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	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review the facility failed to obtain orders and implement wound care in a timely manner. This affected one resident (#40) of two reviewed for wound care. The facility census was 93. Findings include: Review of Resident #40's medical records revealed an admitted [DATE] with diagnosis that included sepsis (blood infection). Review of care plan dated 05/21/22 revealed no information related to wound care. Observation on 05/25/22 at 8:22 A.M. revealed Resident #40 in a wheelchair propelling himself through the hall. Resident #40 had a dressing to his right leg that was tattered and not intact. Resident #40 appeared upset and was yelling and swearing. Attempted interview with Resident #40 at time of observation revealed Resident #40 was having pain in his right leg and was upset the nurse would not give him Tylenol. Resident #40 further stated he was upset the dressing to his right leg had not been changed since 05/20/22 when he had arrived at the facility from the hospital. Resident #40 had stated he did not want to discuss anything else and stated he was leaving the facility. Observation on 05/25/22 at 9:06 A.M. revealed Registered Nurse (RN) #855 in Resident #40's room removing the Resident #40's tattered dressing. Interview with RN #855 at time of observation confirmed Resident #40 arrived at the facility on 05/20/22 from the hospital and had no orders regarding the leg wound since his arrival. RN #855 stated the dressing had not been changed due to the lack of wound orders. Resident #40 confirmed his dressing had not been changed since his arrival. RN #855 continued to remove an Ace wrap and gauze. Observation of the leg revealed what appeared to be three separate wound areas that had been packed, the skin around the wound areas areas appeared reddened. The gauze dressing had dried green, brown, and bloody drainage with a foul odor detected. RN #855 confirmed the presence of the drainage and odor and discarded the old dressing. RN #855 did not clean the wound areas and stated she was unsure if she should clean the wounds because there were no physician orders regarding the wound. RN #855 applied new gauze and the old soiled Ace wrap to Resident #40's leg. Resident #40 stated to RN #855 you can't put that shit back on me. RN #855 then threw away the soiled Ace wrap, retrieved a clean Ace wrap which she applied over the gauze. Review of physician orders from 05/20/22 through 05/25/22 revealed no orders related to wound care. (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

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	06/02/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's physician orders dated 05/26/22 revealed orders to change right leg dressing every other day, remove old dressing and packing, clean with normal saline, apply Xeroform (petroleum based gauze), wrap with absorbent pads, gauze and Ace wrap. This deficiency substantiates Complaint Number OH00132653.

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	366114	A. Building B. Wing	06/02/2022

