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	09/01/2022

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure four residents (Resident #69, #70, #78, #82) were provided assistance with activities of daily living (ADL). This affected four residents (Resident's #69, #70, #78, #82) out of six residents reviewed for ADL. Findings include: 1. Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses including diabetes mellitus type two, muscle weakness, abnormalities of gait and mobility, and malignant neoplasm of the prostate. The resident's shower, bathing days were listed as Monday and Thursdays in the evening. Review of Resident #82's Care Plan, dated 07/11/22, revealed the resident had an activities of daily living (ADL) function due to weakness and morbid obesity. Interventions included assist the resident with activities of daily living (dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed, bed mobility with two person assist, honor the resident's choices and preferences whenever possible, two person assist with incontinent care, two person assist for transfers. Review of Resident #82's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had intact cognition, required extensive one person physical assistance for dressing, extensive two person physical assistance for toilet use and personal hygiene, and one person physical assistance for bathing. Review of Resident #82's Ambassador Rounds checklist revealed on 08/04/22 the question of if the bed had a mattress and was made was answered no, and no sheet on bed and staff was notified. Review of the facility second floor shower schedule revealed Resident #82 was scheduled for showers Tuesdays and Fridays during the day shift. Interview on 08/16/22 at 9:46 A.M. with Resident #82 revealed today was his shower day. Resident #82 stated Tuesday and Fridays were his shower days and he was supposed to get a shower in the morning on those days. Resident #82 stated he was ready and there was some hesitation from the staff as to whether he was going to get a shower and could the surveyor check into it. (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
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/16/22 at 12:15 P.M. with Activities Director (AD) #645 revealed she was Resident #82's resident ambassador. AD #645 stated Resident #82 had some questions about his shower schedule because he was recently moved from third shift showers to day shift showers. AD #645 stated Resident #82 might have missed a shower and Resident #82 also requested bigger sheets to fit his bed. AD #645 stated she filled out Ambassador Round forms when she made rounds for Resident #82 and wrote concerns on the forms. AD #645 indicated the forms were given to the Administrator once they were filled out. Interview on 08/16/22 at 3:30 P.M. with the Director of Nursing revealed a new resident shower schedule was recently completed because it was not clear what days the residents were supposed to have a shower. The DON stated some residents were moved around and were concerned they would not get a shower. The DON stated the facility was working with the residents to find out which days worked best for the residents to get their showers. Interview on 08/16/22 at 3:55 P.M. with Resident #82 revealed he did not get shower today because the staff could not a find hoyer pad. Resident #82 stated he was offered a bed bath but he wanted a shower. Resident #82 stated he has been asking the staff to cut his fingernails for three weeks, but the nurses told him they only had small clippers and his fingernails were too long for small clippers. Observation of Resident #82's fingernails revealed they were about three quarters to one inch long, some had jagged edges and there was yellowish brown material under the fingernails. Resident #82 stated it was embarrassing to have such long fingernails. Resident #82 stated the staff could not find a sheet to cover his bed and pointed to his mattress. Observation of the mattress revealed no sheet and a bare mattress with nothing covering the mattress. Resident #82 stated there were no sheets large enough to cover his bed, there was a sheet on the bed but it was bunched up underneath him, and he was laying on the bare mattress all day. Registered Nurse (RN) #511 walked into the room and when made aware of the sheet bunched under the resident reached underneath the resident and pulled the sheet out so it was not bunched under the resident any longer. Observation of the sheet revealed it was a flat sheet, not fitted and did not cover the entire bariatric mattress. RN #511 stated the sheet did not fit the bed correctly. Interview on 08/16/22 at 4:15 P.M. with Certified Nursing Assistant (CNA) #600 revealed the facility was usually short on hoyer pads. CNA #600 stated Resident #82 needed a bariatric hoyer pad and he would look around for one so he could give Resident #82 a shower. CNA #600 stated the hoyer pads could usually be found in the laundry department, and a lot of times sheets were not the correct size for the bed. CNA #600 stated sometimes he borrowed the bariatric hoyer pads from other residents if he could not find one. Observation on 08/16/22 at 4:27 P.M. with the DON of Resident #82 confirmed he had long jagged fingernails with yellowish brown material under the nails and stated she would make sure they were clipped shorter. The DON confirmed Resident #82 did not receive a shower and there was not a bariatric size hoyer