

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 28923 Based on record review, review of personal inventory sheets, review of grievance/concern logs, review of email correspondence between a resident representative and the facility, interviews, and policy review, the facility failed to ensure resident representative reports of missing personal items were addressed in a timely manner. This affected one (Resident #2) of three residents reviewed for missing personal items. Findings include: Review of Resident #2's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease, post-traumatic stress disorder, anxiety disorder, age-related macular degeneration, and bilateral hearing loss. Review of Resident #2's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had minimal difficulty in hearing and her speech was clear. She was able to make herself understood and was usually able to understand others. Her cognition was on the high end of being moderately impaired. She was not known to reject care or display any behaviors. On 12/04/24 at 11:27 A.M., an interview with Resident #2's representative revealed she reported to the facility that the resident was missing personal items that included a white/maroon colored fleece blanket and a gray t-shirt that was 2X in size. She stated she reported the items missing to the facility's Social Service Director (SSD) about three weeks ago. She also stated she had sent an email to the facility's management team about the missing personal items, but had not heard anything back yet. She claimed the items were still missing and had not been replaced or reimbursed. She provided a copy of the email that she had sent to the facility regarding the resident's missing items. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365770	Facility ID: 365770 If continuation sheet Page 1 of 11

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the email correspondence from Resident #2's representative to the facility staff revealed the representative sent an email to the facility's Admissions Director, Administrator, Director of Nursing (DON), Social Service Director (SSD), and the Business Office Manager on 10/02/24 at 2:42 P.M. The email indicated she had attached a scan of her Amazon clothing orders for the resident in order to try to keep track of what she had and what was missing. She had to visit the laundry area the night before because the resident only had two tops hanging in her closet and another in the laundry basket that the family brought in so they could do her laundry. They had two signs hanging in the resident's room to let the staff know that the family was doing the resident's laundry. The family opted to do her laundry because they did not want her clothing to be worn out prematurely due to the heat of the water used by the facility and the dryers they used. The scanned Amazon clothing order list indicated a short sleeve nightgown that was aqua-green and a size XX-large was missing. There was also a women's plus size V-neck rolled short sleeve casual soft Summer t-shirt medium gray and 2 XL in size that was indicated to be missing. Review of an email correspondence from the facility's DON to Resident #2's representative dated 10/02/24 at 2:50 P.M. revealed the DON acknowledged receiving the email and thanked the representative for sending the email to allow them to address some of the issues she was having. The DON indicated the facility's Administrator was out of the building on that date, but she would make sure her concerns were addressed with their team. The email correspondence further showed Resident #2's representative responded to the DON's email on 10/02/24 at 2:54 P.M. thanking her for the response and she told the DON an all points bulletin (APB) on the missing clothing probably wouldn't hurt either. Review of Resident #2's personal belongings inventory sheets revealed an inventory of the resident's personal belongings was obtained upon her admission to the facility on [DATE] and again on 07/23/24. The inventory sheet for 07/23/24 revealed the resident was known to have in her possession a three stretch t-shirts size 2X, with one of the three being [NAME] gray in color. There was no indication that a white and maroon colored fleece blanket was part of the resident's belongings. The resident personal belongings inventory sheet for 07/23/24 was signed by both the resident's representative and a facility nurse indicating they had read and acknowledged that was an accurate listing of her belongings. Review of the facility's grievance/concern log for the past three months revealed there was no documentation to indicate there had been any reports of missing personal items pertaining to Resident #2 during the past three months. Missing items were included on the logs for other residents. On 12/04/24 at 3:10 P.M., an interview with Resident #2 revealed she has had issues with some of her personal items coming up missing. She was not sure exactly what was missing and indicated her daughter had been handling that. On 12/05/24 at 10:38 A.M., an interview with Certified Nursing Assistant (CNA) #125 revealed she was aware of Resident #2 having a white/maroon colored fleece blanket while in the facility. She stated it was usually draped across the foot of her bed. She was not sure if the resident had the blanket in her possession as she did not recall still seeing it across her bed. She was aware there was a gray t-shirt that was reported as being missing, but she believed it was found on another resident and returned to the resident. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 11:44 A.M., an interview with CNA #133 revealed she recalled a couple of weeks ago one of Resident #2's shirts was found on another resident. She stated they saw the other male resident wearing it, but noticed it just did not look right on him. It looked like a woman's shirt as it had a V-neck and the short sleeves were rolled at the end. They took it off the other resident and found it had Resident #2's name on it. They placed it in the resident's laundry basket so the family could take it home and wash it. She reported she believed that t-shirt was teal in color and was not a gray one. She was not aware of a gray t-shirt being missing or anything about a white and maroon fleece blanket. Personal inventory sheets were completed on paper and were to be done upon a resident's admission. They gave them to the nurse's after they were completed. She denied inventory sheets would be updated after the resident's admission even if things were brought in by the family later. On 12/05/24 at 2:04 P.M., an interview with SSD #200 revealed she had been the facility's SSD for the past two years. She was aware of their being reports of missing personal items for Resident #2. She stated it was a [NAME] gray t-shirt and a maroon/white swirl pattern blanket that was reported missing. The daughter had sent her a photo of the blanket and she was told what else was missing and had passed it on to management. She reported everyone was made aware to include the Administrator, DON, and laundry staff. She checked her phone and verified the reports of the missing clothing was received on 11/18/24. She indicated she received a phone call from the daughter about 10 minutes before getting the photo sent to her to let her know about the missing items. She was asked what she did when a resident or family reported it missing. She stated she usually passed the information along and it got put on the grievance/concern log. She was not sure if she had put it on there, or if someone else did. She stated she was in the middle of a few things when that call was received. She did not hear anything back from the resident's daughter and just quite frankly forgot everything about it. She was given a copy of the grievance/concern log and verified there were no reports of missing items indicated for Resident #2 on 10/02/24, when the initial email was sent about missing items or on 11/18/24, when she was called again about the missing items. On 12/05/24 at 2:45 P.M., an interview with the facility's Administrator revealed she had a soft file on concerns they had received from Resident #2's family. She confirmed there had been reports of missing personal items to include a blanket and a gray colored t-shirt. She acknowledged the missing items had not been logged onto their grievance/ concern log where missing items were recorded. She did not have a missing item report for the missing blanket or shirt. She confirmed an email was received from the resident's daughter about the missing items, but they did not have any evidence she had a blanket in her possession that fit that description. She indicated the staff documented items present upon admission on a personal inventory list, but it was the responsibility of the family to complete a personal inventory list for any additional items brought in after their admission. She confirmed a personal belongings inventory sheet dated 07/23/24 did show the resident was known to have a gray t-shirt that was 2X in size. She reported it was the facility's corporate policy that they were not responsible for lost items, especially if the resident's family was doing their laundry. She claimed the resident's daughter did not want them to mark the resident's name in her clothing, since it was their intent to launder her clothing. She acknowledged the facility would be responsible for keeping the resident's personal belongings inventory sheet updated and was responsible for replacing missing items the resident was known to have while in the facility. She acknowledged the facility staff were still sending the resident's clothing to their laundry room to be processed at times when it had been made known that the family would do that. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 4:05 P.M., an observation noted the Administrator and the DON to enter the room of Resident #2 to discuss her missing personal items. The Administrator informed the resident the facility would be replacing her lost items for her. On 12/05/24 at 4:12 P.M., a follow up interview with the Administrator revealed she had talked to the corporate office and it was decided that they would go ahead and replace the resident's missing personal items. Review of the facility's policy from Embassy Healthcare on Concerns/ Grievances revealed it was the policy of the facility and in accordance with 483.10 (f) (1) Grievances, the facility would honor the resident's right to voice concerns and/or grievances without discrimination or reprisal. Such concerns and/or grievances would include, but was not limited to, treatment which had been furnished or not furnished. Other forms of grievances could include management of funds, lost items, and/or violation of rights. The SSD would coordinate the facility system for collecting concerns and tracking concerns for timely and appropriate response. Social services would instruct facility staff to submit to the SSD that all concerns received would be investigated within 72 hours following receipt of the concern. Within seven days following the receipt of the concern, the facility would inform the complainant with the results of the investigation. The resident/ family concern form was to be completed when a resident and/or family member had a concern that must be addressed by the facility. The form should be used to document specific concerns and in the event of missing items brought forth by the resident and/or family. When the concern was related to missing items, complete the missing items form. Time frames for resolution would remain the same as above. Concerns submitted to the SSD would be presented to the Administrator as soon as the form was completed. The administrator/designee would forward the concern form to the appropriate management representative. Social services would maintain a concern log in order to track concerns and/or missing items. This deficiency represents non-compliance investigated under Complaint Number OH00160107 and is an example of continued non-compliance from the survey 11/22/24.