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 Based on record review and interviews the facility failed to obtain morphine, in a timely manner for Resident #100 who was under hospice care. This affected one of three residents reviewed for hospice care. The facility census was 93. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE] and a discharge to the hospital on 04/29/22. Diagnoses included malignant neoplasm of prostate, secondary and unspecified malignant neoplasm of lymph node, neoplasm related pain and adult failure to thrive. Review of the admission orders revealed an order for Seroquel (antipsychotic) 50 milligrams (mg) by mouth at bedtime for agitation, Seroquel (antipsychotic) 50 mg by mouth in the morning for agitation, Morphine Sulfate tablet extended release (narcotic) 30 mg by mouth two times a day for pain, acetaminophen suppository (analgesic) 650 mg insert rectally every four hours for mild pain, Haloperidol (antipsychotic) 5 mg give 0.5 by mouth every four hours as needed for agitation, Haloperidol (antipsychotic) 5 mg give one tab by mouth every four hours as needed for agitation, lorazepam (benzodiazepine) 1 mg one tab by mouth every two hours as needed for anxiety and shortness of breath, Morphine Sulfate Solution (narcotic) 20 mg/milliliter (ml) give 0.75 ml by mouth every one hour as needed for pain and dyspnea (shortness of breath), Morphine Sulfate Solution 20 mg/ml give one ml by mouth every one hour as needed for pain and dyspnea. Review of the admission assessment dated [DATE] revealed Resident #100 was cognitively impaired and had no pain. Review of a Facility Visit Record authored by Hospice Registered Nurse (HRN) #405, dated 04/28/22, revealed prescriptions had been faxed to the pharmacy and the facility Registered Nurse (RN) #875 was aware. Review of the medication administration record (MAR) revealed Resident #100 was administered Seroquel 50 mg at bedtime on 04/28/22. On 04/28/22 and 04/29/22 the MAR indicated, under Morphine Sulfate ER tablet Extended Release 30 mg, to see progress notes. Review of progress notes revealed no entries dated 04/28/22. Further review of the MAR revealed Resident #100 was administered Haloperidol 5 mg, 0.5 tab on morning of 04/29/22 at 11:12 A.M. On 4/29/22 at 2:00 P.M., Resident #100 was administered morphine sulfate solution 20 ml by mouth for a pain level of six (over 24 hours had lapsed since Resident #100 received morphine which was ordered twice daily and every hour as needed). Review of a progress note dated 04/29/22 timed 5:45 P.M. indicated Resident #100 spit the medication out and it was ineffective. Another note also dated 04/29/22 at 5:45 P.M. revealed medication was effective. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospice physician's progress note dated 04/29/22 revealed Hospice Medical Doctor (HMD) #435 described Resident #100's general appearance as moderately distressed and he appeared anxious. The note indicated the facility had not arranged for prompt delivery of opioids despite having valid prescriptions. It stated Resident #100's symptoms appeared to match opioid withdrawal as well as rapidly deteriorating clinical condition. HMD #435 ordered liquid morphine to be expedited and administered immediately. Interview on 05/24/22 at 11:00 A.M. with Regional Administrator #590 revealed Resident #100 was admitted on [DATE] around 10:00 P.M. and had no prescriptions. Regional Administrator #590 stated the hospice nurse came in on 04/28/22 with the prescriptions. Regional Administrator #590 said the medications ordered for Resident #100 were in their starter box but because Resident #100 was at a pain level of zero they did not administer the scheduled medications. Interview on 05/25/22 at 8:41 A.M. with Hospice Administrator (HA) #400 revealed Resident #100 was admitted to the facility from their hospice center as his symptoms were under control. HA #400 explained Resident #100 had a late admission on 04/27/22 and HRN #405 made a visit around 11:30 P.M. on 04/27/22. During that visit Resident #100 appeared comfortable and HRN #405 faxed the prescriptions to the pharmacy. On 04/28/22 Hospice Social Worker (HSW) #410 visited around 11:00 A.M. and met with Licensed Practical Nurse (LPN) #840 who questioned HSW #410 about the medications. HSW #410 indicated a nurse would be in shortly. HRN #415 came in some time between 1:30 P.M. and 2:00 P.M. and saw prescriptions in the chart and sent them to the pharmacy. On 04/29/22, HMD #435 and HRN #420 indicated Resident #100 was uncomfortable and symptomatic. HA #400 stated the son was upset Resident #100 was uncomfortable. HA #400 stated the physician's note indicated opioid withdrawal. HA #400 stated the doctor wrote Resident #100 indicated he was cold and in pain. Interview on 05/31/22 at 2:20 P.M. with the Director of Nursing (DON) revealed the facility faxed the pharmacy three times beginning 04/28/22 at 1:30 A.M. without success. The DON said the pharmacy closed at 11:00 P.M. The DON stated she also made three calls to the pharmacy. The DON verified Resident #100 had not been medicated on 04/28/22 until after 7:00 P.M. The DON confirmed they had a starter box containing the medications and unless there was a clinical reason to hold the medication, such as slow respirations, the nurses should have administered the routine medications regardless of the resident's pain level. Interview on 06/01/22 at 10:32 A.M. with the Pharmacist #150 revealed the pharmacy was never closed. Pharmacist #150 described the process of when a facility needed a medication, such as morphine, from the controlled starter box, which included filling out a form called Authorization to pull. Once the pharmacy received this form, they verified there was a prescription and then returned the form to the facility. Pharmacist #150 verified the medications Resident #100 was prescribed were in the controlled and non-controlled starter boxes. This deficiency substantiates Complaint Number OH00132713 and OH00132579.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview and record review the facility failed to ensure residents did not receive unnecessary medications. This affected two of eight residents (#3 and #79) reviewed for medications. The facility census was 93. Finding include: 1. Review of Resident #3's medical records revealed an admitted [DATE] with diagnosis that included dysphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had intact cognition. Review of current physician orders revealed Resident #3 was ordered Lovenox (blood thinning medication) 40 milligram (mg) in the morning, beginning on 03/30/22. Review of the Medication Administration Record (MAR) for May 2022, revealed documentation indicating the ordered Lovenox was scheduled to be administered at 7:00 A.M. each day. Further review of MAR for May 2022 revealed the Lovenox was documented as being administered as ordered. Telephone interview on 06/01/22 at 10:58 A.M. with the Director of Nursing (DON) revealed she was unable to state why the resident was on Lovenox due to no documented diagnosis or history of blood clots and no diagnosis to support the use of the medication. The DON stated she would contact the physician for clarification. A follow up interview with the DON on 06/01/22 at 11:16 A.M. revealed the physician indicated Resident #3 had Covid-19 in December of 2021 and was ordered Lovenox while acutely ill with the virus. The DON stated the physician gave a verbal order to discontinue the Lovenox. 2. Review of Resident #79's medical records revealed an admitted [DATE] with diagnoses including muscle weakness and contracture of the right knee. Review of the care plan dated 03/12/22 revealed Resident #79 had the potential for bleeding related to anticoagulant medications, and interventions included administer medications as prescribed Review of the MDS assessment dated [DATE] revealed Resident #79 had impaired cognition. Review of current physician orders revealed Resident #79 was ordered Heparin (blood thinning medication administered via injection) one milliliter (mL) two times a day, beginning on 03/21/22. Review of the MAR for May 2022 revealed documentation the Heparin was administered as ordered. Telephone interview on 06/01/22 at 10:58 A.M. with the DON revealed she was unaware why Resident #79 was ordered Heparin and stated she would contact the physician for clarification. (continued on next page)

