Ombudsman revealed on 10/15/24 she had requested a meeting with Corporate Staff due to resident concerns (fresh water, bed linens, call lights, dietary concerns, medication administration, Hoyer lift education, etc.) she has reported to the facility staff (Administrator and previous DON, whom now is the Assistant Director of Nursing) and are not being addressed. The Ombudsman reported she tried reaching out to the new Director of Nursing (DON) however she has not been able to talk with her because she was either busy or in a meeting. The residents were still voicing concerns with not receiving fresh water, bed linens, dietary concerns, etc. as of today. The Ombudsman was having another care conference today with the facility due to Resident #68's family concerns from 09/17/24, that still have not been addressed to the family's or her satisfaction. She had requested Corporate Staff to attend this meeting as well. The facility was not addressing resident concerns she has reported over the last few months. 2. Review of Resident #68's care conference note in the electronic medical record dated 09/17/24 revealed concerns (meal tray preferences, boost time frames, medication, and staffing issues) were reviewed with the daughter, social worker, nursing administration, Administrator, and Ombudsman. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's soft file dated 09/17/24 revealed handwritten notes with a list of concerns including needs fed at all meals, if daughter not here, sometimes takes 30 plus minutes, if she eats less than 50% she gets a boost, always gets peanut butter and jelly (PBJ) sandwich with all meals, doesn't' like lemonade or OJ, never gets water on meal trays, doesn't' get hot tea, weekends no help with meals and eating, make sure aides notice thing on trays if missing, issues with constipation lately, making sure medication given daily, laid in bed for four days straight, needs twenty minutes to sit on bedside to have bowel movement, fresh new cups, floating heels daily, repositioning needs every two hours, missing two shirt protectors, therapy not updating, prune juice daily, hair washed once weekly, Hoyer lift training/education, and go to church on Sunday. There was an additional note that was labeled Ombudsman that indicated no improvement with ice water. Review of Resident #68's care conference note in the electronic medical record dated 11/05/24 revealed concerns reviewed included PBJ with all meals, audits to be done for ice water, up and down schedule, ancillary services, staffing, and boost instead of boost breeze. There was a handwritten note to add a peanut butter and jelly sandwich (PBJ) to all meals, ice water, up and down schedule, ancillary services, boost, and night managers. Review of the facility's soft file dated 11/05/24 revealed handwritten notes with a list of concerns including boost administration, magic cups not being substituted with mighty shakes, barrier cream availability, break down on heels, repositioning, education on Hoyer lift, call lights on chair and bed, not getting fresh cups and water, not getting help with meals, PBJ, still getting Lemonade, staffing issues, and ensure staff do bed baths instead of waiting on hospice. Interview on 11/05/24 at 8:25 A.M., with the Ombudsman revealed she had another care conference set up today for Resident #68 at 2:00 P.M. and had requested corporate staff to attend due to previous concerns from 09/17/24 involving Resident #68 and other resident concerns from 10/15/24 have not been addressed. The family had documentation and photos to support concerns. The resident needs assistance with meals and the family came in and the resident's meal tray was sitting next to her. The resident was supposed to have a supplement four times a day and it still wasn't being administered, the facility doesn't have barrier cream for the resident and all the residents had to share one tube of barrier cream. The nurse would give staff a medication cup with a small amount of barrier cream in it. The resident's daughter had photos of medication left on her beside table, and concerns medication not administered per orders. There were concerns of lack of communication with staff. The facility was to put a communication book together for the agency staff to know the resident's routines and likes but it was never done. The facility just put a turn schedule in the closet. The dietary staff were not reading the meal tickets and kept giving the resident lemonade when it's on her dislikes on the meal tickets. The family have concerns with ice water not being given. The family were told the facility was out of foam cups and the Administrator reported they had some, but agency staff don't know where they were at. Resident #68's daughter reported there were no cups this weekend after staff were supposed to be educated on where to find the cups. Resident #68s' family had concerns with improper use of the Hoyer lift and where afraid staff were going to break the resident's (recliner) chair. In the September meeting the Administrator was supposed to educate staff on the Hoyer lift but education was not provided. and said she thought the concern was staff was not washing the resident's hair. Even after having meetings nothing gets resolved. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/06/24 at 1:30 P.M., with Resident #68's daughter revealed she had a care conference 09/17/24, with the facility and again yesterday (11/05/24) and discussed the same concerns she had in September. The daughter reported she wasn't asking for much but felt like giving up and just going with it because it was a losing battle, and it could be worse. The family member shared text messages and photos from 07/26/24 to present between the Administrator, the DON (who is now the Assistant Director of Nursing), and herself. The messages included photos of pain patches that had not been changed for three days, pills found on the floor and bed in the resident's room, etc. The family showed pictures of meal tray not in reach, call light not in reach, fluids not in reach, heel boots not in-place, heels not elevated, alternative meals not provided per request, etc. The family also had meal tickets with notes they had kept supporting photos. The facility keeps sending Lemonade on her meal trays even though her meal ticket said no lemonade, the meal ticket indicated to provide water with each meal and the resident doesn't get it. Resident #68 doesn't' get fresh ice water, supplements as ordered, assistance with meals, nor does staff transfer her safely in a Hoyer lift, and she was afraid they were going to break the resident's recliner chair. Interview on 11/06/24 at 3:17 A.M., with Corporate Nurse (CN) #116 confirmed the facility had a general meeting in October with the Ombudsman to discuss general concerns. The facility had a meeting with Resident #68's daughter and the Ombudsman and had discussed concerns including assistance with meals, supplements, barrier cream, heel boots, call light, request to be up in chair, staff training on Hoyer lift, changing clothes, new chair, PBJ sandwich with each meal, ground meat, staff education on reading meal tickets, and having more staff on weekends. CN #116 reported the facility doesn't document every concern in the medical record and there should have been concern forms completed, however the general meeting in October with the Ombudsman was not documented on a concern form. She had educated Resident #68's family to report concerns in real time when the incidents occur to help the facility identify the problem. Some of the resolutions to the family's concerns were to administer boost four ounces seven times a day with meals and med pass. The facility ordered barrier cream that can be kept in the resident's room. Before it was a zinc product and could not be kept in the room. They are going to have two call lights one for the bed and one for the chair to help detect movement since the resident can't use the call light. Staff would be educated to provide care even if hospice was coming, staff would be trained on the Hoyer lift, a new broda chair for comfort was ordered by hospice, and staff would get the resident up more and during times the family requested. The order for the ground meat was corrected due to it was put in for a one-time order, the resident's meal ticket was updated, dietary would be educated, and the facility was going to add a weekend manager and/or late-night manager. Interview on 11/07/24 at 12:35 P.M., with the Director of Nursing (DON) revealed the facility was currently working on audits for supplements, unattended medications, meal preferences, ice water, and changing bed linens after a shower. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/12/24 at 11:09 A.M., with Resident #68's daughter revealed the concerns addressed in September and on 11/05/24 were still not addressed. The daughter provided photos that the heel boots nor was the resident's feet elevated while she was in bed over the weekend. The photos showed the boots sitting in the chair near the bed. The resident still didn't have barrier cream. The staff finally broke her mom's recliner due to not using the Hoyer correctly. The daughter demonstrated that one staff stands behind the recliner and leans over of the back of the recliner and grabs the Hoyer lift pad and pulls the resident back and lets her slide down the back of the recliner. The daughter reported the weight of the staff member leaning over the back of the recliner and resident's weight on the back of recliner back snapped the bars on the back of the recliner. The resident didn't get supplements twice over the weekend while she was visiting. During the last care conference on 11/05/24 her mom was to get seven small cups of boost (four times a day with her Tylenol and with each meal). She didn't' get fresh water on Saturday. The cup still had Friday's date and the same smiling face someone had drawn on the cup. The daughter shared a photo of the resident call light hanging off the bed over the weekend when she arrived. They still haven't brought the second call light for the recliner/chair as discussed in the meeting on 11/05/24. On Thursday she was left up six hours and was not checked and changed and she had confirmed that with one of aides. She has another care conference set up on 11/19/24 to follow up on concerns. Interview on 11/13/23 at 12:15 P.M., with the DON revealed she could not find any staff education regarding assisting residents with meals, whoever she provided education on 11/11/24 (after surveyor observed concern with resident not receiving assistance with lunch meal). The DON confirmed Resident #68 medication administration record had missing documentation that the supplements was administered. The maintenance director added a second call light in Resident #68's room today. There was no documented evidence staff were educated on the Hoyer lift and the staff did break the recliner over the weekend and the facility will replace the recline. The DON reported she was not aware staff were not implementing heel boots or elevating heels and would start audits. 3. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including but not limited to lymphedema, diabetes, neuropathy, depression, anxiety, and insomnia. Review of the facility's concern log and report dated 10/31/24 revealed Resident #4 reported to the Ombudsman that Agency Certified Nursing Assistant (CNA) #545 was engaging in a political view conversation and the resident had asked him to stop the conversation during care. The CNA had also stretched the resident's leg too far during care. The Assistant Director of Nursing (ADON) #153 spoke to CNA #545 and he recalled having a conversation months ago about politics but be thought they were just having fun because how blown up it all was now. The ADON educated the CNA not to provide care or engage with the resident and to assign another staff to his room assignment and education was provided to the CNA on 10/31/24 and 11/01/24 to avoid offensive conversations particularly religion/politics. There was no evidence the concern regarding the resident's leg being stretched was addressed. Review of Resident #4's progress notes dated 09/07/24 to 11/07/24 revealed no evidence of any incident involving Resident #4's and CNA #545 was documented. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/05/24 at 7:07 A.M., 11/06/24 at 7:42 A.M., and 11/13/24 at 7:30 A.M., with Resident #4 revealed an Agency CNA (CNA #545) did not treat him with respect and dignity recently and the facility permits the Agency CNA to work. The resident reported CNA #545 was providing care to him and was making comments about his music and saying the singers were witches, Satan, and belonged to cults. He made inappropriate comments about a singer. Then he started on him about voting for (a said presidential candidate). Resident #4 reported he kept telling CNA #545 he didn't want to discuss politics, and the staff member kept on and on and asking him if he was (a said presidential candidate) and told him he better not vote for (a said presidential candidate). CNA #545 then pulled his leg up to wash under it which was a very uncomfortable position for the resident and caused him pain the rest of the day. He has never had anyone left his leg to wash under it. Staff usually have him roll to his side to wash the back side of his body. The resident had reported his concerns to the Ombudsman and the ADON came and spoke to him. He told the ADON he preferred that CNA #545 not provide care to him anymore and the ADON kept asking if the facility hired CNA #545 full time, would he permit the CNA to provide care to him. The resident reported the ADON kept asking him the same question and he kept telling her No, he didn't want the CNA to provide care to him. Resident #4 reported he felt CNA #545 had mentally abused him related to the politics and music comments and physically abused him for raising his leg in a position that caused him increased pain. The facility didn't address his concern regarding the CNA lifting his leg. The ADON was just concerned about what would happen if they hired the CNA full-time, according to Resident #4. Interview on 11/05/24 at 8:25 A.M. with the Ombudsman revealed Resident #4 was upset and had reported concerns to her regarding CNA #545 discussing politics and music views. She had reported the concern to the Administrator and was told the Agency CNA would not be returning to the facility. Interview on 11/12/24 at 4:23 P.M., via email with the Director of Nursing (DON) revealed Resident #4 reported his concern to the ombudsman on 10/31/24 indicating issues with CNA #545 were not acute. The resident was assessed on 10/30/24 by the ADON and wound doctor and verbalized zero complaints of pain/discomfort at that time. The CNA provided a statement and education was provided on 11/01/24 and assignment changes per request. The ADON reassessed the resident on 11/06/24 with the wound doctor. An allegation of abuse was reported on 11/06/24 and a self-reported investigation (SRI) submitted, and investigation begun. Interview on 11/18/24 at 8:42 A.M., with the DON revealed the facility had completed the Abuse investigation and determined the allegation was not abuse. The resident had perceived it as a respect and dignity issue. Review of the facility's policy titled Customer Service undated revealed every person in the facility deserves to be always treated with respect and dignity. No matter Who they were before they were here, once they come through our door, they are our resident or guest, and every staff person will treat them with respect. Always treat our residents as you would want them to treat you. Know each person's preference about care and ask them how they would like it done. Treat each person as an adult no matter what their cognitive function level is. All residents are entitled to self-choice-speak to the resident respectfully, explaining care as needed and giving the resident the chance to respond and to refuse. Be as gentle as possible-a resident may have pain, pain on movement, stiffness, fragile skin, etc. that was not apparent to you. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled Resident Rights dated 06/01/24 revealed the resident had a right to be treated with respect and dignity. This deficiency represents non-compliance investigated under Master Complaint Number OH00159408 and Complaint Number OH00159399.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 controlled drug receipts, review of the medication administration audit report, review of controlled medication shift change logs, review of staff schedules, review of the facility investigation, review of a self-reported incidents (SRI), interviews, and policy review the facility failed to ensure resident narcotics were not misappropriated. This affected four (Resident #7, #12, #51, and #56) of five records reviewed for misappropriation. The facility had identified 46 residents (#2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14, #15, #16, #19, #21, #22, #23, #24, #24, #26, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #42, #48, #51, #52, #53, #54, #55, #56, #57, #58, #500, and #501) that had medication/treatment errors. The facility identified eight residents affected by misappropriation (#7, #12, #13, #16, #21, #22, #31, and #37). Findings included: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the mouth and tongue, dysphagia, and gastrostomy. Review of Resident #51's medication administration record (MAR) and orders dated 11/2024 revealed the resident was ordered Oxycodone 10 milligrams (mg) one tablet via nasogastric (NG) tube every four hours (midnight, 4:00 A.M., 8:00 A.M., noon, 4:00 P.M., and 8:00 P.M.). On 11/07/24 Agency Registered Nurse (ARN) #700 administered an Oxycodone 10 mg at midnight, 4:00 A.M., 8:00 A.M., noon. On 11/09/24 ARN #700 administered one dose of Oxycodone 10 mg at 8:00 A.M. Review of Resident #51's medication administration audit report dated 11/06/24 to 11/08/24 revealed ARN #700 had signed off she administered Oxycodone 10 mg on 11/07/24 at midnight, 4:57 A.M., 8:25 A.M., and 12:17 P.M. On 11/09/24 ARN #700 had only administered one dose of Oxycodone 10 mg at 8:39 A.M. Review of Resident #51's controlled drug receipts for Oxycodone 10 mg revealed on 11/07/24 ARN #700 signed out #26 of Oxycodone 10 mg on 11/07/24 the time was not legible, #25 on 11/07/24 time was not legible, #24 at 5:30 A.M., #23 at 8:00 A.M., and #22 at noon. The ARN #700 had removed five doses in twelve hours (midnight to noon) and the resident was only ordered four doses from midnight to noon (midnight, 4:00 A.M., 8:00 A.M., and noon). On 11/09/24 ARN #700 had removed #11 of the Oxycodone at 8:00 A.M., #10 at 11:00 A.M., and #9 2:00 P.M. from the controlled drug receipt. The resident was not due or ordered Oxycodone at 2:00 P.M. There was no evidence ARN #700 had documented the 11:00 A.M. or the 2:00 P.M. dose on the MAR. Review of Agency Licensed Practical Nurse (LPN) #503's statement dated 11/09/24 revealed she had taken over ARN #700's medication cart at 2:00 P.M. Upon taking over med cart, this nurse noticed that medications had been signed out in the MAR but were not given as they were still present in the medication cart. Medication was also signed out in the narcotic accountability log, however, were not signed out on the MAR. (continued on next page)

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	365770	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #114 revealed on 11/09/24 there was an incident with ARN #700 and the ARN left around 2:00 P.M. Another agency nurse (Licensed Practical Nurse #503), who was working as an aide that day, took over the medication cart. LPN #503 had noticed Resident #51's scheduled medication were signed off as administered, however his bag of medication was still in the cart, except for the Oxycodone. The control sheet indicated Resident #51 had three Oxycodone removed on 11/09/24 and ARN #700 had signed out one at 2:00 P.M., however she didn't have access to the cart at that time and she didn't document all the Oxycodone doses on the MAR. The LPN #114 and #503 went to speak to the Resident #51 and he had confirmed ARN #700 had only been in his room twice that day and confirmed ARN #700 had only flushed his g-tube twice and there was no way she administered three Oxycodone. The resident was not sure what medication ARN #700 had given him due to his medication were crushed and administered in his tube. Interview on 11/13/24 at 4:21 P.M., with Resident #51 confirmed he did not receive three Oxycodone on 11/09/24 from ARN #700 due to she had only administered medication/flushed his tube twice that morning. The resident was not sure which medication, if any, was administered that day due to medication were administered via his g-tube. The resident recalled having pain in his mouth/face that day. Interview on 11/18/24 at 4:17 P.M. with the Director of Nursing (DON) and Corporate Nurse (CN) #116 verified the MAR and the controlled drug receipts for the Oxycodone entries. 2. Medical record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses including depression, post-traumatic stress disorder, migraines, sleep apnea, and panic disorder. Review of Resident #56's MAR and orders dated 11/2024 revealed the resident was ordered Ativan 0.5 mg twice daily (rise and bedtime) and one as needed every 24 hours for anxiety. The resident received the rise and bedtime dose on 11/09/24 and didn't receive any as needed Ativan on 11/09/24. Review of Resident #56's controlled drug receipts dated 10/24/24 revealed the pharmacy had sent 60 tablets of Ativan 0.5 mg. The last dose signed out was 11/09/24 at 9:13 A.M. leaving one Ativan remaining in the narcotic card. Review of Resident #56's-controlled drug receipts dated 11/07/24 revealed the pharmacy had sent 60 tablets of Ativan 0.5 mg. The first dose was signed out 11/09/24 at 9:00 P.M. Review of the controlled medication shift change log for Southeast medication cart dated 11/06/24 to 11/15/24 revealed no evidence ARN #700 had reconciled the controlled medication count with LPN #503, who resumed responsibility for the medication at 2:00 P.M. per LPN #503's statement. Further review ARN #700 had removed an Ativan 0.5 mg card from the cart on 11/09/24 and didn't have a second signature. There should have one Ativan remaining in the card per the controlled drug receipt form. Review of Resident #56's statement dated 11/09/24 revealed the resident reported she was unsure if she received her medication as ordered. There was no evidence of a follow up interview. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #114 revealed on 11/09/24 there was an incident with ARN #700 and the ARN left around 2:00 P.M. Residents were voicing they didn't receive medication and when staff reconciled the controlled medication counts, they found discrepancies. Resident #56 had requested to talk to the Agency nurse because she thought she gave her a Melatonin instead of her Ativan. LPN #114 reported Resident #56 was alert and oriented and knew her medications. Interview on 11/13/24 at 4:23 P.M. and 11/18/24 at 8:39 A.M. with Resident #56 confirmed on Saturday 11/09/24 she didn't receive her as needed Ativan upon request from the tall agency nurse. Interview on 11/18/24 at 3:28 P.M. with the DON and CN #116 verified there was an unaccounted-for Ativan that was removed from the medication cart, no reconciliation of the narcotics completed when ARN #700 left and LPN #503 assumed responsibility of the cart. Lastly, they verified ARN #700 removed the card of Ativan from the medication cart without a second nurse to witness the removal which is a facility requirement. 3. Medical record review revealed Resident #12 was admitted to the facility 12/11/22 with diagnoses including Huntington's disease, aphasia, and heart failure. Review of Resident #12's MAR and orders dated 11/2024 revealed the resident was ordered Percocet 5-325 mg one tablet every eight hours as needed for pain. The resident had received one dose on 11/07/24 at 11:18 A.M., that was administered by ARN #700. Review of Resident #12's Percocet 5/325 mg-controlled drug receipt dated 08/07/24 revealed the pharmacy had dispensed 10 pills. ARN #700 signed out #2 on 11/24 (documented as written, no year provided) at 11:18 A.M and 11/24 (documented as written; no year provided) at 8:00 A.M. Prior to ARN #700 signing out the Percocet the resident last dose was administered on 09/29/24. Review of Resident #12's second Percocet 5/325 mg-controlled drug receipt dated 08/15/24 revealed the Pharmacy dispensed 60 pills. ARN #700 had signed out on 11/08 (no year documented) at 10:00 A.M., 11/09 (no year documented) at 7:15 A.M., and 11/09 (no year documented) at 1:00 P.M. Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #114 revealed on 11/09/24 there was an incident with ARN #700 and the ARN left around 2:00 P.M. Residents were voicing they didn't receive medication and when staff reconciled the controlled medications, they found discrepancies. When she was re-reconciling narcotics on Northeast cart, they noticed Resident #12 had four Percocet removed. Interview on 11/13/24 at 4:27 P.M, with Resident #12 revealed he doesn't take pain medication, nor does he have pain Interview on 11/18/24 at 8:30 A.M, with Agency LPN #518 confirmed the resident has not voiced any concerns including pain and has never requested pain medication. Interview on 11/18/24 at 8:35 A.M., with Certified Nursing Aide (CNA) #149 confirmed the resident never reports or request pain medication. The resident had surgery a few months ago and was in some discomfort but has recovered. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/18/24 at 3:28 P.M., with the DON and CN #116 confirmed during the SRI investigation the facility had identified there was four of the five Percocet's for Resident #12 that were not documented on the MAR. The facility would replace the four Percocet's that were not documented on the MAR. ARN #700 only documented one Percocet on 11/07/24 at 11:17 A.M. 4. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including diabetes, osteoarthritis, restless leg syndrome, carpal tunnel, cervicalgia, muscle spasm, osteoporosis, and polyneuropathy. Review of Resident #7's MAR and orders dated 11/2024 revealed Percocet 5-325 mg every eight hours as needed for pain for 30 days and scheduled twice daily (rise and bedtimes). On 11/09/24 the resident received a onetime order for Percocet that was administered at 3:08 P.M. on 11/09/24. The resident did not receive the as needed Percocet on 11/09/24. Review of Resident #7's Percocet 5/325 mg-controlled drug receipt dated 11/08/24 to 11/12/24 revealed ARN #700 removed #28 at 11:00 A.M. and #27 at noon. Review of unwitnessed statement dated 11/09/24 revealed the DON took a verbal statement from Resident #7 on 11/09/24 that indicated on 11/09/24 she waited, and waited, and waited for her morning medication and lunch time came. The nurse (ARN #700) pulled the medication cart and parked it in front of the door. She took scissors, opened them up (medication packet) she was in the drawer popping staff in her mouth, looked like it was from the left-hand side where the narcs are. I couldn't tell if she was talking to someone else because she said, hey girl she took off down the hallway leaving the cart blocking the doorway. My eyes aren't great. I pushed the cart out of my way. She came back and took the cart up to the nurse's station, I followed her. She asked if I was going to smoke, and I said no I want my meds. You said you were going to give me my meds. She gave me my meds. I looked at my meds and my Percocet was not in there. I didn't say anything to her about my Percocet missing. I know why my Percocet looks like, they are white and round. Review of the MAR revealed several missing med administrations for the 11/09/24. The resident had a onetime dose of Percocet given at 3:08 P.M. for pain rated a 10 on a 0-10 pain scale. Interview on 11/12/24 at 9:00 A.M and 10:02 A.M., with Resident #7 revealed on Saturday 11/09/24 she didn't receive her medication as ordered. She waited all morning for her medication and finally the nurse came to her room and placed the medication in the doorway. The nurse (ARN #700) took three pills out of the narcotic box and put them in her mouth. The resident reported by that time she was in so much pain from recently fracturing her sternum she didn't know what to do. The nurse then put something in her bra and walked away leaving the medication cart in her doorway. The nurse returned and started to walk up the hallway. She asked the nurse for her meds, and she told her NO. The resident reported she followed the nurse up the hall because she needed her medications. The nurse finally gave her medication except for the Percocet. She observed the nurse trying to give another resident the wrong medication and then another resident reported he didn't get his Neurontin. She knew something was not right, so she reported her concerns to staff. Interview on 11/12/24 at 12:29 P.M, with the DON revealed the facility initiated on SRI for misappropriation on 11/10/24. Resident #7 had voiced concerns she didn't receive her Percocet and staff noticed discrepancies when they reconciled the controlled medications. The facility called the physician and received a onetime order for Percocet for pain for Resident #7. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #114 revealed on 11/09/24 there was an incident with ARN #700 and the ARN left around 2:00 P.M. Resident #7 reported to nursing staff she didn't get her Percocet that morning. Resident #7 was alert and oriented and knew her medications. Interview on 11/18/24 at 3:28 P.M., with the DON and CN #116 confirmed during the SRI investigation the facility had identified there were two Percocet's on 11/09/24 at 11:00 A.M. and 12:00 P.M., that were not documented on the MAR and the resident confirmed she did not receive her Percocet. The facility would replace the two Percocet. 