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	03/20/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33019 Based on observation and interview, the facility failed to ensure an ice machine was clean and sanitary. This had the potential to affect all residents residing in the facility. The census was 76. Findings include: Observation on 3/19/25 at 12:35 P.M. with Dietary [NAME] # 100 revealed brownish-black, mold-like appearing areas located on the white plastic shield inside of the facility's ice machine. The exterior of the ice machine appeared to have water stains, fingerprints, and dust-like debris. The ice machine was located outside of the kitchen, in a dining room/common area. Interview on 03/19/25 at 12:36 P.M. with Dietary [NAME] #100 confirmed there was brownish-black, mold-like appearing areas located on the white plastic shield located inside of the ice machine, and stated she was unaware of a cleaning schedule or cleaning log for the ice machine. Interview and observation on 03/19/25 at 12:40 P.M. with the Administrator confirmed there was brownish-black, mold-like appearing areas located on the white plastic shield inside of the ice machine and the exterior of the ice machine did not appear to be clean. The Administrator stated the ice machine would be taken out of commission until it was cleaned and sanitized. This deficiency demonstrates non-compliance investigated under Master Complaint Number OH00163676 and Complaint Numbers OH00163596 and OH00162928.

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