

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Embassy of Lyndhurst		STREET ADDRESS, CITY, STATE, ZIP CODE  1575 Brainard Rd Lyndhurst, OH 44124	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38091</p> <p>Based on review of facilities self reported incidents (SRIs), medical record review, policy review, family interview, staff interview, and facilities policy review, the facility failed to ensure residents responsible parties and medical practitioners were notified of an instance of potential sexual abuse. This affected two (Residents #100 and #101) of three residents reviewed for notification of change. The facility census was 60.</p> <p>Findings Include:</p> <p>Resident #100 was admitted to the facility on [DATE] with diagnoses that included epilepsy, major depressive disorder, anxiety disorder and [NAME]-[NAME] syndrome. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was moderately cognitively impaired and required extensive assistance of two staff persons for completing her activities of daily living (ADLs). Review of census records revealed Resident #100 was her own responsible party but relied on her mother to make all necessary medical and financial decisions. Resident #100 was discharged to another skilled nursing facility on 07/29/24.</p> <p>Resident #101 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, dementia and Alzheimer's disease. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #101 was cognitively intact and required supervision for completing his activities of daily living.</p> <p>Review of SRI #250039 dated 07/24/24 revealed on 07/23/24 at approximately 9:15 P.M., Registered Nurse Shift Supervisor (RNSS) #700 notified the Director of Nursing (DON) that Resident #101 was in Resident #100's room and possibly engaging inappropriate touching of Resident #100 breasts. RNSS #700 stated that State tested Nursing Assistant (STNA) #500 alleged that she witnessed Resident #101 rubbing Resident #100's breasts.</p> <p>Interview with the mother of Resident #100 on 07/30/24 10:10 A.M. revealed she had not been notified of the events of the SRI and was only notified by a friend that is also an employee at the facility during a personal phone call that was not intended to be regarding her daughters care.</p> <p>Further review of the medical record for Residents #100 and #101 revealed no evidence any individual whether family or medical practitioner had been notified of the potential sexual abuse between Residents #100 and #101.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The DON verified no evidence was present that Resident #100 and #101's doctors or families/responsible parties were notified of the alleged sexual abuse incident between Residents #100 and #101 on 07/23/24 in an interview on 07/29/24 at 11:15 A.M</p> <p>Review of the facility policy entitled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revealed The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies. A. The state licensing/certification agency responsible for surveying/licensing the facility B. The local/state ombudsman C. The resident representative D. Adult protective services (where state law provides jurisdiction in long-term care) E. Law enforcement officials F. The residents attending physician G. The facility medical director.</p> <p>Review of the facility policy dated 02/01/21 entitled Change in a Residents Condition or Status the facility will promptly notify the resident, his or her attending physician, and the resident resident representative of changes in the resident's medical/mental condition and/or status.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156168 and Complaint Number OH00156099.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38091</p> <p>Based on review of self-reported incidents (SRIs), medical record review, policy review, police report review, family interview and staff interview, the facility failed to ensure Resident #100 was free from sexual abuse. This affected one of three residents reviewed for abuse. The facility census was 60.</p> <p>Findings Include:</p> <p>Resident #100 was admitted to the facility on [DATE] with diagnoses that included epilepsy, major depressive disorder, anxiety disorder and [NAME]-[NAME] syndrome. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was moderately cognitively impaired and required extensive assistance of two staff persons for completing her activities of daily living (ADLs). Resident #100 was discharged to another skilled nursing facility on 07/29/24</p> <p>Review of the care plan dated 07/19/21 revealed Resident #100 has noted behaviors such as attention seeking, making false accusations of staff and others and rejection of care. The medical record also noted another care plan dated 07/23/24 which revealed Resident #100 has numerous communication deficits including making her self understood.</p> <p>Resident #101 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, dementia and Alzheimer's disease. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #101 was cognitively intact and required supervision for completing his activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of self-reported incident (SRI) #250039 dated 07/24/24 revealed On 07/23/24 at approximately 9:15 P.M., Registered Nurse Shift Supervisor (RNSS) #700 notified the Director of Nursing that Resident #101 was in Resident #100's room and possible engaging inappropriate touching of Resident #100 breasts. RNSS #700 stated that State tested Nursing Assistant (STNA) #500 alleged that she witnessed Resident #101 rubbing Resident #100's breast. Upon notification RNSS #700 immediately entered the room and received a statement from Resident #101 regarding the incident. Resident #101 stated he was in Resident #100's room giving Resident #100 her favorite candy, and Resident #100 had told numerous employees she liked Resident #101 and asked him to come