5. Review of the facility's SRI #253897 dated 10/10/24 revealed on 10/09/24 there was an allegation ARN #700 had misappropriate controlled medications for eight residents (#7, #12, #13, #16, #21, #22, #31, and #37). The perpetrator was suspended immediately, residents interviewed and assessed who could have been affected, staff statements obtained, local police department notified, staffing agency notified. Alerted by staff that they had concerns with the nurse's demeaner. The nurse was suspended and police notified. A drug screen was completed with negative results. Investigation was started with resident interviews where concerns were noted with medication discrepancies with documentation and concerns with residents stating they did not receive their medications. No witnesses to the event or concerns. Nurse denied any wrongdoing. All resident responsible parties were made aware of the situation with no further concerns. Allegations reported to the local police department, staffing agency, medical board, board of nursing, and board of pharmacy. As a result of the investigation the facility cannot conclude misappropriation occurred. Due to the process breakdown and lack of documentation the investigation was inconclusive at this time. The perpetrator stated no wrongdoing and had negative drug screen results. Review of the DON's undated timeline for 11/09/24 revealed at 1:19 P.M. she was notified by LPN #114 that ARN #700 was falling asleep. At 1:24 P.M. the DON spoke to the ADON and agreed to send ARN #700 home. At 2:20 P.M., the DON received notification from LPN #114 that there were medication discrepancies. The medication count was correct, but concerns with accuracy of how medication were signed off and resident's were verbalizing not receiving pain medication. At 2:23 P.M., the administrator was called and discussed calling 911 for evaluation. At 2:30 P.M. ARN #700 was in the facility parking lot. Staff were directed to get license plate number and at 2:36 P.M. reported to police; At 2:43 P.M. spoke to ARN #700 but had to hang up related to the police calling back; At 2:48 P.M. the police department phoned the DON and stated she was no longer at the facility. At 2:49 P.M. the DON phoned ARN #700 back to determine her location. At 2:53 P.M. the DON called the police department back to communicate. At 2:57 P.M., the DON phoned the corporate clinician to update on the situation and drove to the facility to begin the investigation. Review of Resident statements dated 11/09/24 revealed 15 residents voiced concerns they didn't receive medication as ordered. Resident reported the nurse was sleepy, gripey, firm, giving the impression not to cross her, argumentative, refusing to recheck blood pressure, and yelled NO when asked to recheck blood pressure, kept hiccupping like she drank too much alcohol, eyes rolling in her head, talking and laughing to self, acting strange, acted like she was on cloud nine, out in out space, acting weird, and smart mouth. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of LPN #102 written statement dated 11/09/24 revealed she had noticed the agency nurse appeared impaired and Resident #7 didn't think she received her pain medications. LPN #103 recounted the narcotics with LPN #102, and they noticed the agency nurse had signed out several doses of Percocet, however they were not signed out correctly, not dated or timed properly. Review of LPN #103's written statement dated 11/09/24 revealed the agency nurse approached the nurse and asked for Tylenol for a headache. LPN #103 gave her Excedrin, and the agency nurse picked up the Tylenol 500 mg bottle and poured some in her hands and went down the northeast hall. Later when doing count with LPN #102 in the top of Northeast medication cart we witnessed three Tylenol 500 mg round white pills. LPN #102 looked them up on her phone to verify. Review of CNA #131's written statement undated revealed on 11/08/24 the nurse seemed to be sleepy while doing medication pass. Around 11:30 P.M.-12:00 A.M. Resident #37 came to the desk and asked for his as needed medication. The nurse told him that she had given him his as needed medication around 8:00 P.M. They started arguing and the resident was very persistent that she didn't get his as needed medication. Review of CNA #124's written statement dated 11/09/24 revealed Resident #31 rang her call light and said she chewed her pill, and it tasted different. In an hour she wanted me to come back and check on her because she was really worried it wasn't the right pill. The CNA told the other nurse because it really worried her, and we continued to watch her. Resident #22 thought she didn't get her as needed medication and wanted the CNA to check with nurse twice. Resident #37 stated he didn't get his as needed medications. Review of ARN #700's statement dated 11/13/24 revealed she was writing a statement to address the recent allegation of medication diversion on 11/09/24 from 6:00 A.M to 2:00 P.M. On the day in question the night before she had worked 6:00 P.M. to 1:00 A.M. and had to be back up at 6:00 A.M. to work on the floor. She was very tired and sleepy the next morning, but she needed to work that shift for an important bill she had to pay as soon as possible. In hindsight, she didn't get enough rest the night before and should have called off for the 6:00 A.M. shift. She affirmed she did not engage in any form of diversion. Review of ARN #700's time sheet dated 11/06/24 to 11/09/24 revealed on 11/06/24 the nurse clocked in at 6:57 P.M. and clocked out 6:00 A.M., on 11/08/24 the nurse clocked in at 6:21 A.M. and clocked out at 12:27 A.M., and 11/09/24 the nurse clocked in at 6:19 A.M. and clocked out at 2:21 P.M. Review of LPN #114's statement undated revealed ARN #700 kept falling asleep at the medication cart. LPN attempted to inform the ARN of issues with her residents but the ARN would not answer. The nurse would not make eye contact with the nurse. The ARN could not walk straight down the hallway and kept swaying. LPN #114 did count with both LPN #103 and LPN #503. ARN had to correct count on Northeast medication cart. Review of a written statement by an unknown author dated 11/09/24 revealed the writer was working on North Hall. The Agency Nurse ARN #700 was falling asleep standing up at the medication cart. She was swerving while walking and slurring her speech. The writer had many complaints from residents that they didn't receive their medications. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/13/24 at 1:51 P.M., with Dietary Aide (DA) #701 revealed on Saturday (11/09/24) ARN #700 was in the hall looking for the biohazard room. DA went to show ARN where the biohazard room was located. The nurse placed her trash in the biohazard ben and then she fell back against the wall and slid down the wall and her eyes rolled back into her head. The nurse then stood up and asked where a resident was so she could administer her medications. The DA directed the nurse to the resident. The nurse gave the resident her pills whole, and she required her pills to be crushed. The resident still had the whole pills in her mouth and the nurse left. The DA went and got the resident a shake so she could swallow her pills. The DA told a Certified Nurse's Aide (CNA) #143 what happened, and she advised the DA to report her concerns to the nurse (LPN #114) The ARN was fine at the beginning of the shift. The DA also called the Administrator to report the incident. The staff started counting narcotic and residents started complaining they never got their medications. The staff tried to keep ARN in the building, but the nurse must have overheard staff talking about calling the police and she said, I'm not staying. Staff was worried for resident safety and there were several kids who play on the street near the facility. They didn't want ARN #700 driving. Interview on 11/13/24 at 2:35 P.M., with LPN #114 revealed ARN #700 worked Friday (11/08/24) 6:00 P.M to midnight and returned the next day (11/09/24) at 6:00 A.M. and was to work till 6:00 P.M. During morning report the nurse kept talking about how tired she was. ARN #700 passed her medication on the front hall and went back to the back hall to pass medication. CNA #130 had reported that ARN #700 was not acting right and was nodding off at the nurse's station. Around 1:00 P.M. LPN #114 called the DON and wanted to know what she wanted her to do. LPN #114 reported originally, she didn't witness the nurse nodding off, but after talking with the DON she noticed the nurse nodding off and a family member noticed the nurse nodding off and was inquiring what was going on. She still thought ARN #700 was just tired. She was directed to pull LPN #503 who was working as an aide to replace ARN #700. She told ARN #700 that they were over staffed and since she worked last night she could leave. ARN #700 reported she was staying till at least 2:00 P.M. LPN #114 reported it was already 1:40 P.M., so she instructed ARN #700 to do narcotic count and give report and it would be around 2:00. ARN #700 took off and went to the bathroom and didn't' give LPN #503 the keys to the medication cart. The next thing they knew ARN #700 was on the other side building counting with LPN #103. LPN #103 only saw a date that was wrong but no discrepancy in the count. Then later when herself and LPN #103 were reconciling narcotics LPN #103 realized four pills were gone for Resident #12 and other issues. Residents started voicing concerns they didn't receive medications. She tried to keep ARN #700 from driving, but the nurse reported Honey, I'm fine. ARN #700 would not make eye contact with her. Interview on 11/18/24 at 7:27 A.M., with Resident #31 revealed she had concerns last week ARN #700 didn't give her prn Oxycodone. The medication the nurse gave her tasted metallic which was not normal. She had reported her concerns to CNA #124, which she must have reported to the DON. The resident reported she trusted ARN #700 was going to give her the correct medications. Interview on 11/18/24 at 3:28 P.M., with the DON and CN #116 confirmed there was a breakdown in the system to prevent drug diversion. The facility could not determine ARN #700 had misappropriated the medication, however the facility could confirm there were narcotics that were missing. The DON and CN #116 confirmed ARN #700's written statement was not obtained until 11/13/24 and she was not drug screened until 11/12/24, which was three days after the allegation/suspicion. The Board of Nursing and Pharmacy were not notified until 11/15/24. The facility had originally identified eight residents that narcotics were misappropriate, however three more residents were identified after the investigation was completed and 46 residents with medication/treatment errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Abuse, Neglect, and Exploitation dated 01/01/24 revealed the facility provides protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. The facility would develop and implement written policies and procedures that would prohibit and prevent misappropriation of resident's property. The facility would provide ongoing oversight and supervision of staff in order to assure that it polices are implemented as written. Background, references, and credential checks shall be conducted on contracted temporary staff and consultants. The facility would maintain documentation of proof that the screening occurred. The facility would assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms. Reporting all alleged violations to the state agency and all other required agencies immediately, but no later than two hours if the event that cause the allegation involves abuse or results in serious bodily injury or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This deficiency represents non-compliance investigated under Master Complaint Number OH00159408 and Complaint Number OH00159399.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 32801 Based on personnel file review, review of the facility Bureau of Criminal Identification (BCI) log, review of employee time sheets, interview, and policy review the facility failed to ensure staff were not permitted to work in a direct care capacity with a disqualifying offense. This had the potential to affect all 72 residents residing in the facility. Findings included: An anonymous concern made on 11/12/24 revealed the Administrator employed staff with criminal backgrounds (felony). This concern was investigated as part of the onsite complaint survey. Review of Certified Nursing Assistant (CNA) #702's application dated 08/12/24 revealed CNA #702 had checked yes to having been convicted or pled guilty to a crime. The CNA documented on the application she had a felony on 07/07/24 in (location) county. The CNA's at the facility work history included she worked as an CNA in a skilled nursing facility from 12/23/23 until 07/03/24. Review of the facility BCI log dated 04/17/24 to 11/11/24 revealed CNA #702 was hired on 08/13/24 and the BCI was submitted on 08/13/24. There was no documented evidence when the BCI report was received, however the background check was documented as being completed on 08/29/24. The log noted the employee was not hired using the personal character standards. The log further noted the employee was terminated for a disqualifying offense that required termination. Review of CNA #702's time sheet revealed the employee worked (providing direct resident care) on 09/08/24 from 6:00 A.M. to 6:15 P.M. and on 09/09/24 from 5:45 A.M. to 3:00 P.M. (after BCI results were completed and the employee was determined to have a disqualifying offense that required termination). Interview on 11/18/24 at 4:42 P.M., with the Administrator confirmed the BCI log did not indicate when the facility received the BCI results, however the log indicated the check was completed on 08/29/24. The facility was unable to provide written evidence as to when the results were actually received. The Administrator confirmed CNA #702 worked on 09/08/24 and 09/09/24 after the BCI was completed on 08/29/24 with a disqualifying offense that required termination. The Administrator also verified CNA #702 documented on her application she had been convicted of or plead guilty to a felony on 07/07/24. Review of the facility's policy titled Background Screening Investigation dated 11/2015 revealed the facility conducts employment background screening checks, references, and criminal conviction investigation checks on direct access employees. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual had been convicted of abuse, neglect, mistreatment of individuals, or theft of property, the applicant would not be employed and/or would be terminated from employment. This deficiency represents non-compliance investigated under Complaint Number OH00159408.