pad for Resident #82 to use so he could have a shower. The DON stated she would check with Housekeeping Supervisor (HS) #601 regarding a bariatric hoyer pad, and the pad might be getting washed because Resident #82 had his own hoyer pad. The DON stated she would check on the status of bariatric fitted sheets for Resident #82's bed. Observation on 08/16/22 at 4:36 P.M. with HS #601 revealed there were 28 bariatric fitted sheets on the nursing unit Resident #82 resided on. The sheets were observed on the clean laundry cart in the shower room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/16/22 at 4:40 P.M. with HS #601 of Resident #82 revealed Resident #82 stated he did not have his own hoyer pad. Interview on 08/16/22 at 4:54 P.M. with CNA 600 revealed he could not find a bariatric hoyer pad and Resident #82 would not be able to get out of bed on second shift or have a shower. CNA #600 stated he typically did not get Resident #82 up on second shift because he could not find a bariatric hoyer pad. Observation on 08/16/22 at 5:05 P.M. of the laundry area with HS #601 revealed hoyer pads had just been washed and were hanging to dry, but there were no bariatric hoyer pads in the laundry area. HS #601 stated she did not know where any bariatric hoyer pads were at this time. Interview on 08/16/22 at 5:05 P.M. revealed the DON attempted to find a bariatric hoyer pad and was unsuccessful. Review of the facility policy, Activity of Daily Living, Supporting, dated 03/2018, included appropriate care and services would be provided for residents who were unable to carry out Activity of Daily Livings's independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene (bathing dressing, grooming, and oral care). 2. Review of Resident #70 medical record revealed and admitted [DATE] with diagnoses including hypertension, morbid obesity, epilepsy, and heart failure. Review of Resident #70 quarterly MDS, dated [DATE], revealed the resident required limited one person physical assist for bed mobility, dressing, and transfers, and extensive one-person physical assist for toilet use and personal hygiene, and one person physical help with bathing. Interview on 08/15/22 at 3:23 P.M. with Resident #70 revealed sometimes the aides did not want to clean her private area because they wanted her to do it. Resident #70 stated she would like to do it but she could not reach her bottom to clean herself properly. Resident #70 stated she had to tell staff to wipe her rear end and her bottom was a little sore when it was wiped. Review of Resident #70 Care Plan, dated 08/16/22, revealed need assistance with ADL's related to history of seizures, history of falls, and weakness. Interventions included the resident will be well groomed and free of odors at all times and will participate as able in ADL self-care, to apply house moisture barrier cream after each incontinence episode, extensive assist of one for bathing, provide incontinence care with routine rounds and as needed, set up and assist as needed for completion of all ADL, and staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly. Interview on 08/17/22 at 9:58 A.M. with Resident #70 revealed she asked an aide this morning to help her clean her bottom and the aide told her she could clean herself. Resident #70 stated she could not reach her bottom to clean it properly. Resident #70 stated she did not have a bowel movement today, but had one yesterday and was never cleaned properly. Resident #70 stated the aide would not help her when she asked to have her bottom cleaned. Resident #70 did not know the aides name. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/17/22 at 10:00 A.M. after surveyor intervention with State tested Nursing Assistant (STNA) #602 and Resident #70 revealed Resident #70 mostly cleaned herself, but if Resident #70 needed assistance STNA #602 would assist her. Resident #70 stated she needed help cleaning herself and wanted to be cleaned now. Resident #70 walked unsteadily into the bathroom and held onto the grab bar and bent over slightly. STNA #602 used a wet wash cloth and proceeded to clean Resident #70. Observation of bowel movement on the wash cloth was confirmed by STNA #602. STNA #602 confirmed she did not offer to help Resident #70 before now to clean her bottom. Review of the facility policy, Activity of Daily Living, Supporting, dated 03/2018, included appropriate care and services would be provided for residents who were unable to carry out Activity of Daily Livings's independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene (bathing dressing, grooming, and oral care). 3. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including reduced mobility, epilepsy, [NAME] -[NAME] Syndrome, and muscle wasting/atrophy. Review of Resident #78 quarterly MDS assessment, dated 07/21/22, revealed the resident had impaired cognition. The resident required two person physical assistance for bed mobility, bathing, toilet use, and transfers, one person physical assistance for dressing and personally hygiene. Review of Resident #78's care plan, dated 08/12/22, revealed the resident had an ADL self-care performance deficit related to non-traumatic subarachnoid hemorrhage, epilepsy, and anemia. Interventions included assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed, two person assist for bed Mobility, encourage participation in daily care and provide positive reinforcement for activities attempted and/or partially achieved, extensive