into her room, and that Resident #101 was her friend. On 07/24/24, the mother of Resident #100 arrived at the facility alleging sexual assault took place during the incident. Resident #100's mother alleged that she received a phone call from an unnamed anonymous employee that Resident #100 was sexually assaulted at the facility by Resident #101. Resident #101 was immediately placed on 15-minute checks to monitor his behavior at the time of the allegation. The Administrator and Director of Nursing started an investigation immediately upon accusation of sexual abuse by Resident #100's mother. During the investigation STNA #500 continued to allege that she witnessed Resident #101 rubbing Resident #100's breast. STNA #500 further stated that Resident #102 was outside of Resident #100 door and witnessed the inappropriate touching. STNA #500 stated she immediately notified the RN Supervisor of her observations and continued to finish her work. No other observations were made and there were no other witnesses to the incident. Resident #100 was interviewed about the alleged incident by facility representatives Resident #100 was asked if Resident #101 touched her and she replied, Yes and that it felt good. Resident #101 restated that he was in her room to give her favorite candy which he knows is [NAME] Cups. He states, She is just my friend. Resident #101 then accused staffing of having a vendetta against him and that he would never hurt anybody. The facility concluded that while the action did happen it was its interpretation that the action was between two consenting adults and not of any abusive nature.</p> <p>Review of the police report and investigation initiated by Resident #100's mother on 07/24/24 revealed, STNA #500 stated to the officer she heard Resident #102 laughing very loudly in the hallway. STNA #500 located Resident #102 inside Resident #100's room and noted Resident #101 also in the room. STNA #500 observed Resident #101 near Resident #100's shoulders on the side of the bed closest to the door. Resident #102 was next to Resident #101, by Resident #100's knees on the same side of the bed. STNA #500 heard Resident #102 say, don't that feel good? STNA #500 stated the lights were off, so she walked over to the foot of Resident #100's bed and observed Resident #102's hospital gown was pulled down to her waist. Resident #100's bare chest was exposed, and Resident #101 was fondling Resident #100's left breast with her right hand. STNA #500 immediately removed Residents #101 and #102 from the room and notified the supervisor at the time. The officer completing the report referred the matter to the agency's detective bureau for investigation in a possible charge of gross sexual imposition (when a person engages in sexual contact with another individual against their will).</p> <p>Interview with Resident #100 on 07/29/24 at 7:45 A.M. revealed Resident #100 admitted that Resident #100 touched her breast as noted in the SRI. Resident #100 answered with a childish giggle and the word yes when asked if her breast were touched by Resident #101. Resident #100 again answered with a childish like giggle and the word yes when asked if she liked her breast being touched and if she felt safe at the facility. Other questions asked of Resident #100 that required answers beyond yes or no were answered with further child like giggles and no further in-depth though process.</p> <p>Interview with Registered Nurse (RN) #500 (Resident #100's nurse) on 07/29/24 at 8:11 A.M. revealed Resident #100 has poor safety awareness and is with it here and there.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with the mother of Resident #100 on 07/29/24 10:10 A.M. revealed Resident #100 suffered multiple brain aneurysms approximately seven years ago and has the mind, maturity and mental capacity of an eight-year-old child. Resident #100's mother further stated that she was moving Resident #100 from the facility due to her feeling unsafe for her daughters well being after the incident with Resident #101. Resident #101 left the facility at approximately 11:30 A.M. on 07/29/24 accompanied by her mother.</p> <p>Interview with the Administrator on 07/29/24 at 2:00 P.M. verified the events of the SRI.</p> <p>Review of the policy entitled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 04/01/21 revealed Resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156168 and Complaint Number OH00156099.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38091</p> <p>Based on record review, staff interview, and facility policy review, the facility failed to ensure it implemented its abuse policy related to an incident of potential sexual abuse against Resident #100. This affected one (Resident #100) of three residents reviewed for abuse. This had the potential to affect all residents. The facility census was 60.</p> <p>Findings Include:</p> <p>Resident #100 was admitted to the facility on [DATE] with diagnoses that included epilepsy, major depressive disorder, anxiety disorder and [NAME]-[NAME] syndrome. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was moderately cognitively impaired and required extensive assistance of two staff persons for completing her activities of daily living (ADLs). Review of census records revealed Resident #100 was her own responsible party but relied on her mother to make all necessary medical and financial decisions. Resident #100 was discharged to another skilled nursing facility on 07/29/24.</p> <p>Review of the care plan dated 07/19/21 revealed Resident #100 has noted behaviors such as attention seeking, making false accusations of staff and others and rejection of care. The medical record also noted another care plan dated 07/23/24 which revealed Resident #100 has numerous communication deficits including making her self understood.