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	366114	A. Building B. Wing	06/02/2022

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview with the DON on 06/01/22 at 11:16 A.M. revealed the physician indicated Resident #79 had a deep vein thrombosis (blood clot) at the hospital at an unestablished time and was ordered Heparin for treatment. The physician gave a verbal order to discontinue the Heparin.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, review of the Medication Administration Record (MAR), review of facility policy titled Insulin Administration, and review of the Medication Technician job description, the facility failed to administer insulin according to physician orders resulting in significant medication errors affecting four residents (Residents #89, #74, #68, and #19). This resulted in Immediate Jeopardy with actual harm or likelihood of actual harm including hyperglycemia (high blood sugar), which could lead to hospitalization and death. This affected four of 32 residents residing on the second floor. The facility identified 38 residents as receiving insulin. The facility census was 93. On 05/26/22 at 4:40 P.M. Administrator #305 and Regional Administrator #590 were notified Immediate Jeopardy began on 05/25/22 at approximately 10:06 A.M. when Medication Technician (MT) #850 stated she was unable to administer insulin for Residents #89, #74, #68 and #19 because she was not qualified and there was not a licensed nurse assigned to the unit to administer insulin. On 05/25/22 Resident #19 who had a diagnosis of diabetes was not given his Humalog (fast acting insulin) 10 units before meals, or his Lantus (long acting insulin) 40 units upon rise. The failure to administer the medication as ordered resulted in a blood sugar of 380 milligrams per deciliter (mg/dl) (normal 70-100 mg/dl) at 4:23 P.M. and a second blood sugar of 493 mg/dl with no time documented as to when the blood sugar was obtained. Resident #89 who had a history of diabetes was not given his Lispro (fast acting insulin) 12 units in the morning, Humalog per sliding scale, (amount of insulin required dependent on the blood sugar) before meals or Humalog 12 units in the afternoon between 11:00 A.M. and 2:00 P.M. The failure to administer the medication as ordered resulted in a blood sugar reading of 344 mg/dl. Resident #74 who had a diagnosis of diabetes was given Humalog due at 8:00 A.M. at 11:42 A.M., and there was no documentation the 11:00 A.M. or 4:00 P.M. sliding scale insulin was administered and no recorded blood sugar readings. Resident #68 who had a history of diabetes did not receive Humalog to be administered per sliding scale two times a day, and there were no documented blood sugar readings. Immediate Jeopardy was removed on 05/27/22 when the facility implemented the following: 05/26/2022 at 5:30 P.M., Residents #89, #74, #68 and #19 were assessed by Regional Quality Assurance Nurse (RQAN) #303 and found with no adverse reactions. All four residents' medical care plans were reviewed as well as a physical assessment completed with no adverse outcomes. RQAN #303 ran a Medication Audit Report for 05/25/2022 to 05/26/22 and all residents were reviewed for potential to be affected related to late or missed medications. All eight resident's medical care plans were reviewed as well as a physical assessment completed with no adverse outcomes. 05/26/2022 at 5:41 P.M., RQAN #303 notified Physician #301, and Physician #302 regarding insulin not administered as ordered for Resident #19, #68 and #74 with no noted adverse reactions. No new orders were given. At 5:45 P.M., RQAN #303 notified Medical Director #300 regarding insulin not being administered as ordered for Resident #89. (continued on next page)

