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	01/16/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30809 Based on medical record review and staff interview the facility failed to ensure an environment free of accidents hazards when smoking materials were not secured to prevent Resident #1 from smoking in his room. This affected one (#1) of three residents reviewed with a diagnosis of dementia on the locked nursing unit and the 24 (#2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24 and #25)additional residents residing on the locked memory care nursing unit. Facility census was 72. Findings include: Clinical record review revealed Resident #1 was admitted on [DATE] with diagnoses including dementia with behaviors, high blood pressure, chronic obstructive pulmonary disease, anxiety, disorder of kidney and ureter, chronic viral hepatitis, malnutrition and traumatic brain injury. A review of Resident #1's Minimum Data Set assessment dated [DATE] indicated Resident #1's cognition was intact. A review of Resident #1's hospital record dated 12/16/24 indicated he had a past medical history including the above listed diagnoses and currently smoked one pack of cigarettes per day. The hospital documentation indicated Adult Protective Services (APS) was involved and had deemed Resident #1 unfit to live alone APS assumed guardianship of Resident #1 until a formal guardian was approved by the court system. APS recommended long term care and orders for transfer to an extended care facility were obtained. A review of Resident #1's admission documentation dated 12/19/24 indicated he refused to allow the staff to inspect the belongings he brought to the facility with him. There was no documentation in Resident #1's record of an inventory of his personal effects. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's nursing progress note dated 01/12/25 indicated at approximately 4:30 P.M. an alarm sounded in Resident #1's room. The staff investigated the alarm and found Resident #1's room filled with smoke. Upon entering Resident #1's room there was smoke coming from Resident #1's wardrobe (furniture used to store clothing). When Resident #1's wardrobe was opened a jacket was found smoldering on the floor of the wardrobe. Certified Nursing Assistant (CNA) #75 picked up the jacket and placed the jacket in the sink in Resident #1's bathroom and doused the jacket with water which extinguished the fire. Smoke had entered the hallway on the nursing unit and the smoke alarm sounded in the nursing unit common area. All residents were checked for safety and evacuated to the common area in the nursing unit. Resident #1 refused to allow the nursing staff to assess him for injury and only stated he was upset and wanted to leave the facility. The nursing staff were able to calm Resident #1 and notified his daughter of the incident. The staff asked Resident #1 how the fire had started and he informed the staff he had lit a cigarette butt he had in his possession and after extinguishing the cigarette he had placed the cigarette butt in the pocket of his leather coat with his lighter. During an interview on 01/15/25 at 2:22 P.M. with Resident #1 he stated he had cigarette butt and a lighter in his possession and had the uncontrollable urge to smoke. Resident #1 state he smoked a few puffs of the cigarette butt and extinguished the cigarette butt and placed the cigarette butt in his leather coat pocket. Resident #1 then placed the leather coat in his wardrobe. Resident #1 verified the information in the above nursing progress note and stated he was aware the facility was a non-smoking facility. An interview with CNA #75 on 01/16/25 at 8:50 A.M. revealed Resident #1 had a diagnosis of dementia and was smoking a cigarette butt in his possession in his room. CNA #75 stated Resident #1 had mild cognitive impairment and was not consistent with the story he told regarding what had happened leading up to placing the hot cigarette butt in his leather jacket coat pocket. Resident #1 originally told CNA #75 he used matches to light his cigarette butt but then changed his story to the use of a lighter. Resident #1 told several different versions of the story regarding smoking in his room. CNA #75 stated he was unsure what to believe but stated Resident #1 was very upset and due to his diagnosis of dementia was unable to remember what had happened accurately. CNA #75 searched Resident #1's burned leather coat but found not smoking materials in the packets of the coat. An interview with the Administrator on 01/16/25 at 9:07 A.M. verified the above findings and stated Resident #1 knew the facility was a nonsmoking facility and agreed to his admission to the facility. The facility obtained an order for a nicotine patch for Resident #1 to curb his desire to smoke cigarettes. The Administrator stated Resident #1 was exit seeking and APS was involved with the determination to admit him to the locked memory care nursing unit at the facility. Resident #1 was homeless prior to his hospitalization and subsequent admission to the facility. Administrator stated Resident #1 had refused to allow the staff to inspect his clothing or belongings brought with him from the hospital upon admission to the facility. The facility policy titled Smoking Policy - Residents revised on June 2024 indicated the following: 1. Prior to, and upon admission, residents were to be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility could accommodate their smoking or non-smoking preferences. (continued on next page)

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