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, and interviews the facility failed to ensure a resident, who was dependent on staff for personal care, received appropriate incontinence products needed for proper incontinence care and was assisted up in her chair daily as per her normal routine. This affected one (Resident #2) of three residents reviewed for incontinence care. Findings include: Review of Resident #2's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), obstructive and reflux uropathy, post traumatic stress disorder, gastrostomy status, macular degeneration, and bilateral hearing loss. Review of Resident #2's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had minimal difficulty with her hearing and clear speech. She was able to make herself understood and was usually able to understand others. Her cognition was moderately impaired with a brief interview for mental status (BIMS) score of 12 (a score of 13-15 was being cognitively intact). She was not known to display any behaviors nor was she known to reject any care. She was dependent on staff for transfers and toilet use. She was coded as always being incontinent of her bladder and bowel. Review of Resident #2's care plans revealed she had a care plan in place for needing assistance for activities of daily living (ADL's) related to cognitive impairment and immobility. The care plan was initiated on 07/02/24. The goal was for the resident to continue to participate in ADLs as able and have no decline in ADLs through next review and for her to be clean, odor-free and appropriately dressed on a daily basis. The interventions included her being a mechanical lift x2 (two staff) for transfers. She required the assist of two for toileting hygiene and for chair to bed transfers. Review of Resident #2's physician's orders revealed the resident went under the care and services of hospice for the diagnosis of COPD on 10/11/24. An order was received for the resident to have the use of an indwelling urinary catheter beginning on 11/22/24. Review of Resident #2's point of care response history for bed to chair and chair to bed transfers for the past 30 days (11/08/24 to 12/07/24) revealed there was a two day period in which the resident was not indicated to have been transferred from her bed to her chair. On 11/21/24 and again on 11/22/24, the nursing assistants documented that activity did not occur. On 12/04/24 at 11:27 A.M., an interview with Resident #2's daughter revealed the facility had issues with supplies more often than she cared to recall. She reported there had been an issue with not having the proper size incontinent brief the resident needed to wear and she was made to wear ones that were too small for her. The resident was a 3 X in incontinent brief sizes and the facility staff had to use medium sized briefs on her. It resulted in her leaking or being saturated through her clothing due to the incontinent brief not being a proper fit. That had been an issue as recent as two weeks ago, but had also happened in the past sometime between 06/26/24 (when she was admitted) and 10/03/24 (when she finished working with therapy at the completion of her 100 days of skilled services). (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at 3:10 P.M., an interview with Resident #2 revealed there had been problems with the facility not having the proper size of incontinent briefs for her resulting in her having to wear smaller ones that did not properly fit. She claimed there had been a time in the past when she was in therapy and was wearing a smaller sized brief. She recalled being incontinent and making a mess, which was embarrassing to her. On 12/02/24 at 3:50 P.M., an interview with Central Supply Employee #250 revealed she was the employee that used to be responsible for ordering supplies. She had been in central supply since July 2023, but did not start being in charge of ordering supplies until January 2024. The facility decided they would start having the corporate office order supplies in October or November of 2024. They only did that for a month or so before they began having issues with the availability of supplies sometime in November 2024. On 12/05/24 at 10:38 A.M., an interview with Certified Nursing Assistant (CNA) #125 revealed Resident #2 did require the use of incontinent briefs. She used to be incontinent of her bladder, but now had the use of a catheter and was only incontinent of her bowels now. The resident needed a size 3 brief. There was a three day time span in which they were out of size 3 briefs. They had to use pull ups or use a blue brief under Resident #2 and another blue brief down the front of her. She reported they were constantly telling the DON, Assistant Director of Nursing (ADON), the unit manager, and the nurses that they were out and would be told they were working on it. She could not recall if that was prior to Resident #2 being under hospice's care or if it was after that. She stated the messes were massive and they were unable to get Resident #2 up out of bed due to that. She used to be up daily, but during that time when they did not have the appropriate size brief, they had to leave her in bed. The family of the resident was mad at them. She denied the management team offered to go to the store to purchase any of the briefs they needed, while they were waiting for them to be delivered. There was a time three to four weeks ago they had no briefs at all. Everyone was wearing pull ups during that time. On 12/05/24 at 11:44 A.M., an interview with CNA #133 revealed Resident #2 had her indwelling urinary catheter for about a month now. They continued to check her for bowel incontinence though. She confirmed the facility definitely had issues with supplies. It happened a lot when