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	366114	A. Building B. Wing	06/02/2022

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	05/26/22 at 6:45 PM, The Ad hoc Quality Assurance Project Improvement (QAPI) committee met to review the Immediate Jeopardy and notified Medical Director #300 of the Immediate Jeopardy situation and removal plan. Administrator #305, Regional Administrator #590, RQAN #303, Medical Director #300 and Acting Director of Nursing (ADON) #595 were in attendance during this meeting. 05/26/2022 at 7:30 P.M. All Nurses (7/7 RNs, 13/13 LPNs) and Medication Technicians (3/3) were educated on the Medication Administration Policy and Procedure. The facility had no contracted employees. In the event contracted staff would be employed, Director of Nursing (DON) #306, Registered Nurse (RN) #307 or designee would provide education on the policies prior to start of their shift. Medication Technicians would not be responsible for administering medications to any residents that required narcotics, insulin or had feeding tubes. The facility would always assign a specific nurse to cover the unit in addition to a medication technician to ensure all medications and treatments would be given as ordered on time. This education was transmitted via the company Paycom Notification Center to each individual staff member by Administrator#305. Nurses and Medication Technicians would be provided written education prior to working their next shift by DON #306, RN #307, or designee. On 5/27/2022, Administrator #305, Regional Administrator #590, RQAN #303, Medical Director #300 and ADON #595 reviewed the QAPI to address pharmacy services. Administrator #305, Regional Administrator #590 and the Minimum Data Set (MDS) Director were in attendance during this meeting. 05/27/22, audits by DON #306, RN #307/designee were initiated and to be conducted on three medication pass audits randomly three times a week to ensure medications were administered as ordered and on time. Audits would continue for the period of one months' time. DON #306 and Administrator #305 would be responsible for completing three medication pass audits at random, three times per week to ensure all medications were administered as ordered and on time. All audits to be kept in Administrator #305's office. At the end of the one-month audit period a QAPI meeting would be held to determine if the facility needed to extend supervision of the medication administration. 05/27/22, ongoing interviews by DON #306, RN #307/designee would be conducted to interview residents three times a week to ensure they were receiving their medications timely. Interviews would be completed for the period of one months' time. DON #306 and Administrator #305 would be responsible for completing three resident interviews at random three times per week to ensure all their medications were administered as ordered and on time. All audits to be kept in Administrator #305's office. At the end of the one-month audit period a QAPI meeting would be held to determine if the facility needed to extend supervision of the medication administration. Although the Immediate Jeopardy was removed on 05/27/22, the deficiency remained at a Severity Level 2 (no actual harm with the potential for minimal harm that is not Immediate Jeopardy) as the facility was continuing to educate staff and was in the process of completing and reviewing audits to determine further action if required. Findings Include: 1. Review of Resident #89's medical records revealed Resident #89 was admitted to the facility on [DATE] with diagnosis of diabetes. Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #89 had intact cognition. Review of the care plan dated 04/19/22 revealed Resident #89 had the potential for impaired metabolic status related to diabetes. Interventions included to administer medications as indicated by physician orders. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of current physician orders for May 2022, revealed Resident #89 was ordered Lispro (fast acting insulin) 12 units upon rise (no time frame indicated), Humalog (fast acting insulin) 12 units in the afternoon (11:00 A.M. to 2:00 P.M.) and Humalog sliding scale (insulin amounts vary depending on blood sugar) to be administered at 8:00 A.M., 11:00 A.M. and 4:00 P.M. Review of Resident #89's MAR for 05/25/22 revealed no documentation the Lispro, or Humalog insulin were administered at 8:00 A.M., or 12:00 P.M. A corresponding progress note indicated medication was not given due to out of timeframe. Further review of the MAR revealed four units of Humalog was administered at 2:09 P.M. by RN #790, for a blood sugar reading of 310 mg/dl, and 12 units of Humalog was administered by RN #790 at 4:40 P.M. (this insulin was ordered to be given between 11:00 A.M. and 2:00 P.M.). Interview on 05/25/22 at 2:10 P.M. with MT #850 revealed she obtained Resident #89's blood sugar approximately 5-10 minutes prior and the blood sugar was 344 mg/dl. MT #850 further stated she was the only personnel who had access to the keys to the medication cart, and no nurse had approached her for the keys to the medication cart