</p> <p>Review of self-reported incident (SRI) #250039 dated 07/24/24 revealed On 07/23/24 at approximately 9:15 P.M., Registered Nurse Shift Supervisor (RNSS) #700 notified the Director of Nursing (DON) that Resident #101 was in Resident #100's room and possible engaging inappropriate touching of Resident #100 breasts. RNSS #700 stated that State tested Nursing Assistant (STNA) #500 alleged that she witnessed Resident #101 rubbing Resident #100's breast. Upon notification RNSS #700 immediately entered the room and received a statement from Resident #101 regarding the incident. Resident #101 stated he was in Resident #100's room giving Resident #100 her favorite candy, and Resident #100 had told numerous employees she liked Resident #101 and asked him to come into her room, and that Resident #101 was her friend. No other actions including protecting the resident or reporting the incident to local enforcement and the state agency were noted in the investigation file until on 07/24/24 when the mother of Resident #100 arrived at the facility alleging sexual assault took place during the incident. Resident #100's mother alleged that she received a phone call from an unnamed anonymous employee that Resident #100 was sexually assaulted at the facility by Resident #101. Upon receiving the allegation from Resident #100's mother the investigation began and was reported to the state agency. Law enforcement was contacted by the mother of Resident #100 and was present in the facility after the sexual assault allegation was lodged.</p> <p>Resident #101 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, dementia and Alzheimer's disease. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #101 was cognitively intact and required supervision for completing his activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with the Administrator and DON on 07/29/24 at 10:45 A.M. revealed the incident was not reported to the state agency or law enforcement until the formal allegation of sexual abuse was made by Resident #100's mother as the facility viewed the incident as a consensual act between individuals who were their own responsible parties and could make their own decisions.</p> <p>Interview with Resident #100 on 07/29/24 at 7:45 A.M. revealed Resident #100 admitted that Resident #100 touched her breast as noted in the SRI. Resident #100 answered with a childish giggle and the word yes when asked if her breast were touched by Resident #101. Resident #100 again answered with a childish like giggle and the word yes when asked if she liked her breast being touched and if she felt safe at the facility. Other questions asked of Resident #100 that required answers beyond yes or no were answered with further child like giggles and no further in-depth though process.</p> <p>Interview with Registered Nurse (RN) #500 (Resident #100's nurse) on 07/29/24 at 8:11 A.M. revealed Resident #100 has poor safety awareness and is with it here and there.</p> <p>Interview with the mother of Resident #100 on 07/30/24 10:10 A.M. revealed Resident #100 suffered multiple brain aneurysms approximately seven years ago and has the mind, maturity and mental capacity of an eight-year-old child.</p> <p>Review of the facility policy entitled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revealed The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies. A. The state licensing/certification agency responsible for surveying/licensing the facility B. The local/state ombudsman C. The resident representative D. Adult protective services (where state law provides jurisdiction in long-term care) E. Law enforcement officials F. The residents attending physician G. The facility medical director. The policy further noted Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions if any are needed for the protection of residents.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156168 and Complaint Number OH00156099.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38091</p> <p>Based on review of facility self-reported incidents (SRIs), medical record review and staff interview the facility failed to ensure a complete and accurate medical record for residents. This affected two (Residents #100 and #101) of three residents reviewed for accuracy of medical records. The facility census was 60.</p> <p>Findings Include:</p> <p>Resident #100 was admitted to the facility on [DATE] with diagnoses that included epilepsy, major depressive disorder, anxiety disorder and [NAME]-[NAME] syndrome. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was moderately cognitively impaired and required extensive assistance of two staff persons for completing her activities of daily living (ADLs). Review of census records revealed Resident #100 was her own responsible party but relied on her mother to make all necessary medical and financial decisions. Resident #100 was discharged to another skilled nursing facility on 07/29/24.</p> <p>Resident #101 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, dementia and Alzheimer's disease. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #101 was cognitively intact and required supervision for completing his activities of daily living.</p> <p>Review of SRI #250039 dated 07/24/24 revealed on 07/23/24 at approximately 9:15 P.M., Registered Nurse Shift Supervisor (RNSS) #700 notified the Director of Nursing (DON) that Resident #101 was in Resident #100's room and possibly engaging inappropriate touching of Resident #100 breasts. RNSS #700 stated that State tested Nursing Assistant (STNA) #500 alleged that she witnessed Resident #101 rubbing Resident #100's breast.</p> <p>Review of the medical records for Residents #100 and #101 revealed no information regarding the incident and any outcomes of the incident.</p> <p>Interview on 07/29/24 at 11:15 A.M. with the DON verified no documentation was present in the medical record regarding the alleged sexual abuse incident between Resident #100 and Resident #101.</p>		