they were out of incontinent briefs. The problem with not having incontinent briefs was about two weeks ago or at least within the last month. She reported they were completely out of briefs and only had a few pull ups, if any at all. Pull ups were very limited as well. She reported Resident #2 wore size 3 briefs. She then recalled there was a time they were using the two blue briefs for Resident #2. One was placed under her and another was placed up the front of her. She confirmed that resulted in them having to leave the resident in bed, so she did not have any accidents in her chair. She thought the supply issue was a communication problem. Before they would tell the nurses when they needed something. The nurses would in turn pass it on to the facility's prior DON. Now they tell the new DON or the unit manager. Central Supply Employee #250 used to handle the ordering of supplies, but had been taken off of it. She was not sure who took over after that. This deficiency represents non-compliance investigated under Complaint Number OH00160107.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, and interviews the facility failed to ensure administrative staff maintained sufficient supplies to adequately care for the residents residing in the facility. This affected one (Resident #2) of three residents reviewed for incontinence and enteral tube feedings. Findings include: Review of Resident #2's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), obstructive and reflux uropathy, post traumatic stress disorder, gastrostomy status, macular degeneration, and bilateral hearing loss. Review of Resident #2's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had minimal difficulty with her hearing and clear speech. She was able to make herself understood and was usually able to understand others. Her cognition was moderately impaired with a brief interview for mental status (BIMS) score of 12 (a score of 13-15 was being cognitively intact). She was not known to display any behaviors nor was she known to reject any care. She was dependent on staff for transfers and toilet use. She was coded as always being incontinent of her bladder and bowel. She was indicated to have a feeding tube that was providing 51% or more of her nutritional intake. Review of Resident #2's physician's orders revealed she was placed under the care and services of hospice on 10/11/24 for the diagnosis of COPD. She also had an order to receive Isosource 1.5 cal at 55 milliliters (ml)/ hour x 10 hours from 6:00 P.M. until 4:00 A.M. every night. The order was in place between 11/01/24 and 11/25/24. She received a second order for her to receive Jevity 1.5 cal at 55 ml/ hour per peg tube via pump to be ran over 10 hours from 6:00 P.M. to 4:00 A.M. every night. That order was in place from 11/26/24 until 12/04/24. She received a third order on 12/04/24 to resume the first order and for the resident to receive Isosource 1.5 cal at a rate of 55 ml/ hour per peg tube via pump to be ran for 10 hours between 6:00 P.M. and 4:00 A.M. Her orders also reflected she was placed under the care and services of hospice on 10/11/24 for the diagnosis of COPD. She had an indwelling urinary catheter placed on 11/22/24. Review of Resident #2's medication administration record (MAR's) for November 2024 revealed the resident did receive Isosource 1.5 cal at 55 ml/ hour between 6:00 P.M. to 4:00 A.M. every night from 11/01/24 through 11/25/24. She was then given Jevity 1.5 cal at 55 ml/ hour every night between the hours of 6:00 P. M. to 4:00 A.M. from 11/26/24 through 11/30/24. Review of Resident #2's MAR's for December 2024 revealed the resident continued to receive Jevity 1.5 cal at 55 ml/ hour nightly between the hours of 6:00 P.M. to 4:00 A.M. from 12/01/24 through 12/03/24. The MAR then reflected she was changed back to Isosource 1.5 cal at 55 ml/ hour between the hours of 6:00 P.M. to 4:00 A.M. beginning the evening of 12/04/24. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's progress notes revealed a nurse's note dated 11/22/24 at 5:21 P.M. that indicated the nurse had spoke with the certified nurse practitioner and received an approval to change the resident's Isosource to Jevity if needed. Another progress note dated 11/22/24 at 5:30 P.M. revealed the approval to supplement Isosource with Jevity 1.5 call was due to the Isosource being on back order. Another nurse's note dated 12/03/24 at 8:00 P.M. revealed the nurse spoke with the nurse practitioner and the resident's daughter regarding an order change back to Isosource related to it's availability. On 12/04/24 between 8:54 A.M. and 9:41 A.M., an observation of Resident #2 noted her to be lying in bed in a supine position with the head of her bed up. The resident had her eyes closed with oxygen on per nasal cannula and in no apparent distress. She was noted to have a couple of rolls of toilet paper sitting on the top of the nightstand next to her bed. She did not have a box of facial tissues in her room at the time the observation was made. She had an indwelling urinary catheter draining to gravity drain. She was covered with a blanket and it was not visible if she was wearing any type of incontinent product. On 12/04/24 at 11:27 A.M., an interview with Resident #2's daughter revealed they have had issues with supplies more often than she cared to recall. She confirmed the resident had to have her enteral tube feeding changed to another type due to supply problems. She has also had issues with not having the proper size incontinent brief to wear and was made to wear ones that were too small for her. She stated the resident was a 3 X in incontinent brief sizes and the facility staff had to use medium sized briefs on her. It resulted in her leaking or being saturated through her clothing due to the incontinent brief not being a proper fit. That had been an issue as recent as two weeks ago, but had also happened in the past sometime between 06/26/24 when she was