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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 controlled drug receipts, review of the medication administration audit report, review of controlled medication shift change logs, review of staff schedules, review of the facility investigation, review of a self-reported incidents (SRI), interviews, and policy review the facility failed to thoroughly investigate an allegation of misappropriation. This affected two resident (#51, #56) of five residents reviewed for misappropriation. The facility census was 72. The facility identified eight residents affected by misappropriation (#7, #12, #13, #16, #21, #22, #31, and #37). Findings included: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the mouth and tongue, dysphagia, and gastrostomy. Review of Resident #51's medication administration record (MAR) and orders dated 11/2024 revealed the resident was ordered Oxycodone 10 milligrams (mg) one tablet via nasogastric (NG) tube every four hours (midnight, 4:00 A.M., 8:00 A.M., noon, 4:00 P.M., and 8:00 P.M.). On 11/07/24 Agency Registered Nurse (ARN) #700 administered an Oxycodone 10 mg at midnight, 4:00 A.M., 8:00 A.M., noon. On 11/09/24 ARN #700 administered one dose of Oxycodone 10 mg at 8:00 A.M. Review of Resident #51's medication administration audit report dated 11/06/24 to 11/08/24 revealed ARN #700 had signed off she administered Oxycodone 10 mg on 11/07/24 at midnight, 4:57 A.M., 8:25 A.M., and 12:17 P.M. On 11/09/24 ARN #700 had only administered one dose of Oxycodone 10 mg at 8:39 A.M. Review of Resident #51's controlled drug receipts for Oxycodone 10 mg revealed on 11/07/24 ARN #700 signed out #26 of Oxycodone 10 mg on 11/07/24 the time was not legible, #25 on 11/07/24 time was not legible, #24 at 5:30 A.M., #23 at 8:00 A.M., and #22 at noon. The ARN #700 had removed five doses in twelve hours (midnight to noon) and the resident was only ordered four doses from midnight to noon (midnight, 4:00 A.M., 8:00 A.M., and noon). On 11/09/24 ARN #700 had removed #11 of the Oxycodone at 8:00 A.M., #10 at 11:00 A.M., and #9 2:00 P.M. from the controlled drug receipt. The resident was not due or ordered Oxycodone at 2:00 P.M. There was no evidence ARN #700 had documented the 11:00 A.M. or the 2:00 P.M. dose on the MAR. Review of Agency Licensed Practical Nurse (LPN) #503's statement dated 11/09/24 revealed she had taken over ARN #700's medication cart at 2:00 P.M. Upon taking over med cart, this nurse noticed that medications had been signed out in the MAR but were not given as they were still present in the medication cart. Medication was also signed out in the narcotic accountability log, however, were not signed out on the MAR. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility SRI Tracking Number 253897 investigation undated revealed the facility only identified that ARN #700 did not sign administration on the MAR for Resident #51's Oxycodone on 11/17/24 at 2:00 A. M., 11/19/24 at 8:00 A.M., 11:00 A.M. and 2:00 P.M. The facility did not identify the discrepancies on 11/07/24 when the resident received an extra dose of Oxycodone on 11/07/24 at 5:30 A.M. nor did the facility identify the resident was not ordered a 2:00 P.M. of Oxycodone, however ARN #700 signed out an Oxycodone at 2:00 P.M. on 11/09/24. Review of Resident #51's statement dated 11/09/24 revealed when asked if he received his medication as ordered he had responded he only had two feedings. There was no evidence an additional statement was obtained for clarification. Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #114 revealed on 11/09/24 there was an incident with ARN #700 and the ARN left around 2:00 P.M. Another agency nurse (Licensed Practical Nurse #503), who was working as an aide that day, took over the medication cart. LPN #503 had noticed Resident #51's scheduled medication were signed off as administered, however his bag of medication was still in the cart, except for the Oxycodone. The control sheet indicated Resident #51 had three Oxycodone removed on 11/09/24 and ARN #700 had signed out one at 2:00 P.M., however she didn't have access to the cart at that time and she didn't document all the Oxycodone doses on the MAR. The LPN #114 and #503 went to speak to the Resident #51 and he had confirmed ARN #700 had only been in his room twice that day and confirmed ARN #700 had only flushed his g-tube twice and there was no way she administered three Oxycodone. The resident was not sure what medication ARN #700 had given him due to his medication were crushed and administered in his tube. Interview on 11/13/24 at 4:21 P.M., with Resident #51 confirmed he did not receive three Oxycodone on 11/09/24 from ARN #700 due to she had only administered medication/flushed his tube twice that morning. The resident was not sure which medication, if any, was administered that day due to medication were administered via his g-tube. The resident recalled having pain in his mouth/face that day. Interview on 11/18/24 at 4:17 P.M., with the Director of Nursing (DON) and Corporate Nurse (CN) #116 confirmed the facility had not identified ARN #700 had signed out a dose on 11/07/24 at 5:30 A.M. that was not documented on the MAR and ARN #700 had documented she administered a 2:00 P.M. dose on 11/09/24 when the resident was not due for an Oxycodone. CN #116 reported they would add Resident #51 to the SRI for misappropriation for the 5:30 A.M. dose on 11/07/24 and the 2:00 P.M. dose on 11/09/24. 2. Medical record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses including depression, post-traumatic stress disorder, migraines, sleep apnea, and panic disorder. Review of Resident #56's MAR and orders dated 11/2024 revealed the resident was ordered Ativan 0.5 mg twice daily (rise and bedtime) and one as needed every 24 hours for anxiety. The resident received the rise and bedtime dose on 11/09/24 and didn't receive any as needed Ativan on 11/09/24. Review of Resident #56's controlled drug receipts dated 10/24/24 revealed the pharmacy had sent 60 tablets of Ativan 0.5 mg. The last dose signed out was 11/09/24 at 9:13 A.M. leaving one Ativan remaining in the narcotic card. Review of Resident #56's-controlled drug receipts dated 11/07/24 revealed the pharmacy had sent 60 tablets of Ativan 0.5 mg. The first dose was signed out 11/09/24 at 9:00 P.M. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled medication shift change log for Southeast medication cart dated 11/06/24 to 11/15/24 revealed no evidence ARN #700 had reconciled the controlled medication count with LPN #503, who resumed responsibility for the medication at 2:00 P.M. per LPN #503's statement. Further review ARN #700 had removed an Ativan 0.5 mg card from the cart on 11/09/24 and didn't have a second signature. There should have one Ativan remaining in the card per the controlled drug receipt form. Review of the facility SRI investigation revealed no evidence the facility had identified the discrepancy regarding the one missing Ativan 0.5 mg on 11/09/24. The controlled medication sift change log was not a part of the facility's investigation. Review of Resident #56's statement dated 11/09/24 revealed the resident reported she was unsure if she receives her medication as ordered. There was no evidence of a follow up interview. Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #114 revealed on 11/09/24 there was an incident with ARN #700 and the ARN left around 2:00 P.M. Residents were voicing they didn't receive medication and when staff reconciled the controlled medication counts, they found discrepancies. Resident #56 had requested to talk to the Agency nurse because she thought she gave her a Melatonin instead of her Ativan. LPN #114 reported Resident #56 was alert and oriented and knew her medications. Interview on 11/13/24 at 4:23 P.M. and 11/18/24 at 8:39 A.M. with Resident #56 confirmed on Saturday 11/09/24 she didn't receive her as needed Ativan upon request from the tall agency nurse. Interview on 11/18/24 at 3:28 P.M. with the DON and CN #116 verified there was an unaccounted-for Ativan that was removed from the medication cart, no reconciliation of the narcotics completed when ARN #700 left and LPN #503 assumed responsibility of the cart. Lastly, they verified ARN #700 removed the card of Ativan from the medication cart without a second nurse to witness the removal which is a facility requirement. Interview on 11/18/24 at 3:28 P.M., with the DON and CN #116 confirmed the facility didn't identify the discrepancy with Resident #56's missing Ativan during their investigation, however they would add it to the misappropriation investigation for ARN #700. Review of the facility's policy titled Abuse, Neglect, and Exploitation dated 01/01/24 revealed the facility provides protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation. This deficiency represents non-compliance investigated under Master Complaint Number OH00159408 and Complaint Number OH00159399.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed record review, review of hospital records, review of hearing results, review of the facility assessment, interviews, and policy review the facility failed to ensure Resident #1 was permitted to return to the facility after an emergency room evaluation. This affected one resident (Resident #1) of three residents reviewed for discharge. Findings included: Closed record review revealed Resident #1 was originally admitted to the facility on [DATE] and discharged with anticipated return on 08/22/24. The resident was readmitted on [DATE] and discharged [DATE]. The resident's diagnoses included encephalopathy, hallucination, disorientation, hypothyroidism, tension headaches, absence of larynx and history of larynx, thyroid, and brain cancer. Review of Resident #1's preadmission screening and resident review (PASARR) dated 08/26/24 revealed the resident hallucinated that caused functional limitations. The resident was receiving anti-psychotics. A referral was made for a level II evaluation. Review of Resident #1's level II results dated 09/10/24 revealed the resident had a diagnosis of psychotic disorder due to hallucinations. The resident's care needs were appropriate to be serviced in any nursing facility setting. The resident required hands on assist with mobility, grooming, toileting, dressing, eating, bathing and hands on assistance for all instrumental activities of daily living (IADL). The resident required care for tracheostomy, intravenous fluids, and 24/7 supervision for safety. The results revealed the nursing facility was required to provide behavioral health services including a comprehensive psychiatric assessment in order to identify behavioral health supports and services that would help mitigate psychotic decompensation and improve quality of life. A behavior management safety plan to decrease inappropriate behaviors and ensure safety. Yearly comprehensive psychiatric evaluation to clarify current psychiatric diagnosis and appropriate treatment. Ongoing evaluation of the effectiveness of current psychotropic medication on target symptoms. Ongoing medication review by a psychiatrist or similar-credentialed professional. The reason for the services were to promote the best quality of life, ongoing medication review to ensure your psychiatric conditions are treated appropriately and a behavior management safety plan addressing your physical aggression. Other recommended services the resident would need to be provided to optimize the resident's health and wellness included informal support from the nursing facility staff, medication evaluation and monitoring for the nursing home designated physician, socialization and recreation activities to decrease isolation, improve mood, and increase peer interactions, respiratory evaluation, family involvement in the individual's care. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's admission assessment with baseline care plan dated 10/07/24 revealed the resident arrived via stretcher from the hospital. The resident had cognitive ability to be oriented to room/surroundings. The resident had speech he used when he chooses to, however frequently foregos verbal communication. He was alert to person only and had impaired cognition or decision-making skills. Interventions included to encourage resident to make routine daily decisions, administer medication as ordered, anticipate needs, communicate with staff, family, and providers regarding needs, do not rush or show impatience/annoyance, and promote dignity. The resident was one-person physical assist for self-care performance and mobility. The resident was able to communicate easily with staff and understand staff. The resident exhibits behaviors and the intervention included to attempt to establish a routine to reduce confusion for the resident, in the event there is a disruptive behavior, re-direct the resident and report the behavior, orient resident to surroundings, and report any behaviors that could affect the resident's quality of life and/or could affect other residents. The resident (representative) plans for a discharge to home and staff would work with resident and family to facilitate a safe discharge. Review of Resident #1's orders dated 10/2024 revealed the resident had a wander guard placed on the left ankle on 10/07/24 and staff were to check function of wander guard daily. On 10/08/24 the resident was ordered Ativan 0.5 milligrams (mg) every eight hours as needed for anxiety/aggression for 14 days, quetiapine 25 mg one tablet daily and two tablet at bedtime for hallucinations. On 10/09/24 the resident was ordered Haldol intramuscular (IM) two mg intramuscularly every eight hours as needed for agitation for 14 days and Risperidone 1 mg/ml administer 0.5 mg twice daily for hallucination and 1 mg at bedtime for hallucinations to start on 10/10/24. Review of Resident #1's progress note dated 10/07/24 revealed report was called from the discharging facility indicating the resident had extremely impulsive behaviors at their facility that required one on one supervision due to his lack of predictability. The resident frequently lost balance during change of direction or position. Resident tended to lean back in a wheelchair and attempts to capsize the seat. Resident was alert and oriented times one. He frequently threw food items and other belongings at staff. Did attempt to hit staff. The resident was administered Haldol (anti-psychotic) at the facility to assist with safety concerns related to his impulsivity and behaviors, however the medication was discontinued prior to discharge. The resident was incontinent to bowel and bladder but does at times request to go to the bathroom and can use the toilet when he chooses to do so. The resident was standby assist for ambulation and transfers. Medication was to be crushed, and mouth checks performed due to resident pockets medicine and spits them out, required feeding assistance. On 10/07/24 and 10/08/24 staff documented the resident's behaviors included wandering, grabbing at staff, defecating in common areas, impulsive behaviors, refusing medication, restlessness, and disrobing. On 10/08/24 at 4:17 P.M. review of a skilled progress note revealed the resident was unaware of safety needs. Unsteady gait and required direct supervision since re-admission due to wandering aimlessly without purpose. Incontinent of bowel and bladder. Sister visits daily for short periods at time. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's physician note (history and physical) dated 10/08/24 revealed the resident was recently hospitalized for encephalopathy of unclear etiology and had an extended inpatient psychiatric hospitalization . Testing showed epileptic tendencies. He was transferred to skilled nursing for ongoing care and therapy. The resident ambulated throughout the facility with brother assisting. He appeared comfortable but very confused. He had difficulty manipulating communication device. Nursing staff concerned with wandering behavior and going into other resident room. Review of the resident's psych progress note dated 10/08/24 and amended on 10/09/24 revealed the resident was seen for medication check and evaluation of hallucinations. The resident was originally admitted to the facility on [DATE]. The resident unable to report when the presenting problems began, however current stressors were coming into the facility. The resident used an electronic device to help with speech due to surgery on his larynx. The nurse helps with clarifying. On approach the resident was resting in bed. He was calm and doesn't appear to be in any pain. He was restless in bed. Later he was noted wandering about the unit with his sister. When approached he becomes upset and agitated. He refused medication and became agitated when offered them. The sister reported the resident had been in the hospital since he was last sent to the hospital with a pink slip. He was manually retrained or one on one for most of his visit. He would become agitated and combative with staff. He has had weight loss because he was not able to feed self. He had been agitated, confused, and combative since his return. He urinated and defecated in the common area last night. He had been difficult to redirect. He has a wander guard on for safety. The resident reported he was having nightmares and flashbacks at times. The diagnosis, assessment, and plan were depression which required monitoring, anxiety (severe exacerbation) requiring interventions, psychosis requiring interventions, agitation (severe exacerbation) requiring interventions, and history of malignant neoplasm of brain which was a possible contributory factor to the hallucinations. The plan included to decrease the Risperdal and increase the Seroquel to target his symptoms. Plan to increase Exelon patch to target cognition and inappropriate urination and defecation. Will provide as needed Ativan and attempt to prescribe both ABH gel and Ativan gel, however the pharmacy was unable to get the Haldol and Ativan powder to make these. Due to his refusal to take medications and severity of his symptoms at times will provide as needed IM medication. Orders to start Exelon patch 9.5 mg every 24 hours, Seroquel 25 mg daily and 50 mg at bedtimes, Ativan 1 mg IM every eight hours as needed, and Risperidone 1 mg at bedtime. Continue to monitor of side effects, monitor mood/behaviors, and encourage resident to participate in groups and activities. Addendum dated 10/09/24 revealed at 9:00 A.M. the facility notified the provider that resident had become aggressive in the middle of the night and threw a dresser drawer on sleeping resident. Facility NP suggested resident to be enrolled in a day program for his behaviors, however he would be unable to participate due to the severity of his current system. At 1:00 P.M. call placed to facility times two and no answer. 2:45 P.M. called facility and spoke to staff who shared the resident refused his medications this morning and was currently on an outing with his sister. Additional orders given to staff to stop the Risperdal tablet and start Risperdal 1 mg per milliliter (ml) solution give 0.5 mg twice a day with meals and 1 mg by mouth at bedtime. May mix in beverage of choice with family's permission. At 7:40 P.M. the facility contracted the provider. The resident became very agitated and was unable to be redirected. He had remained noncompliant with medication. He was entering others rooms and was not redirectable. Given the situation that happened again this morning and his history of combative, aggressive behavior will give an order for Haldol 2 mg IM every eight hours as needed for 14 days. This medication would only be used when nonpharmacological interventions have failed, and the resident was experiencing severe, distressing symptoms. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes revealed on 10/09/24 at 5:30 A.M. the resident had wandered in another resident's room and removed a dresser drawer from the nightstand and dropped it on the resident's legs while she was lying in bed. The resident's sister was contacted and was coming in to sit with the resident. At 7:36 A.M. the resident's sister reported she was unable to stay any longer, the resident was sound asleep. It was explained she would have to stay due to the resident requiring one on one and the facility was awaiting another staff member to get to the facility to relieve her. The sister agreed to stay. Review of a progress note revealed on 10/09/24 at 3:17 P.M., resident returned after a leave of absence with sister. The resident's sister was provided admission consents that needed signed. The sister indicated she would take them home and review them and return tomorrow. Continued review of progress notes revealed on 10/09/24 at 3:30 P.M., a social service note indicated multiple referrals were sent on this date for placement for the resident. On 10/09/24 at 6:14 P.M. staff called sister to see if she was able to come into the facility to attempt to redirect and calm the resident down, but she reported she was unable to come in this evening. On 10/09/24 at 8:12 P.M. the Director of Nursing (DON) arrived at facility at 7:50 P.M. and the resident was running down the hallway with staff member attempting to catch up with him. The resident was visibly agitated. Not able to sit down. The psych nurse practitioner (NP) was notified with a new order for Haldol two milligrams (mg) every eight hours as needed for 14 days for agitation/psychosis. The resident's sister was notified and reported He just needs to be able to rest. Registered Nurse (RN) administered Haldol in left upper arm. One on one remained in place. On 10/10/24 the resident continued to wander hallways attempting to enter other resident rooms. At 3:00 P. M. the resident's sister arrived at facility and was directed to administrator's office at this time. At 3:30 P.M. Community ambulance arrived at the facility to transport the resident to emergency room for a psych evaluation. Review of psych progress note dated 10/10/24 revealed an audio visit was conducted for ongoing agitation. The resident was a male resident presenting with a history of anxiety, agitation, and hallucinations. Per staff the resident was having ongoing agitation and combative behavior. He had been intrusive and wandering in and out of other's rooms. He was not complaint with medication and had not been receptive to redirection. When redirected his behaviors escalate. In the past 24 hours he had been very impulsive and threw a drawer of a dresser on a sleeping peer. The facility would like to send the resident to the hospital for a psychiatric evaluation. Plan to pink slip to the hospital due to the severity of his symptoms. The note included the resident had been a danger to others. The resident was not able to be assessed due to telephone visit. The telephone encounter lasted 12 minutes. Review of Resident #1's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident had an unplanned discharge with return not anticipated. The assessment noted the resident had severe cognition impairment and had behaviors symptoms not directed towards others and rejection of care. The resident was dependent for personal hygiene, dressing, and bathing. He required supervision of oral hygiene and eating. The resident received antipsychotics, antianxiety, and anticonvulsant medications. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's pink slip dated 10/10/24 at 1:10 P.M. revealed the slip was to the Chief Clinical Office at a local hospital from the facility's psych NP. The pink slip indicated the resident was mentally ill subject to hospitalization by court order under division B Section 5122.01 of the revised code due to the resident representing a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behaviors, evidence of recent threats that places another in reasonable fear of violent behavior and serous physical harm, or other evidence of present dangerousness. The NP also checked the resident would benefit from treatment in a hospital for his mental illness and needs such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others. There was an additional type note for statement of belief that indicated the resident had been restless, agitated, combative and not been complaint with medication since returning to the facility. He was confused and becomes upset when his is redirected. He was intrusive and becomes combative at time. He had been impulsive and over the past few days has demonstrated behaviors consistent with a risk to other residents, such as throwing a dresser drawer on a sleeping peer. This resident would benefit from inpatient evaluation and stabilization due to the severity of his behaviors. Further review of Resident #1's medical record revealed no evidence of a court order for the hospitalization . Review of Resident #1's interact communication form dated 10/10/24 at 3:00 P.M. revealed the resident symptoms had gotten worse since 10/07/24. The resident had symptoms prior. The resident had received Haldol 2 mg IM after all interventions unsuccessful. What makes the condition worse and better was blank. The form included the resident was danger was to self or other, physical aggression, and behavioral changes. The resident would be transferred to a local hospital for behavioral symptoms. Review of Resident #1's transfer form dated 10/10/24 at 2:00 P.M. revealed the resident's sister was aware of the clinical situation and was notified of the transfer. The transfer form indicated the resident was uneasy to redirect, wandering around building and in other resident rooms, aggressive towards staff and residents. refusing care, running down halls, slamming doors on people, hallucinating, and destruction of facility property. He was at risk to harm self and others. Review of Resident #1's immediate discharge notice dated 10/10/24 revealed the notice was hand delivered in person to Resident #1's sister. The notice included due to the circumstance noted below, the resident would be transferred from the facility immediately or as soon as appropriate arrangements for transfer can be made. Th reason for the transfer was the safety of individuals in the home were endangered and the reason for the urgency was the safety of individuals in the home were endangered. The notice included how to appeal. Review of Resident #1's emergency room notes dated 10/10/24 at 5:20 P. M, revealed the psychiatrist would not admit the resident and indicated the resident needed to be transferred back to the nursing home. At 5:23 P.M. the emergency room physician note revealed the resident was brought into the emergency room from a nursing facility for psychiatric evaluation. The resident had a history of dementia and reportedly yesterday was running up and down the halls and throwing furniture. He hit a fell ow with a drawer, so they sent him here (to the hospital) on a pink slip. He was reportedly not allowed back at the facility. His sister was on her way (to the hospital). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon hospital assessment, the patient was in no acute distress. The nursing home was refusing to take the resident back and sent him with discharge papers. Patient was evaluated by psychiatric nurse provider who discussed patient with psychiatrist on-call. The resident was not appropriate for admission to the (hospital) behavioral unit. Plan to admit patient to as he will need nursing home placement. Case management was involved. On 10/10/24 at 5:59 P.M. hospital staff spoke to Resident #1's sister in the emergency room , per the sister the nursing facility sent the resident to the hospital via squad due to the resident's continued behaviors. Call placed to the nursing home director. At 6:24 P.M. case manager (CM) had spoken to the facility Director of Nursing (DON) to discuss potential discharge back to their facility. The DON stated that there had been multiple situations which had put the other residents and staff in danger at their facility. CM placed call to social worker and Administrator at the nursing home and awaiting call back from both. At 7:26 P.M. the Unit Manger Consultant spoke to the Administrator at the nursing facility, and they had contacted the State ombudsman regarding the immediate discharge of the resident from the facility due to the resident's behaviors and safety for their residents. Call place to hospital social worker to discuss case. At 7:48 P.M. the Unit Manger Consultant spoke to the Administrator again at the nursing facility and she reported they had sent out referrals (to other facilities) and were awaiting acceptance. The Administrator recommended referrals to a home in Cleveland. Review of Resident #1's hospital history and physical dated 10/10/24 revealed per the emergency room the resident was no longer able to return to the nursing facility. The sister was at bedside and felt this had caused more confusion for the resident. She also felt the resident receive adequate help at the facility. Work-up in the emergency room thus far was unremarkable. Case management was consulted for placement. His mood was appropriate, and he was calm and cooperative. He was hungry. Review of Resident #1's hospital social service note dated 10/14/24 revealed there was a court hearing regarding if the resident's immediate discharge notice was appropriate. Review of the hearing officer results dated 10/19/24 revealed on 10/10/24 the Ombudsman had filed an emergency appeal to challenge the facility discharge notice. The primary challenge made by the Ombudsman on Resident #1's behalf to the discharge was that the nursing home failed to adequately prepare for a safe and orderly discharge of Resident #1. The Ombudsman asserted that there was no true emergency to justify an emergency discharge, and that Resident #1 was entitled to a 30-day Discharge Notice and a discharge to a place that would accept him and meet his health care and safety needs. The Ombudsman also contends the hospital where Resident #1 was discharged was incapable of meeting Resident #1's health care and safety needs. The Ombudsman asserted that hospital was a short-term hospital, not appropriate for long-term care, and therefore, not capable of meeting Resident #1's health care and safety needs. According to the testimony of a Social Worker at the hospital, Resident #1 was not able to be admitted to the psych unit because he did not meet the admission criteria of indications, he was not homicidal or suicidal. The hospital was ready to discharge Resident #1 because there was no further care they could have provided him. The nursing home facility believed they had exhausted all available options to address and care for Resident #1's behavioral issues. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before a facility may involuntarily transfer or discharge a resident, the facility must provide written notice to the resident and the resident's representative. The written notice must include the information mandated by Ohio law. Normally, the notice must be provided a least thirty days in advance of the transfer or discharge, unless certain specified circumstances exist. In the matter of the discharge of Resident #1 the Immediate Discharge Notice was provided to the resident and his representative/sister on October 10, 2024, the same day he was discharged to the hospital. The reason for not providing a thirty-day notice in advance of the discharge was listed in the Notice as An emergency exists in which the safety of individuals in the home is endangered. An issue was noted as to whether giving the resident and his representative/sister notice of his discharge just hours before he was transported to the hospital meets the statute's requirement that the notice shall be provided as many days in advance of the transfer or discharge as is practicable. A notice to transfer or discharge served on a resident less than twenty-four hours before discharge would not be in compliance with the language. There was little or no evidence presented by the nursing facility to sufficiently establish that an emergency existed on 10/10/24 that endangered the safety of individuals in the home to justify providing the resident and his representative a few hours' notice, at most, that resident was being immediately discharged and removed from facility. The nursing facility failed to prove by a preponderance of the evidence that its Immediate Discharge Notice complied with O.A.C. 3701-61-03(A), and R.C. 3721.16(A)(1). Residents and staff at a skilled nursing facility such as nursing facility have the right not to have their safety threatened or endangered by anyone. Disruptive or agitated behavior by a resident, however, may not be adequate alone to justify a discharge from a facility. Skilled nursing facilities which should have the experience and ability to address such behaviors. A facility should have a comprehensive care plan with input from mental health professionals when needed to address the particulars of the behavioral status of a resident. A facility should ameliorate behavior problems exhibited by a resident as best it can before proposing to discharge or transfer the resident. The facility did not include any reports or assessments from Psych of Resident #1's behaviors or care plans. There were indications in the progress notes that beginning on 10/08/24 there were orders to administer medications to address the resident specific behaviors, i.e. Ativan, Exelon Transdermal Patch, Vimpat, Quetiapine Furnarate, Risperdal, and finally IM Haldol. But the resident was discharged from nursing facility within approximately 72 hours after readmission, with little time to determine whether these medications or other clinical methods would be successful. The location proposed in the Discharge Notice to discharge Resident #1 does not comply with State requirements (at O.A.C. 3701-61-05(A)) because there was inadequate preparation to ensure a safe and orderly discharge from skilled facility. It was significant that the hospital would not keep the resident because it was unable or unwilling to meet Resident #1's applicable health care and safety needs. The licensed social worker employed at the hospital, testified that Resident #1 was only admitted to the hospital because the skilled nursing facility refused to take him back. She further stated that technically the resident should be discharged from the hospital right away. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	To provide adequate preparation to ensure a safe and orderly transfer or discharge of the resident there should be a plan formulated prior to the transfer or discharge. If skilled nursing facility had a discharge care plan in anticipation of Resident #1's discharge, the facility did not describe or present it at the hearing. Ideally the development of the plan would include participation from the resident's representatives and/or family members and would address the resident's orientation and adjustment to the alternative living location. There was nothing in the records presented by the nursing facility which evidence that physician or any psychologist or psychiatrist justified or agreed with facility's decision to immediately discharge and transfer the resident to the hospital. The facility failed to show by a preponderance of the evidence that prior to the immediate discharge of Resident #1 on October 10, 2024, the facility adequately prepared the resident to ensure a safe and orderly transfer and discharge to a facility that was obligated to have accepted Resident #1 and was able to meet Resident #1's mental health care and safety needs. Interview on 11/05/24 at 8:24 A.M. with the Ombudsman revealed Resident #1 was improperly discharged from the facility on 10/10/24. The resident had been readmitted on [DATE] and had an incident on 10/09/24 (entered a resident room and threw a dresser drawer), however there was no incident on 10/10/24 that warranted an emergency discharge. The notice provided to the family indicated an immediate discharge or until he could be placed in a safe environment. On 10/10/24 the facility transferred the resident to the hospital; however, he was not admitted originally, but since the facility refused to permit the resident to return, the hospital had to keep him until the 10/18/24 when they found alternative placement for him. Following the discharge, an appeal was filed and the resident did win, however at that time the resident's sister was afraid to have him return to the facility for fear they (the facility) would just discharge him again. The sister tried to help and would come in and sit with him because the facility reported they didn't have enough staff. The Ombudsman revealed the Administrator just handed the resident's sister a discharge notice and told her they called the squad to take him to the hospital without any type of notice. The Ombudsman felt the resident fell through the cracks. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/24 at 11:02 A.M., with Resident #1's sister revealed she was not aware the facility was going to transfer her brother to the hospital on 10/10/24 or give him a discharge notice until she had stopped by the facility to drop of some papers that she had to sign for her brother's admission and to visit. When she arrived the administrator handed her the immediate discharge notice, a bed hold paper with zero days remaining, and a transfer notice and told her the ambulance was on the way to get her brother. The sister stated, the facility dumped her brother at the hospital. The emergency room wanted to send him back a few hours later but the facility would not take him back. The resident had to stay in the hospital for a week before the case manager could find her brother placement at another facility. The sister revealed the facility had been trying to push him out since August 2024 and kept giving her the run around. The facility would call her to come and sit with her brother because they didn't have enough staff to provide care to him. She felt like she was a babysitter. They were supposed to provide one on one care, but they only did it if they had the time and staff. The staff would refuse to provide care to him and would say he stunk or he was gross. The facility the resident was at now had someone from Medicaid who comes and sits with him. The facility was supposed to arrange that for her brother, but they never did. The resident has dementia and was scared to death and with his communication barrier, due to having larynx cancer, he was not able to communicate with staff and would get agitated. The facility didn't try to communicate appropriately with the resident. The resident would get frustrated because he could not find his room or communicate with the staff. During the interview, the sister shared she had appealed the discharge notice that had been issued, and the judge ruled in their favor but she didn't feel the facility would treat her brother any better and would just issue another discharge notice and not try to rehabilitate the resident. She felt the facility just wanted him out. The sister did indicate the location of the new facility where the resident was residing was inconvenient for the family due to being an hour away and they can't visit as much. When he lived at this facility, it was convenient as she lived near by and could visit often. Interview on 11/06/24 at 1:33 P.M. with the hospital licensed social worker (LSW) revealed the facility had dumped the resident in the emergency room in October 2024. The resident had been seen by psych and deemed not appropriate for admission, nor did he need psych treatment. When the hospital went to discharge the resident back to the facility, they were told they would not accept him back and she was referred to speak to the Administrator. The Administrator would not return her calls nor did the facility assist in finding alternative placement for the resident. The resident had to stay at the hospital until she could find placement. The LSW reported she was part of the hearing that was in favor of the resident but the resident had not returned to the facility for treatment since. Interview on 11/12/24 at 9:29 A.M. with the Administrator confirmed Resident #1 was readmitted to the facility on [DATE] and on 10/09/24 he was having behaviors and threw a dresser drawer on another resident. On the 10/10/24, she issued the resident's sister an immediate discharge notice and transfer notice. The resident was immediately transferred to the hospital and it was her understanding the resident was admitted to the hospital. The resident did not return to the facility. Review of the facility assessment dated [DATE] revealed that the facility provides care psychiatric/mood disorders including psychosis (hallucination, delusions, etc.), impaired cognition, mental disorder, depression, bipolar, schizophrenia, post-traumatic stress disorder, anxiety, and behavior that needs interventions. The facility would mange the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with [TRUNCATED]

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, observation, and interview the facility failed to ensure residents received assistance and supervision during lunch dining. This affected one (Resident #62) of three residents reviewed for meal assistance. Findings include: Record review revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including traumatic subarachnoid hemorrhage, dysphagia, gastrostomy, hypothyroidism, for assistance with personal care, Alzheimer's, dementia, and heart disease. Review of Resident #62's [NAME] Data Set (MDS) dated [DATE] revealed the resident had a feeding tube and was ordered a mechanically alter diet. The resident required substantial/maximal assistance (helper does more than half the effort) with eating. The resident had severe cognition impairment. Review of Resident #62's nutritional plan of care dated 10/17/24 revealed to address any chewing/swallowing/signs of aspiration, assist with feeding needs as needed, monitor weights every month and as needed, and provided diet as ordered. Review of Resident #62's speech therapy notes dated 10/17/24 to 11/06/24 revealed the resident had failed a bedside swallowing exam in the hospital and a PEG (feeding tube) was placed and speech therapy was working with the resident. The resident arrived at the facility with a puree diet consistencies and thin liquids and with tube feeding orders. The resident had impaired laryngeal/pharyngeal performance. The resident exhibited difficulty with oral containment/secretion management 0-25% of the time and required supervision/assistance at mealtime due swallowing safety 26-49%. The resident benefitted from cuing to clear oral cavity and lip seal. Review of Resident #62's weight dated 10/22/24 revealed the resident weighed 134.6 and 11/05/24 she weighed 131.2. Review of Resident #62' meal intakes dated 10/13/24 to 11/06/24 revealed there was 24 meals without documentation, ten refusals, 18 meals she ate 0-25%, 14 meals she ate 26-50%, 3 meals she ate 51-75%, and one meal 76-100%. Review of Resident #62's skilled note dated 10/22/24 to 11/06/24 revealed the resident required one on one with meals/feeding. Review of Resident #62's physician orders dated 11/2024 revealed a pureed diet with regular thin liquids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/06/24 at 1:00 P.M., revealed four residents were sitting in the dining area on South. There was no staff present. Resident #47 and Resident #62 were sitting at the same table. Resident #47 had a regular textured diet and Resident #62 had a pureed texture diet. Neither resident had eaten anything off their trays, nor was there any observation of staff cueing or assisting the residents. Certified Nurse's Aide (CNA) #133 returned a cart to the kitchen and spoke a few words to the residents, however, didn't notice they were eating or encourage them to eat, and then left. Resident #47 then attempted to feed her regular diet to Resident #62 who required a pureed diet. At no time did staff intervene or check on the residents. The surveyor left the dining room to walk up the hall to get the Director of Nursing (DON). The day prior the Surveyor had briefly observed the same two ladies while walking by the dining room due to Resident #62 didn't have a meal tray and Resident #47 did. The DON returned to the South dining room with the Surveyor and confirmed Resident #47 was still attempting to feed Resident #62 her dinner. The DON confirmed there was no staff present and Resident #62 should be supervised because she was on an altered diet. The DON left the dining room to find staff. The surveyor continued to observe the two residents and Resident #47 continued to try to feed her tray to Resident #62 and there still was no staff present. The DON was standing by the nurse's station and there were two staff observed behind the nurse station. The DON asked staff to come to the dining room after they finished their charting. The DON reported the area on South was not a dining room anymore, however the tables have not been removed. The facility was going to move the tables and new furniture was ordered. Interview on 11/07/24 at 8:30 A.M., with the DON confimred Resident #62 should have not been left unattended in the lounge yesterday (11/06/24) with her lunch tray. The lounge was a dining room, however it was closed before she started. The new furniture should arrive today and the tables were removed. She didn't believe the issue was a staffing issue why the resident was left unattended, however it was a staff being non-compliant.