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	12/05/2024

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 0697 Level of Harm - Minimal harm or potential for 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** 32650 Based on observation, interview, medical record review, and policy review, the facility failed to ensure Resident #17, who had chronic pain syndrome and received routine and as needed medication to treat pain, was provided pain medication as requested to effectively manage her chronic pain. This affected one resident (#17) of three residents reviewed for pain management. The facility census was 66. Findings Include: Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, chronic pain syndrome, major depression disorder, anxiety disorder, and insomnia. Review of the physician's orders for Resident #17 revealed on 02/27/24 the resident was admitted to hospice for the diagnosis of ALS. She was receiving Ambien (a hypnotic medication for sleep) 10 milligrams (mg) between 11:30 P.M. and 12:30 A.M., Ativan (anti-anxiety medication) 0.5 mg every four hours as needed, Gabapentin (a medication used to treat nerve pain) 900 mg four times a day and Morphine Sulfate Concentrate (narcotic pain medication) 20 mg/milliliter (ml) 0.5 ml every two hours as needed for moderate pain or 1.0 ml every two hours for severe pain. The resident also received Kadian (an extended-release dose of Morphine) 20 mg three times a day for pain. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/29/24, revealed Resident #17 was cognitively intact, was dependent on staff for all personal care, received scheduled pain medication and as-needed pain medication, had almost constant pain affecting her sleep and daily activities, rated the pain as a seven on a zero to 10 pain scale (zero indicating no pain and 10 as the worst pain), and received hospice services. Review of the care plan for Resident #17 revealed she had chronic pain related to disease process of ALS and receiving end-of-life care with hospice. Interventions included administer pain medication as ordered, control pain with use of opioid (narcotic) pain medication and rest, notify physician if interventions were unsuccessful or if current pain complaint was a significant change from past complaint of pain. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) dated 11/01/24 through 11/30/24 for Resident #17 revealed her pain was to be monitored five times a day for pain management with a start date of 06/27/24. Further review of the MAR revealed the pain level was being assessed at 6:00 A.M., 10:00 A.M., 2:00 P.M. 6:00 P.M. and 10:00 P.M. For the date range of 11/20/24 to 11/24/24 Resident #17's pain level varied between zero to eight on most days (with 15 of 25 pain levels between five to eight and ten of 25 being zero to three) and on 11/25/24 at 6:00 P.M. her pain level was seven and at 10:00 P.M. her pain level was 10. Further review of the MAR for November 2024 revealed Resident #17 was compliant with taking her medications as ordered. On 11/25/24 at 2:00 P.M. Kadian was administered to Resident #17 and Gabapentin was administered at 6:00 P.M. Morphine Sulfate Concentrate one milliliter was given at 12:28 P. M. for a pain level of seven and documented as effective, and no further doses were provided on 11/25/24. The Kadian was due to be administered at 10:00 P.M. and was marked as given at 10:00 P.M. Review of the document titled On-Call Communication, dated 11/26/24, timed 12:25 A.M. and authored by Hospice Registered Nurse (HRN) #400 revealed HRN #400 documented received call from patient reporting that she is having extreme pain and that she has not been medicated all evening. Patient reporting that she has been asking for pain medication since 8:00 P.M. Call placed to facility with no answer. Call placed to patient and patient states her aide is with her now. Aide requested FN (floor nurse) (stated name of nurse who was Licensed Practical Nurse #334) to come to patient's room to talk with this writer about medications. FN heard in background and would not speak to this nurse. This nurse heard FN state she would get patient her routine medication now. Patient to receive Ambien, Gabapentin and Morphine. Instructed patient to call this nurse back if she does not get her medications. Patient verbalizes understanding. Review of the facility document titled Disciplinary Action Form, dated 11/26/24, revealed Licensed Practical Nurse (LPN) #334 received written disciplinary action by the Director of Nursing (DON) due to failure to complete assigned job duties. Interview with LPN #334 on 12/02/24 at 4:14 P.M. revealed she neither confirmed nor denied not giving Resident #17 the Morphine Sulfate Concentrate when the resident requested it as needed on 11/25/24. LPN #334 stated Resident #17 wanted her breakthrough medicine of Morphine Sulfate Concentrate to be given at the same time as she received her Kadian, Ambien, and Gabapentin, however, hospice indicated the resident could have the Morphine Sulfate Concentrate 30 minutes to one hour after receiving her Kadian. LPN #334 said Resident #17 was aware she could not take both morphine doses (referring to the Kadian and the Morphine Sulfate Concentrate) at the same time. LPN #334 stated the resident just wanted to take her medications the way she wants to, not as they were ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #17 on 12/03/24 at 10:45 A.M. revealed on 11/25/24 the resident had requested her breakthrough pain medication of Morphine Sulfate Concentrate from LPN #334 starting at 8:00 P.M. but never received it until after midnight. Observation of Resident #17 revealed the resident was only able to move a few fingers on her left hand, the resident was totally dependent on staff for all her care needs. The resident was unable to reposition in bed without assistance. The resident then revealed scheduled doses of Kadian were given at 6:00 A.M., 2:00 P.M., and 10:00 P.M. She received her Gabapentin at 6:00 A.M., 12:00 P.M., 6:00 P.M. and 12:00 A.M. She stated she preferred to take her Ambien at midnight along with her Gabapentin and Kadian. The resident said she needed the breakthrough pain medication of Morphine Sulfate Concentrate to keep her pain controlled. The resident stated after requesting the Morphine at 8:00 P. M., by the time she finally received it (after midnight), she was in extreme pain. The resident stated she finally called the hospice provider around midnight and told her the facility would not administer her Morphine Sulfate Concentrate as ordered. The resident said LPN #334 would not speak to on-call Hospice Registered Nurse (HRN) #400. The resident said she also sent a text message to the Administrator about what was happening and showed this surveyor the message. Interview with the Administrator on 12/03/24 at 11:30 A.M. revealed (following this incident) the plan for Resident #17 was to not have LPN #334 provide care for her again. LPN #334 received disciplinary action on 11/26/24 for an incomplete assignment and lack of communication with management regarding on-shift occurrences. The Administrator verified this was related to not giving Resident #17 her as needed pain medication upon request. Telephone interview was conducted with HRN #400 on 12/03/24 at 3:57 P.M. HRN #400 revealed she was the on-call nurse for hospice the night of 11/25/24. On 11/26/24 at 12:25 A.M. HRN #400 said she received a call from Resident #17 who said she had been in horrible pain since 8:00 P.M. and had been asking for her breakthrough pain medication since then but had not received any. HRN #400 said she called the facility then, but no one answered. She then called the resident back who told her LPN #334 was at the door. HRN #400 told Resident #17 she wanted to speak with LPN #334. The hospice nurse was on speaker phone and heard LPN #334 refuse to speak with her. Resident #17 said she received the medication shortly thereafter. Interview with the Administrator and the DON on 12/03/24 at 4:10 P.M. revealed they were under the impression that the concerns of Resident #17 were that she wanted her breakthrough medication of Morphine Sulfate Concentrate at the same time as her routine dose Kadian. The DON was not aware Resident #17 had requested and not received her Morphine Sulfate Concentrate when she requested it on 11/25/24 at 8:00 P.M. Review of the facility undated policy titled Medication Administration, revealed medications were administered by licensed nurses in accordance with professional standards of practice and according to physician orders. This deficiency represents noncompliance investigated under Complaint Number OH00160337.