STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41526 Based on observation, interview, record review, and facility policy review the facility failed to provide feeding assist for Residents #5 and #6 and personal care assist with a mechanical lift for Resident #35 in a dignified and respectful manner. This affected three residents (#5, #6 and #35) of three residents reviewed for dignity and respect. The facility census was 68. Findings include: 1. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including quadriplegia and anxiety disorder. Physician orders effective October 2024 indicated a regular diet, texture and consistency, and to give feeding assistance with all meals as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] specified Resident #5 had no cognitive impairment and was dependent on one staff physical assist for eating. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis, chronic pain syndrome, anxiety disorder, and need for assistance with personal care. Physician orders effective October 2024 indicated a regular diet and texture and thin consistency, and to give feeding assistance with all meals as needed. The quarterly MDS assessment dated [DATE] specified Resident #6 had no cognitive impairment and required extensive one staff physical assist with eating. Observation on 10/09/24 at 12:45 P.M. revealed the lunch meal tray cart was delivered to hallway for Residents #5 and #6. Certified Nursing Assistant (CNA) #209 began delivering the meal trays at 12:52 P.M. Observation on 10/09/24 at 1:03 P.M. CNA #209 delivered Resident #6's meal tray to the room by placing it onto the bedside table adjacent to the bed and out of the resident's reach. CNA #209 left the room without setting up the meal tray, and then delivered Resident #5's meal tray to the room across the hallway. Resident #5 was sitting up in a high back electric wheelchair near the center of the room. CNA #209 placed the meal tray onto a nearby table out of the resident's reach and left the room without setting up the meal tray and continued to deliver meal trays to other residents down the hallway. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/09/24 at 1:05 P.M. with Resident #5 complained the meal trays were frequently placed in the room out of reach and then the staff leave, then when the staff come back, they sometimes shovel food into my mouth so fast just to get it done. Observation at 10/09/24 at 1:06 P.M. of Licensed Practical Nurse (LPN) #265 who walked past the rooms of Residents #5 and #6 and did not provide meal tray set up or feeding assist. Observation on 10/09/24 at 1:09 P.M. of CNA #209 who entered Resident #5's room then set up the meal tray and began feeding the resident while standing next to the resident. Interview on 10/09/24 at 1:10 P.M. with Resident #6 complained about wanting to eat the meal nearby but no one had come for a long time to help. So, there was no choice but to wait. Observation on 10/09/24 at 1:11 P.M. an unknown staff member walked past Resident #5's room who was being assisted by CNA #209 to eat and offered to obtain a chair for CNA #209 to sit down. CNA #209 responded to the unknown staff member it was not needed because Resident #5 was done. CNA #209 gathered up the meal tray, left the room, walked past Resident #6's room which still had the untouched meal tray and placed Resident #5's tray onto the meal delivery cart. CNA #209 then began collecting used food trays from other residents nearby. Observation on 10/09/24 at 1:13 P.M. of Assistant Director of Nursing (ADON) #250 who entered Resident #6's room and talked with the resident. The meal tray remained untouched. Interview on 10/09/24 at 1:14 P.M. with CNA #209 verified the above observations with Residents #5 and #6, and then in reference to Resident #6 stated she did not help that resident because the resident did not want her in the room. CNA #209 continued to explain there was another aide assigned to that resident but denied knowing who it was. CNA #209 walked away from the interview and continued to collect used meal trays from other residents, while making no attempt to address Resident #6's need. Observation on 10/09/24 at 1:15 P.M. of ADON #250 who exited Resident #6's room with the meal tray still untouched. Interview at the time of the observation with ADON #250 stated a plan to return to the room, set up the meal and assist Resident #6 to eat. When questioned regarding CNA #209's report of not being able to help Resident #6, ADON #250 denied there were any concerns between Resident #6 and CNA #209, and it was expected that all nursing staff would help the residents. Review of the facility policy, Assistance with Meals, revised March 2022, revealed residents who could not feed themselves would be fed with attention to safety, comfort and dignity. 2. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including diabetes mellitus type two, vascular dementia, epilepsy, gastrostomy status, and schizoaffective disorder. Physician orders effective October 2024 indicated a mechanical lift for transfers. The quarterly MDS assessment dated [DATE] revealed Resident #35 had severe cognitive impairment. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/10/24 at 1:45 P.M. while walking down the hallway past Resident #35's room revealed CNAs #209 and #236 moving Resident #35 toward the bed who was lifted from the wheelchair and encased in a mechanical lift sling. The door was not closed and there were no privacy curtains blocking the view. Upon seeing the surveyor, CNA #209 pushed the door hard enough for it to close on its own to remain with the mechanical lift which held Resident #35. Interview on 10/10/24 at 1:48 P.M. with CNA #209 after leaving Resident #35's room verified the observation and stated the door could either be closed or left open because there was nothing showing to require privacy for the resident. Interview on 10/10/24 at 1:52 P.M. with CNA #236 stated at first that CNA #209 had just entered the room and was just about to shut the door but when questioned as to why CNA #236 would initiate a mechanical lift transfer without the second staff member because Resident #35 was already lifted, CNA #236 corrected the statement to the door should have been shut while completing the transfer. This deficiency represents non-compliance investigated under Master Complaint Number OH00158439.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on record review, review of a facility fall investigation, review of staff disciplinary forms, review of a facility procedure and interview, the facility failed to provide adequate assistance to Resident #35 during incontinence care to prevent a fall with injury. This affected one resident (#35) of three residents reviewed for incontinence care. The facility census was 68. Actual harm occurred on 08/05/24 when Resident #35, who was severely cognitively impaired, required two staff assistance for bed mobility and was incontinent, sustained a fall out of bed when staff were providing incontinence care. At the time of the incident, the staff failed to maintain the resident's safety in bed. The resident exhibited pain to the left side of the head with swelling and bruising to the left cheek and eye and pain with range of motion to the left elbow. Resident #35 was transferred to the hospital and returned with a diagnosis of a head injury and multiple contusions. Findings include: Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including diabetes mellitus type two, vascular dementia, epilepsy, gastrostomy status, and schizoaffective disorder. Review of the fall risk evaluation dated 03/04/24 revealed Resident #35 was at high risk for falls having had a history of falls, impaired cognition, dependence with continence, being confined to a chair and not able to attempt standing without physical help. Review of the care plan updated 07/01/24 revealed Resident #35 was incontinent and required total staff assistance with toileting and bed mobility. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had severe cognitive impairment and required extensive assistance from two staff for toileting and bed mobility. The assessment revealed the resident was always incontinent of bowel and blader. Review of the nursing progress note dated 08/05/24 at 6:45 A.M. revealed Resident #35 was being changed and slid to the floor embraced by staff. Review of the nursing progress note dated 08/05/24 at 10:00 A.M. revealed Resident #35's left upper cheek had increased swelling and the resident complained of pain in the left arm and left lateral rib cage area. The nurse practitioner ordered the resident to be transferred to the hospital. Review of the nursing progress note dated 08/05/24 at 1:26 P.M. revealed Resident #35 had a fall and during morning medication administration complained of pain to the left arm and within two hours had a swollen left cheek with bruising. The resident subsequently was transferred to the hospital. Review of the nursing progress note dated 08/05/24 at 3:21 P.M. Resident #35 returned to the facility at 3:30 P.M. by ambulance. The resident was diagnosed with a facial contusion. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital discharge information dated 08/05/24 revealed Resident #35 was diagnosed with a fall. Multiple imaging was completed to the brain, cervical spine, facial bone, left elbow, femur, hip, ribs and shoulder which resulted in an additional diagnosis of head injury with multiple contusions. Review of the facility fall investigation dated 08/05/24 revealed Resident #35 was being changed by Certified Nurse Aide (CNA) #207 and CNA #279 when the resident slid out of bed onto the floor while the staff tried to break the fall which resulted in swelling and pain to the left face and upper cheek area. A written witness statement from CNA #207 reported helping change Resident #35 when she slid out of bed, and CNA #279 helped stop the fall to the floor. A written witness statement from CNA #279 reported assisting the resident when she slid off the bed and trying to stop the fall as much as possible bracing the resident. Review of the nursing progress note dated 08/06/24 at 1:10 P.M. identified as a late entry revealed the interdisciplinary team reviewed Resident #35's fall, and it was noted the resident rolled out of bed while being assisted with toileting needs. A nursing assistant (unnamed) broke the fall. Resident #35 had swelling to the left side of the face and was sent to the hospital for evaluation. Grab bars to both sides of the bed were implemented (as a result of the incident). Review of the nurse practitioner progress note dated 08/06/24 revealed Resident #35 was examined due to being sent to the hospital on 08/05/24 following a fall from the bed with facial injury. Per the hospital, multiple imaging was completed, and the resident returned with no new orders and a diagnosis of facial contusion. Resident #35 had bruising and swelling to the left eye and cheek and cried out with range of motion to the left elbow. Review of disciplinary action forms dated 08/06/24 revealed CNA #207 and CNA #279 received a written warning for aggressive care due to Resident #35 being over-rolled to point where the resident was rolled off the bed. The performance improvement identified was to properly roll residents on their side during incontinence care. Review of the nursing progress notes from 08/06/24 through 08/16/24 revealed Resident #35's left cheek and eye orbit remained swollen and bruised with intermittent complaints of pain to the left side including the shoulder, elbow, and arm. Interview on 10/10/24 at 1:22 P.M. with Director of Nursing (DON) verified the above findings and indicated after the details of the incident were discussed with CNA #207 and CNA #279. The DON revealed it was understood that Resident #35 was over-rolled and fell on to the floor. The DON revealed the nursing assistants (CNAs) were at fault and caused the resident's fall to occur. Following the incident both CNAs received a reprimand followed by an in-service on incontinence care and repositioning. On 10/16/24 at 4:05 A.M. a telephone interview with CNA #207 revealed she remembered when Resident #35 fell , but the STNA denied being present during the incident and denied writing a witness statement or receiving disciplinary action as a result of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a follow-up interview on 10/16/24 at 9:18 A.M. with CNA #207, the STNA continued to state she had not been present nor was she providing care for Resident #35 at the time of the fall on 08/05/24. CNA #207 revealed CNA #230 had reported to her being involved with the incident along with CNA #201. On 10/16/24 at 9:39 A.M. a telephone interview with Licensed Practical Nurse (LPN) #264 revealed the LPN recalled the incident with Resident #35 on 08/05/24 stating the two nursing assistants present were CNA #201 and #230. The LPN revealed the CNA staff reported a fall occurred while they were changing the resident when they rolled her over, she moved about in bed causing her to slide out of the bed. On 10/16/24 at 9:45 A.M. a telephone interview with CNA #230 revealed she recalled Resident #35's fall on 08/05/24. At the time of the interview CNA #230 revealed she was providing care to Resident #35 at the time of the fall. CNA #230 stated CNA #201 was assisting with providing Resident #35 incontinence care. While rolling the resident over, CNA #230 stated she stepped away (from the resident) to grab a washcloth when Resident #35 started moving her legs and rolled over more. CNA #230 revealed they could not pull the resident back, and the resident fell out of the bed toward CNA #201 who did try to stop the fall but could not. Interview on 10/16/24 at 9:50 A.M. with the DON and Administrator verified the cause of Resident #35's fall remained consistent despite a discrepancy with which staff were actually present at the time of the incident. Review of the undated facility procedure, Turning Patients Over in Bed, revealed before turning a resident, position residents closest to the side of the bed to ensure they will not end up too far on the edge of the other side of the bed which increases the chance of falling off the bed. This deficiency represents non-compliance investigated under Complaint Number OH00157983.