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to implement an effective pain management program, including the administration of scheduled and as needed opioid medication for Resident #7. Actual Harm occurred on 11/09/24, when Resident #7, who was identified with chronic pain and a new onset of acute pain related to a fall resulting in a fractured sternum, did not receive her scheduled or as needed Percocet (narcotic pain medication) as requested, resulting in uncontrolled pain that affected the resident's ability to participate in activities of daily living and required the administration of a one-time emergent dose of Percocet to re-gain control of the resident's pain. This affected one resident (#7) of five residents reviewed for pain. Findings included: Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including chronic pain, diabetes, osteoarthritis, carpal tunnel, cervicalgia, muscle spasm, and chest pain. Review of Resident #7's pain care of plan, initiated on 05/10/21 and revised 04/16/24, revealed the resident had pain related to peripheral neuropathy, peripheral vascular disease, osteoporosis, gastric reflux disease, muscle spasms, cardiac disease, restless leg syndrome, bilateral knee and rib pain, and carpal tunnel release. Interventions included encourage to request pain medication before pain becomes severe, offer analgesics per physician order, and attempt non-pharmacological intervention prior to administering medications. Review of the October 2024 physician's orders revealed an order (dated 07/24/24) for the narcotic pain medication, Percocet 5/325 milligrams (mg) one tablet twice daily for chronic pain. Review of Resident #7's annual Minimum Date Set (MDS) assessment dated [DATE] revealed the resident had taken scheduled and as needed pain medication. The assessment noted the resident's pain had rarely or not at all affected activities of daily living. The resident's pain, at its worst on a scale of 0-10 and in the last five days, been a three (on a 0-10 scale with 0 meaning no pain and 10 being the worst pain ever) during the assessment period. Review of Resident #7's progress note dated 10/23/24 at 2:32 A.M., revealed a Certified Nursing Assistant (CNA) reported to the nurse that the resident fell in (her) bathroom. The resident was sitting on her bed when the nurse walked in. Noted a moderately raised bump to the crown of the head. Tender to touch. Resident reported neck, shoulders and top of chest feeling sore from being jolted. Resident explained that she fell asleep on the toilet and woke up when she fell forward and hit her head on the sink. Resident explained that she got herself back to bed before ringing her call light. Review of Resident #7's progress note dated 10/26/24 at 11:48 A.M., revealed the resident approached the nurse and reported she was hurting in her back, chest and she reported something was wrong and wanted a computed tomography (CT) scan. The resident was transferred to the emergency room . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #7's progress note dated 10/26/24 at 3:55 P.M., revealed the resident returned to the facility via cot accompanied by paramedics. Resident received a final diagnosis of a closed fracture of the sternum (breastbone) resulting from her fall that occurred on 10/23/24. New order received for Percocet Oral Tablet 5-325 mg one tablet by mouth every eight hours as needed for pain for 30 days. The resident received as needed (PRN) pain medication and stated that it was effective. Review of Resident #7's progress note dated 11/04/24 at 4:11 P.M., revealed the resident denied worsening pain or discomfort associated with (her) sternum fracture at this time. Review of Resident #7's provider note dated 11/08/24 revealed the resident was seen for a follow up on chronic conditions including pain and chronic obstructive pulmonary disease. The note revealed the resident's pain was controlled with Percocet, Tylenol, Voltaren gel, and muscle rub. The note also reflected the resident's pain was exacerbated due to a recent fall and sternal fracture. The resident started Percocet 5/325 twice daily on 07/28/24 and Percocet 5/325 mg every eight hours as needed for 30 days on 10/26/24 for better control which had been helpful. Further review of the provider note revealed the resident was seen today in her room and reported her chronic pain continued to be exacerbated due to the recent fall and sternal fracture. The resident reported the addition of as needed Percocet has been helpful at bringing her pain to a tolerable level. No noted adverse effect of additional pain medication availability. Resident reported it was difficult to take a deep breath due to the pain associated with it (the sternal fracture). Review of Resident #7's undated Percocet control sheet revealed on 11/09/24 Registered Nurse (RN) #700 (a contracted agency staff nurse) had signed out Percocet 5/325 mg at 7:11 A.M., 11:00 A.M., and 12:00 P. M. (each time a narcotic is removed from the double locked narcotic drawer, the number assigned to the pill removed from the bubble pack is documented on the narcotic control sheet in order to quickly identify the number of narcotics contained in that bubble packet are remaining according to the narcotic control sheet and account for removed doses of the narcotic medication). Review of Resident #7's orders and Medication Administration Records (MAR) dated 11/2024 revealed the resident was ordered Percocet 5/325 mg one tablet by mouth twice daily upon rise (6:00 A.M. to 10:00 A.M.) and bedtime (6:00 P.M. to 10 P.M) and as needed every eight hours for pain. RN #700 documented she administered the rise dose of Percocet 5/325 mg on 11/09/24. There was no documented evidence on the MAR that the as needed Percocet was administered on 11/09/24 (the 11:00 A.M. or the 12:00 P.M. doses as signed out on the Percocet Control Sheet). Further review of the medical record revealed there also was no evidence a pain assessment (numerical pain rating or location of the resident's pain) was completed at the time the prn doses of Percocet were documented on the narcotic sheet. Review of the MAR and Percocet Control Sheet revealed a one-time dose of Percocet 5/325 mg was administered on 11/09/24 at 3:08 P.M for pain assessed to be rated a 10 out of 10. However, review of Resident #7's progress notes revealed no documentation the resident was having increased pain on 11/09/24 resulting in the one-time order of Percocet 5/325 mg. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/12/24 at 9:00 A.M. and 10:02 A.M. with Resident #7 revealed she didn't get several of her scheduled morning medications on Saturday 11/09/24 which included a scheduled pain pill. The resident reported she recently had a fall and fractured her sternum. The resident stated on the morning of 11/09/24 she waited and waited for her morning medication. Finally, RN #700 arrived at her room and put the medication cart right in front of her door. The nurse left the cart in front of her door but never gave her any medications. The resident reported she used her good arm and pushed the medication cart out of the way so she could exit her room. Resident #7 asked the nurse for her meds and RN #700 responded No, I'm going up the hall. Resident #7 followed the nurse up the hall and requested her morning medications. The resident stated RN #700 gave her medication, however there was no Percocet in the medication cup. The resident reported she could not get out of bed most of the day and could not participate in activities because the pain in her sternum was so severe. Interview on 11/13/24 at 1:56 P.M., with Regional Support Nurse (RSN) #116 confirmed Resident #7 did not get her pain medication on 11/09/24 resulting in increased pain requiring a one-time order for Percocet 5/325 mg to be administered (because RN #700 had documented on the narcotic sheet she had removed three Percocet from the narcotic drawer for Resident #7 but did not document the administration of two of the doses). RSN #116 verified the facility had confirmed Resident #7 had not received her scheduled medication, resulting in a pain rating of 10/10 and the physician had to order a one-time dose since too many doses had already been signed out for Resident #7. Interview on 11/13/24 at 2:35 P.M., with Licensed Practical Nurse (LPN) #600 revealed she had worked dayshift on 11/09/24 and Resident #7, who is alert and oriented and knowledgeable about her medications, reported she didn't receive any pain medications on 11/09/24 (it was after 2:00 P.M. this date) and her pain was not controlled due to not receiving medications for pain, especially with a sternum fracture. The LPN verified the resident's physician had to be contacted for a one-time dose of Percocet for the resident's pain. Review of the facility's policy titled Pain Management dated 08/22/22 revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The facility would use a pain assessment tool, which was appropriate for the resident cognitive status, to assist in consistent assessment of the resident's pain. This deficiency represents non-compliance investigated under Master Complaint Number OH00159408 and Complaint Number OH00159399.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of concern form, review of pharmacy communication, interview, and policy review the facility failed to ensure medication were readily available and administered as ordered. This affected one (Resident #4) of three residents reviewed for pain management. Findings included 1. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including diabetes and neuropathy. a. Review of Resident #4's orders dated 09/2024 revealed the resident was ordered Insulin Glargine Solution 100 units/milliliter (ml) 14 units subcutaneously at bedtime for diabetes. Review of Resident #4's and Medication Administration Record (MAR) dated 09/2024 revealed on 09/18/24 the resident did not receive his Insulin Glargine Solution 100 units/milliliter (ml) 14 units subcutaneously at bedtime for diabetes and to see nurses note. The resident was to have his blood sugar obtained at bedtime and documented with the Administration of the insulin. There was no evidence the resident blood sugar was obtained. Review of Resident #4's EMAR progress note dated 09/18/24 revealed Insulin Glargine Solution 100 units/milliliter (ml) 14 units subcutaneously at bedtime for diabetes was not administered due to the resident blood sugar was too low to give this medication. There was no evidence the provider was notified nor was there orders to hold. Review of Resident #4's concern form dated 09/19/24 revealed the resident reported the agency nurse brought him the wrong pills and he told her, and she then brought him the correct pills, but he never got his insulin, nasal spray or his yucky drink. The resolution was the agency nurse was provided education and no longer permitted to provide care to Resident #4 per the resident request. There was an additional typed noted provided with the concern log indicating the agency company was notified the nurse was not permitted to return to the facility. There was no evidence an investigation was completed regarding the possible medication error. Interview on 11/06/24 at 7:42 A.M., with Resident #4 confirmed on 09/18/24 he didn't receive his insulin, nasal spray and the nasty drink. Interview on 11/13/24 at 8:08 A.M. and 9:19 A.M., with the Director of Nursing (DON) confirmed there was no documented evidence the resident's blood sugar was obtained on 09/18/24 or evidence the provider was notified the insulin was not administered. The DON confirmed there was no parameters to hold the insulin and there was no statement from the nurse as part of the investigation. b. Interview on 11/12/24 at 8:58 A.M. and 9:57 A.M. with Resident #4 revealed on Saturday 11/09/24 the agency nurse never gave him his Lyrica for neuropathy pain all day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's orders dated 11/2024 revealed to administer Lyrica 150 milligrams (mg) twice daily (early and dinner) for chronic neuropathy pain. Review of Resident #4's MAR dated 11/2024 revealed on 11/09/24 the dinner dose of Lyrica 150 mg for chronic neuropathy pain was not administered and coded 9 (other-see nurses note). Review of Resident #4's EMAR progress note, and nursing note dated 11/09/24 revealed no documented evidence why the Lyrica 150 mg was not administered nor was there documentation the provider was notified. Review of a fax to pharmacy dated 11/09/24 at 6:41 A.M., revealed the facility had sent a fax to pharmacy to re-order Resident #4's Lyrica 150 milligrams (mg). Interview on 11/13/24 at 8:08 A.M. and 9:19 A.M., with the DON revealed during their investigation it was determined that the resident's Lyrica was not available for administration. The DON confirmed staff failed to re-order the Resident #4's Lyrica timely resulting in the medication not being available to administer. The DON confirmed staff didn't send the re-ordered Lyrica until 11/09/24 at 6:41 A.M. and the medication never arrived in time to administer. 2. Review of the medication times provided by the facility undated revealed early was 3:00 A.M. to 6:00 A.M. and dinner was 2:00 P.M. to 5:00 P.M. Review of Resident #4's orders dated 11/2024 revealed to administer Lyrica 150 milligrams (mg) twice daily (early and dinner) for chronic neuropathy pain. Review of Resident #4's Lyrica 150 mg control sheet dated 10/25/24 to 11/09/24 revealed the resident received his Lyrica on 10/26 at 1:43 P.M., 10/27/24 at 6:16 A.M., 10/28/24 1:00 P.M., 10/29/24 at 1:30 P.M., 10/31/24 1:10 P.M., 11/04/24 1:40 P.M., and 11/05/24 1:00 P.M. Interview on 11/13/24 at 10:13 A.M., with the DON confirmed Resident #4 had received his Lyrica on 10/26 at 1:43 P.M. which would have been too early for the dinner dose, 10/27/24 at 6:16 A.M., which would have been too late for the early dose, 10/28/24 1:00 P.M., which was too early for the dinner dose, 10/29/24 at 1:30 P.M., which was too early for the dinner dose, 10/31/24 1:10 P.M., which was too early for the dinner dose, 11/04/24 1:40 P.M., which was too early for the dinner dose, and 11/05/24 1:00 P.M. Which was too early for the dinner dose. Interview on 11/13/24 at 1:20 P.M. with Corporate Nurse (CN) #116 revealed the facility didn't have a policy on medication times for early, rise, lunch, dinner, or bedtime, however the electronic medical record software company permits nurses to administer the medication an hour before and after the time frame. For example, early was 3:00 A.M. to 6:00 A.M. and the software allows nurse to administer form 2:00 A.M. to 7:00 A.M. Rise would be 5:00 A.M. to 11:00 A.M., lunch would be 9:00 A.M. to 3:00 P.M., dinner would by 1:00 P.M. to 6:00 P.M., and bedtime 5:00 P.M. to 11:00 P.M. Nurses would have to use their nursing judgement to ensure medication times didn't overlap inappropriately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 2:12 P.M., with the facility pharmacy (Pharmacist #1000) revealed there would be no one hour before or after if the facility wasn't using specific times. For example, if a mediation was scheduled at 6:00 A.M., staff would have an hour before or an hour after to administer medication. If the facility was using upon rise, they would have from 6:01 A.M. to 9:59 A.M. to administer the medication and bedtime would be 6:01 P.M. to 9:59 P.M. There would be no one hour leeway and the medication would have to be administered within the time frame. Review of the facility's policy titled Medication Administration dated 08/22/22 revealed medication is administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Medication times include twice daily (9:00 A.M. to 9:00 P.M., bedtime (9:00 P.M.), daily (9:00 A.M.), four times daily (9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M.,) and every eight hours (6:00 A.M., 2:00 P.M., and 10:00 P.M.). This deficiency represents non-compliance investigated under Master Complaint Number OH00159408 and Complaint Number OH00159399