to obtain insulin or other medication. Interview on 05/25/22 at 4:17 P.M. with Resident #89 revealed his blood sugar was taken a few minutes ago and he was told by the nurse that his blood sugar was high. He stated the actual number was not told to him and he had been given 12 units of insulin. Resident #89 further stated he did not receive his insulin on previous occasions but could not recall specifics dates or times. Interview on 05/31/22 at 10:03 A.M. with ADON #595 revealed she had assisted MT #850 with some of her medication administration. ADON #595 stated she had given various insulins and narcotics during the shift however she had not documented the administration of the medications in a timely manner. ADON #595 said there were some medications that had not been administered on 05/25/22 but could not be more specific on what these medications were. 2. Review of Resident #74's medical records revealed an admitted [DATE] with diagnosis that included diabetes. Review of the MDS assessment dated [DATE] revealed Resident #74 had impaired cognition. Review of the care plan dated 04/13/22 revealed Resident #74 was at risk for hyper/hypoglycemia (high and low blood sugars) related to diabetes and interventions included administer medications as ordered. Review of current physician orders for May 2022, revealed Resident #74 was ordered six units of Humalog before meals at 8:00 A.M., 11:00 A.M. and 4:00 P.M. Review of Resident #74's MAR for 05/25/22 revealed the 8:00 A.M. dose of Humalog was administered at 11:42 A.M. by ADON #595, and there was no documentation the 11:00 A.M. and 4:00 P.M. doses were administered. 3. Review of Resident #68's medical records revealed an admitted [DATE] with diagnoses that included difficulty walking, stroke with right sided weakness and diabetes. Review of the MDS assessment dated [DATE] revealed Resident #68 had intact cognition. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plan dated 04/16/22 revealed Resident #68 had an impaired metabolic status related to diabetes and interventions included monitor glucose levels and administer insulin as ordered. Review of current physician orders for May 2022, revealed Resident #68 was ordered Humalog per sliding scale two times a day. Review of Resident #68's MAR for 05/25/22 revealed no documented blood sugar readings or insulin was administered upon rise (no time frame indicated) or at 4:00 P.M. 4. Review of Resident #19's medical records revealed an admitted [DATE] with diagnoses that included diabetes and long-term use of insulin. Review of the care plan dated 03/24/22 revealed Resident #19 had impaired metabolic status related to diabetes and interventions included monitor glucose levels and administer insulin per physician orders. Review of the MDS assessment dated [DATE] revealed Resident #19 had intact cognition. Review of current physician orders for May 2022, revealed Resident #19 was ordered 40 units of Lantus in the morning, 10 units of Humalog before meals, and sliding scale coverage. During observation on 05/25/22 at 1:15 P.M. Resident #19 was yelling out for a nurse, upon entering Resident #19's room, he inquired about his insulin, and stated he had not received his morning or afternoon doses. Resident #19 stated he had already consumed his breakfast and lunch and stated his sugar was probably going to be high. Interview with RN #790 at 1:23 P.M. revealed RN #790 was not aware Resident #19 had not received his insulin. RN #790 said she would speak with Resident #19. At 1:27 P.M., RN #790 entered Resident #19's room and he informed her he had not received his insulin and his blood sugar had not been checked. Resident #19 also told the nurse this had occurred before. RN #790 informed Resident #19 she would have to wait until MT #850 returned to the floor because she did not have keys to the medication cart. Interview on 05/25/22 at 2:08 P.M. with RN #790 revealed she obtained Resident #19's blood sugar and it was 390 mg/dl. RN #790 administered Resident #19's standard order of 10 units of Humalog. Review of Resident #19's MAR for 05/25/22 revealed no documentation the Lantus which was due upon rise (no time frame specified) was administered. Further review revealed the 8:00 A.M. ordered 10 units of Humalog was documented as not given due to it was outside of the time frame (blood sugar was 170), 11:00 A.M. dose was not documented, and no blood sugar reading was recorded on the MAR, and the 4:00 P.M. dose was administered at an unknown time (no time was recorded), with a blood sugar reading of 493 mg/dl. Further review of the MAR revealed the sliding scale Humalog due at 8:00 A.M. had not been given due to outside of the timeframe, 11:00 A.M. dose was administered at 2:08 P.M. with a blood sugar reading of 380 mg/dl, and the dose due at 4:00 P.M. had not been documented as given. Interview on 05/31/22 at 10:03 A.M. with ADON #595 and Regional Administrator #590 revealed several medications had not been documented accurately and some had not been given. ADON #595 stated she had made some errors in documentation but was not specific, and stated it was a crazy day. (continued on next page)