admitted and 10/03/24, when she finished working with therapy at the completion of her 100 days of skilled services. There had also been a problem with the facility not having facial tissues for the residents. She had found a couple rolls of toilet paper on the resident's nightstand in place of a box of tissues that the resident liked to have on hand. The resident used them to tuck in the front of her shirt collar to help when she drooled or dribbled when taking drinks. She blamed the supply issue to a particular employee that was in charge of ordering supplies. She stated she did not know what the issue was, but the employee evidently did not understand how much they needed to order to be able to meet the demands of the residents they were taking care of. On 12/04/24 at 3:10 P.M., an interview with Resident #2 revealed there had been times where she has ran out of facial tissues and the facility did not have any to give her. She was not too concerned about it and was usually able to get them if she really needed them. Her daughter had brought her in some when the facility did not have any. She also confirmed there had been problems with the facility not having the proper size of incontinent briefs for her resulting in the facility staff putting smaller ones on her that did not properly fit. She claimed there had been a time in the past in which she was in therapy and was wearing a smaller sized brief. She recalled being incontinent of her bowels and making a mess, which was embarrassing to her. She denied any recent issues with not having the proper size of incontinent briefs, but they were now being supplied through hospice. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/02/24 at 3:50 P.M., an interview with Central Supply Employee #250 revealed she was the employee that used to be responsible for ordering supplies. She had been in central supply since July 2023, but did not start being in charge of ordering supplies until January 2024. The facility started having the corporate office order supplies in October or November of 2024. They only did that for a month or so, before they began having issues with the availability of supplies sometime in November 2024. She placed orders every Monday and Wednesday for deliveries on Tuesdays and Thursdays. When the corporate office took over ordering supplies, they wanted to place orders every couple of weeks. The first order the corporate office placed in November did not come until 11/20/24. They were in need of briefs as their supply was running low. She was not made aware the staff were using smaller size briefs on residents, due to not having the proper size they needed. They got a hold of the corporate office when supplies were low and fast tracked an order. They placed an order on 11/20/24 and got it the next day. They (facility's management staff) told the corporate office, after that happened, that they would go back to having her (Central Supply Employee #250) order the supplies. She denied any issues with not having facial tissues available. When she was in charge of supplies, she would check daily Monday through Friday to see what they had on hand and put out supplies as needed. The corporate office did not have anyone on site to check supplies like she did. She was asked to place a case of briefs in Resident #2's room about two or four weeks ago. The facility used to supply her with briefs, but believed hospice was doing that now since she was under their care. She was not aware of any problems with enteral tube feeding solutions not being available. She was aware that some had been changed to Jevity from Isosource, but thought that was due to the corporate office wanting them to use up the Jevity they had on hand. She was not sure exactly what Resident #2 currently had ordered in regards to her tube feeding. She stated she would have to get with the nurse to see what they were actually using (1000 ml closed bags or the 250 ml cartons) to get her the 550 ml she received nightly. She used a running inventory list to keep track of what supplies they had on hand before, when she handled the ordering of supplies. When the corporate office took over ordering supplies, she handed that all over to them. She stated since she took over the ordering of the supplies on 12/01/24, she would start a running inventory again. On 12/04/24 at 4:52 P.M., an interview with LPN #100 revealed the facility has had some issues with ordering supplies when the corporate office took over. When they were low on supplies, they were required to put it in the dashboard. She stated she felt, by the time they let them know and when they received it, they were usually out. She stated it was a lot better when Central Supply Employee #250 was in charge of ordering supplies. Facial tissues not being available for resident use had been an issue a couple weeks ago. They had some, but were getting low the last time she saw them. She was not sure if they ran completely out. She confirmed Resident #2's daughter did tell her they had to bring facial tissues in for the resident due to her not having any. She recalled that was two or three weeks ago and she was informed of that over the phone during shift change. She shared that information with the night shift nurse. She denied she actually checked to see if they had any tissues or not. The night shift nurse was aware of them having some in the medication room and was to take the resident some back. They were using the 1000 ml closed bags of Isosource 1.5 cal for Resident #2. She denied they had any 250 ml cartons of Isosource 1.5 cal on the South unit and she did not think they had any on the North unit. She reported the other resident that had Isosource bolus feedings on the South unit may have had some in the medication cart. She called the nurse practitioner and got the okay to switch to Jevity 1.5 cal that they had on hand, in the event that they ran out of Isosource before the shipment was received. She stated they were interchangeable and just made by a different company. She was not aware of there being any problems with incontinent briefs. Hospice had been providing briefs to Resident #2 since she had been under their care and services since October 2024. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 10:38 A.M., an interview with Certified Nursing Assistant (CNA) #125 revealed Resident #2 did require the use of incontinent briefs. She used to be incontinent of her bladder, but now had the use of a catheter and was only incontinent of her bowels now. The resident needed a size 3 brief. There had been an issue in the past in which the facility ran out of size 3 briefs. She stated it was a supply issue and they had since changed suppliers. Since the facility's new Director of Nursing (DON) took over, they were not having as much of an issue with that anymore. There was a three day time span in which they were out of size 3 briefs and that was after the new DON was there. They had to use pull ups or use a blue brief under Resident #2 and another blue brief down the front of her. She reported they were constantly telling the DON, Assistant Director of Nursing (ADON), the unit manager, and the nurses that they were out and would be told they were working on it. She could not recall if that was prior to Resident #2 being under hospice's care or if it was after that. She reported that problem occurred before the resident had her indwelling urinary catheter placed. She stated the messes were massive and they were unable to get Resident #2 up out of bed due to that. She used to be up daily, but during that time when they did not have the appropriate size brief, they had to leave her in bed. The family of the resident was mad at them. She felt they were threw them under the bus because the family was told it would be taken care of it and blamed the aides for the lack of care provided. She denied the management team offered to go to the store to purchase any of the briefs they needed, while they were waiting for them to be delivered. She denied they had ever went to the store to purchase anything they were out of. They just got the facial tissues in and had been out of those for quite a while. There was a two week period she worked in which tissues were not available. The facility just recently opened a CNA closet for supplies to be readily available. When they were out of tissues, it was before the CNA supply closet was created. They checked five different areas in which they might have been stored in, but were not able to find any. They were not able to find any during that two week period. She reported they have had issues with incontinent briefs not being available that was more than just with the size 3's. There was a time three to four weeks ago they had no briefs at all. Everyone was wearing pull ups during that time. The corporate office took over ordering supplies when there had been previous issues with supplies not being available. She felt it only got worse after corporate took that over. That was when they were told they were getting new suppliers. They (corporate office) were not on-site to see what they had and what was needed. She felt there was a communication issue as to why supplies were not readily available. It would get passed on to management, but did not make it's way to the corporate level to order. It had been getting better after they changed things back to the way they were. Central Supply Employee #250 had things set up prior to the corporate office taking over. It was getting back to how it was before. It was not drastic when Central Supply Employee #250 was in charge of supplies before. Shipments were usually received the following day and they did not completely run out of things. Supplies at that time were just getting low. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 11:44 A.M., an interview with CNA #133 revealed Resident #2 had her indwelling urinary catheter for about a month now. They continued to check her for bowel incontinence though. She confirmed the facility definitely had issues with supplies. It happened a lot when they were out of incontinent briefs, cups, lids, straws etc. They have had issues with facial tissues as well not being available. The problem with not having incontinent briefs was about two weeks ago or at least within the last month. They were completely out of briefs and only had a few pull ups, if any at all. Pull ups were very limited. She reported Resident #2 wore size 3 briefs. Since hospice has cared for her, she has had the incontinence briefs she needed. She believed the issue they had with that might have happened after Resident #2 was getting hers through hospice. The issue had been since the facility's new DON started there, but she could not recall how long that had been. She recalled there was a time they were using two blue briefs for Resident #2 putting one under her and the other up the front of her. She confirmed that resulted in them having to leave the resident in bed, so she did not have any accidents in her chair. She also confirmed they had been completely out of facial tissues during that same time period (two to four weeks ago). She recalled one former resident that was in need of some, but they looked everywhere and could not find any. She had heard a nurse talk about not having enough supplies and made the comment that it was embarrassing that they did not even have enough supplies on hand to take care of the residents. She thought the supply issue was a communication problem. Before, they would tell the nurses when they needed something. The nurses would in turn pass it on to the facility's prior DON. Now they tell the new DON or the unit manager. Central Supply Employee #250 used to handle the ordering of supplies, but had been taken off of it. She was not sure who took over after that. This deficiency represents non-compliance investigated under Complaint Number OH00160107.		