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 32801 Based on review of concern log, review of food committee meeting minutes, observation, interviews, and policy review the facility failed to ensure dietary staff were competent to carry out functions of food delivery. This had the potential to affect all 72 residents, except Resident #51, whom the facility identified as nothing by mouth (NPO). Findings included: Review of the concern log dated 09/06/24 to 10/31/24 revealed 10 concerns were reported regarding food preferences and receiving food items per order. Review of food committee meeting minutes dated 10/02/24 revealed the kitchen was running out of wheat bread and they needed more snacks and more of a variety. Interview on 11/05/24 at 7:07 A.M. and 11/06/24 at 7:42 A.M. with Resident #4 revealed the food was not much better since the last time the kitchen was surveyed in September and received citations. One day he didn't even receive a meal tray. The facility uses the excuse the truck didn't come and that was why they were running out of food, but he heard it was because of the budget, and they can only order so much, and it was not enough for all the residents. Review of the breakfast menu for 11/05/24 revealed cream of rice, sausage patty, and apple muffin. Interview on 11/05/24 at 7:21 A.M. and 2:22 P.M. with an anonymous staff member #800 revealed the food was burnt, dietary was not following menus, meals are late almost every day, they run out of food, not providing the correct fluid textures and portion sizes, or the correct adaptive equipment ordered. The staff member provided photos showing small portion sizes, which a resident only got a meatball sandwich and slaw, and the meal ticket said no slaw. Another photo provided was of a former resident meal tray that received pureed, and she was supposed to be on a regular diet. Observation on 11/05/24 at 7:37 A.M. of breakfast meal revealed the residents were to receive a cream of rice, apple muffin and sausage patty, however there was no muffins or sausage patty. [NAME] #200 reported there was no more sausage patties and only the residents in the dining room and northeast received sausage patties and everyone else received bacon. The cook reported the apple cake was made in place of the apple muffin. The pureed and mechanical soft diets received sausage gravy because she didn't have sausage for them. Resident #71 was to receive fruit loops three days a week, however the facility didn't have fruit loops so [NAME] #200 replaced them with cornflakes. Interview on 11/05/24 at 8:25 A.M. with the Ombudsman revealed residents have voiced concerns with not receiving diets as ordered, mealtimes, not receiving requested items, residents not receiving assistance with meals Interview on 11/05/24 at 1:52 with Licensed Practical Nurse (LPN) #115 revealed some days meal trays are received late and the kitchen does run out of the main food items frequently. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/05/24 at 2:14 P.M., with LPN #114 revealed meals were not delivered timely all the time and residents have voiced concerns they were not getting food items they ordered. Interview on 11/05/24 at 2:40 P.M., with anonymous staff member #801 revealed meals were late a lot of the time. The kitchen was running out of food and coffee. Interview on 11/06/24 at 10:18 A.M., with Resident #2 revealed meals were hit and miss. The facility was still running out of food items. Interview on 11/06/24 at 11:18 A.M., with Resident #66 revealed the food was no better than when the facility received kitchen citations in September 2024. The meal times still vary and were too far apart and the food was still awful. Interview on 11/06/24 at 11:30 A.M., with Resident #71 confirmed she didn't get her fruit loops yesterday. The resident reported she doesn't like corn flakes because they are difficult for her to swallow sometimes when they get soft, but she ate them yesterday anyway. Interview on 11/06/24 at 12:00 P.M., with Resident #56 revealed she doesn't' always get food items she orders, and the mealtimes vary. Interview on 11/06/24 at 9:34 A.M., with the Assistant Director of Nursing (ADON) #153 revealed occasional meals were late and she has heard occasional food items were not available, however it has improved. Interview on 11/07/24 at 6:24 A.M. with Certified Nursing Aide (CNA) #150 revealed last night meal trays were late and didn't come out until 6:30 P.M. The mealtimes vary and residents have complained they are not getting food items they ordered. Interview on 11/07/23 at 6:30 A.M., with CNA #117 revealed mealtimes vary and run late frequently. Interview on 11/07/24 at 7:36 A.M., with Resident #31 revealed the kitchen frequently runs out of food. She usually orders tomato soup and peanut butter and jelly sandwiches. The eggs are usually raw and smell like raw eggs and it makes her sick to her stomach to smell. Interview on 11/07/24 at 8:14 A.M. with Dietary Manger #201 revealed she had just started on 10/01/24 and the left side of the oven has not been working properly and the staff had not been using it. The right-side seal was not working properly; however, the oven was still functional. The DM reported she looked in the freezer and found sausage patties, but the staff never looked or called her on 11/05/24 or she would been able to tell them where it was since she put the delivery away. She was not aware the staff used sausage gravy for the pureed and mechanical soft diets on 11/05/24. The DM confirmed trays were late last night 11/06/24 because they were trying to get the apples up to temp. The DM reported she had just provided education on 10/28/24 regarding mealtimes, food temperatures, reading meal tickets, adaptive equipment, and stocking (supplies). Review of mealtimes undated revealed the dining room on north was 7:00 A.M., 12:00 P.M., and 5:00 P.M. Northeast Hall was 7:15 A.M., 12:15 P.M., 5:15 P.M., Northwest Hall 7:25 A.M., 12:25 P.M. and 5:25 P.M. Southwest Hall 7:40 A.M., 12:40 P.M., and 5:40 P.M., and Southeast 7:50 A.M., 12:50 P.M., and 5:50 P.M. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 11/06/24 at 8:30 A.M. revealed the breakfast trays had just arrived at Southwest Hall. Observation confirmed with DON at 8:30 A.M. on 11/06/24. The DON confirmed the mealtime sheet indicated 7:40 A.M. for breakfast. Interview on 11/07/24 at 1:30 P.M., with Resident #68's daughter revealed she requires assistance with meals and she doesn't get it. The daughter reported you never know what time meals will arrive. Sometimes lunch will come at 12:30 P.M. and sometimes it may be 1:30 P.M. Sunday dinner didn't come to 7:30 P.M., and her mom was usually in bed by that time. Her mom has trouble swallowing food and she was to have ground meats and doesn't always receive ground meats. The kitchen sends lemonade even though the meal ticket states no lemonade. They are to send water and tea on the tray and she rarely receives water on her tray. The daughter had notes on meal tickets that she shared with the surveyor. On 10/24/24 they were having a cold sandwich, and her mom doesn't like cold sandwiches, so they ordered grilled cheese, tomato soup, and cottage cheese, which was on the meal ticket, however she never received it. This deficiency represents non-compliance investigated under Complaint Number OH00159399.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 32801 Based on review of the concern log, review of the food committee meeting minutes, interview, observation, and policy review the facility failed to ensure meals were provided per menu and resident preferences. This had the potential to affect 71 of 72 residents who receive meals from the facility kitchen. The facility identified one resident(Resident #51)to receive nothing by mouth. Findings included: Review of the concern log dated 09/06/24 to 10/31/24 revealed 10 concerns were reported regarding food preferences and receiving food items per order. Review of food committee meeting minutes dated 10/02/24 revealed the kitchen was running out of wheat bread and they needed more snacks and more of a variety. Review of the breakfast menu for 11/05/24 revealed cream of rice, sausage patty, and apple muffin. Observation on 11/05/24 at 7:37 A.M. of the breakfast meal revealed the residents were to receive a cream of rice, apple muffin and sausage patty, however there was no muffins or sausage patties. [NAME] #200 reported there were no more sausage patties and only the residents in the dining room and northeast received sausage patties and everyone else received bacon. The cook reported the apple cake was made in place of the apple muffin. The pureed and mechanical soft diets received sausage gravy because she didn't have sausage for them. Resident #71 was to receive fruit loops three days a week, however the facility didn't have fruit loops so [NAME] #200 replaced them with cornflakes. Interview on 11/05/24 at 7:07 A.M. and 11/06/24 at 7:42 A.M. with Resident #4 revealed the food was not much better from the last ast survey in September when the kitchen was issued citations. One day he didn't even receive a meal tray. The facility uses the excuse the truck didn't come and why they were running out of food, but he heard it was because of the budget, and they can only order so much, and it was not enough for all the residents. Interview on 11/06/24 at 11:30 A.M., with Resident #71 confirmed she didn't get her fruit loops yesterday. The resident reported she doesn't like corn flakes because they are difficult for her to swallow sometimes when they get soft, but she ate them yesterday anyway. Interview on 11/06/24 at 12:00 P.M., with Resident #56 revealed she doesn't' always get food items she orders. Interview on 11/07/24 at 1:30 P.M., with Resident #68's daughter revealed her mom has trouble swallowing food and she was to have ground meats and doesn't always receive ground meats. The kitchen sends lemonade even though the meal ticket states no lemonade. They are to send water and tea on the tray and she rarely receives water on her tray. On 10/24/24 they were having a cold sandwich, and her mom doesn't like cold sandwiches, so they ordered grilled cheese, tomato soup, and cottage cheese, which was on the meal ticket, however she never received it. (continued on next page)

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Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/07/24 at 8:14 A.M. with Dietary Manger #201 revealed she had just started on 10/01/24 The DM reported she looked in the freezer and found sausage patties, but the staff never looked or called her on 11/05/24 or she would been able to tell them where it was since she put the delivery away. She was not aware the staff used sausage gravy for the pureed and mechanical soft diets on 11/05/24. The DM reported she had just provided education on 10/28/24 regarding mealtimes, food temperatures, reading meal tickets, adaptive equipment, and stocking and the concerns were still an issue. Interview on 11/07/24 at 7:36 A.M., with Resident #31 revealed the kitchen frequently runs out of food. She usually orders tomato soup and peanut butter and jelly sandwiches. The eggs are usually raw and smell like raw eggs and it makes her sick to her stomach to smell. This deficiency represents non-compliance investigated under Complaint Number OH00159399.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 32801 Based on review of mealtimes, observation, and interview, the facility failed to ensure meals were delivered timely. This had the potential to affect 71 of 72 residents receiving meals from the facility kitchen. The facility identified one resident (Resident#51) to receive nothing by mouth. Findings included: Interview on 11/05/24 at 7:21 A.M. and 2:22 P.M. with an anonymous staff member #800 revealed meals are late almost every day. Interview on 11/05/24 at 1:52 with Licensed Practical Nurse (LPN) #115 revealed some days meal trays were delivered late. Interview on 11/05/24 at 2:14 P.M., with LPN #114 revealed meals were not delivered timely all the time. Interview on 11/05/24 at 2:40 P.M., with anonymous staff member #801 revealed meals were late a lot of the time. Observation on 11/06/24 at 8:30 A.M. revealed the breakfast treys had just arrived at Southwest Hall. Observation confirmed with DON at 8:30 A.M. on 11/06/24. The DON confirmed the mealtime sheet indicated 7:40 A.M. for breakfast. Interview on 11/06/24 at 12:00 P.M., with Resident #56 revealed meal times vary. Interview on 11/07/24 at 6:24 A.M. with Certified Nursing Aide (CNA) #150 revealed last night meal trays were late and didn't come out until 6:30 P.M. The mealtimes vary. Interview on 11/07/23 at 6:30 A.M., with CNA #117 revealed mealtimes vary and run late frequently. Interview on 11/07/24 at 1:30 P.M., with Resident #68's daughter revealed you never know what time meals will arrive. Sometimes lunch will come at 12:30 P.M. and sometimes it may be 1:30 P.M. Sunday dinner didn't come to 7:30 P.M., and her mom was usually in bed by that time. Interview on 11/07/24 at 8:14 A.M. with Dietary Manger #201 revealed she had just started on 10/01/24 and the left side of the oven has not been working properly and the staff had not been using it. The right-side seal was not working properly; however, the oven was still functional. The DM confirmed trays were late last night 11/06/24 because they were trying to get the apples up to temp. The DM reported she had just provided education on 10/28/24 regarding mealtimes but the issues were still occurring. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of mealtimes undated revealed the dining room on north was 7:00 A.M., 12:00 P.M., and 5:00 P.M. Northeast Hall was 7:15 A.M., 12:15 P.M., 5:15 P.M., Northwest Hall 7:25 A.M., 12:25 P.M. and 5:25 P.M. Southwest Hall 7:40 A.M., 12:40 P.M., and 5:40 P.M., and Southeast 7:50 A.M., 12:50 P.M., and 5:50 P.M. This deficiency represents non-compliance investigated under Complaint Number OH00159399.