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	06/02/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Medication Technician job description effective 11/29/21 revealed responsibilities included delivery of routine oral, inhalation and topical medications under direct supervision of a licensed nurse. Review of the facility policy titled Insulin Administration revised 09/14 revealed only appropriately licensed personnel shall draw and administer insulins and check blood glucose readings per physician orders. This deficiency substantiates Complaint number OH00132653.

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	06/02/2022

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, record review, and policy review the facility failed to maintain appropriate infection control procedures while administering medications. This affected two residents (#77 and #53) of three residents observed for medication administration. The facility census was 93. Findings include: 1. Review of Resident #77's medical records revealed an admitted [DATE] with diagnoses that included, diabetes and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had intact cognition. Review of physician orders for May 2022 revealed Resident #77 was ordered, 10 units of Humalog (fast acting insulin) one time a day at breakfast, and Lantus (long acting insulin) 31 units one time a day, Brimonidine (glaucoma eye drops) one drop in the eye, and dorzolamide (glaucoma eye drops), two drops int both eyes. Observation of medication pass on 05/25/22 at 11:07 A.M. with Registered Nurse (RN) #885 for Resident #77 revealed when obtaining a finger stick blood sugar she did not wear gloves. RN #885 returned to the medication cart and drew up 10 units of Humalog insulin and 31 units of Lantus insulin, re-entered Resident #77's room and administered the insulin into Resident #77's resident left arm. RN #885 did not wear gloves or complete hand hygiene as she obtained the blood sugar and administered the insulin. Further observation revealed RN #885 returned to the medication cart, obtained Resident #77's ordered eye drops and returned to Resident #77's room, administered the eye drops without wearing gloves or completing hand hygiene. Interview with RN #885 immediately after the observation revealed she was not aware she was required to wear gloves during blood sugar checks and stated I don't like to wear gloves when administering eye drops. RN #885 confirmed she did not complete hand hygiene after medication administration. 2. Review of Resident #53's medical records revealed an admitted [DATE] with diagnoses that included depression, epilepsy and organ transplant. Review of physician orders for May 2022 revealed Resident #53 was ordered clonazepam (anti anxiety medication) 0.5 milligrams (mg) twice a day and Lacosmide (seizure medication) 300 mg daily, and oxycodone (narcotic pain medication) 2.5 mg every four hours. Observation of medication pass on 05/25/22 at 11:27 A.M. with RN #885 for Resident #53 revealed RN #885 obtaining Resident #53's ordered Lacosmide two tablets, clonazepam one tablet and then obtained oxycodone one tablet from the narcotic drawer. RN #885 placed the medications into her bare hands and had then placed them into a medication cup. Interview with RN #885 immediately after completion of medication administration confirmed RN #855 placed the pills into her bare hand and did not complete hand hygiene before of after medication administration. (continued on next page)

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	06/02/2022

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Medication Administration dated 06/21/17 revealed medications should never be touched with fingers. This deficiency substantiates Complaint Number OH00132653.