assist of one for dressing and hygiene, extensive to total assist of one for bathing, honor resident's choices and preferences whenever possible, mechanical lift with two staff for transfers, extensive two person assist with incontinent care. Review of Resident #78's assessments and progress notes from 07/01/22 through 08/17/22 did not reveal documentation of a reddened, excoriated area on Resident #78's left upper thigh and buttock. Review of Resident #78's physician orders from 07/01/22 through 08/17/22 did not reveal orders for a reddened excoriated area on Resident #78's left upper thigh and buttock. Interview on 08/16/22 at 4:09 P.M. with Family Member (FM) #604 revealed the care in the facility was deplorable. FM #604 stated Resident #78 was reeking of urine on 08/15/22 and smelled badly. FM #604 stated Resident #78 had a wound on her leg between the upper thigh and buttock, and it caused Resident #78 to have pain when the area was wiped with a cloth, and nothing was being done about it. FM #604 stated Resident #78's incontinent brief was not changed timely and she was not given personal care when needed. FM #604 stated she did not think Resident #78 received showers. FM #604 stated she reported all this to the Administrator but the Administrator she talked to was not at the facility now. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/17/22 at 9:36 A.M. of STNA's #412 and #417 providing incontinence care for Resident #78 revealed this was the first time Resident #78 was changed since the STNA's arrived at 7:00 A.M. STNA's 412 and #417 stated Resident #78 was not given a shower but was provided a bed bath on her scheduled bathing days. Resident #78 stated she wanted to have a shower and STNA #417 stated Resident #78 always said she wanted a shower but didn't know what she was saying. Observation of Resident #78 revealed her incontinence brief was very wet and there were reddened excoriated areas on the upper left thigh where the thigh met the buttocks. STNA #417 stated the area looked the same as it did yesterday. When asked if a nurse was notified about the reddened excoriated area STNA #417 stated she thought the nurse was aware of it. STNA #417 stated she did not know the name of the nurse she told about the reddened area. Interview on 08/17/22 at 9:36 A.M. of Licensed Practical Nurse (LPN) #603 revealed she was not aware of a reddened excoriated area on Resident #78's left upper thigh near the buttock. Review of Resident #78's progress notes on 08/17/22 at 2:08 P.M. included a STNA informed the nurse that Resident #78 had some excoriation to her left gluteal fold and left posterior upper thigh. Certified Nurse Practitioner made aware of the current skin issues and new orders for the patient to be seen by the wound team, and to apply zinc cream after each incontinence episode . Family made aware of the current skin alterations no further questions or concerns noted. Review of the facility policy, Activity of Daily Living, Supporting, dated 03/2018, included appropriate care and services would be provided for residents who were unable to carry out Activity of Daily Living independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene (bathing dressing, grooming, and oral care). 4. Review of Resident #69's medical record revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, cognitive communication deficit, muscle weakness, and dementia. Review of Resident #69's quarterly MDS assessment, dated 06/23/22, revealed the resident was cognitively intact. The resident required total dependence with two-person physical assist for bed mobility, toilet use, and transfers, total one person dependence for dressing, one person assistance for personal hygiene and bathing. Review of Resident #69's skin grid, dated 07/11/22, revealed the resident had a left buttock abrasion. The area measured 2 length by 2 width by 0.1 depth. The area was healed by 07/18/22. Review of Resident #69's care plan, dated 07/26/22, revealed the resident had a left buttock abrasion. Interventions included air mattress to bed, dressing per order, follow wound NP/MD as needed, and observe for signs and symptoms of infection. Review of Resident #69's care plan, dated 07/26/22, revealed the resident had an ADL self-care performance deficit related to a diagnosis of CVA/TIA, dementia, depression, generalized weakness, left hemiplegia, impaired mobility, and pain. Interventions included assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed. bed Mobility with two person assist, encourage participation in daily care and provide positive reinforcement for activities attempted and/or partially achieved, mechanical lift with two staff for transfers, toileting with two person assist with incontinent care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/17/22 at 9:58 A.M. with Resident #69 revealed she wanted to have a shower but was typically given a bed bath. Interview on 08/17/22 at 10:00 A.M. with STNA #602 revealed Resident #69 had not been given a shower for awhile. STNA #602 could not remember the last time Resident #69 was given a shower. STNA #602 stated she gave Resident #69 a bed bath and not a shower because Resident #69 did not want a shower because she was afraid of falling. STNA #602 stated she had never used the shower bed to give any resident a shower and was not even sure where it was located. Interview on 08/17/22 at 10:18 A.M. with Resident #70 revealed Resident #69 smelled bad sometimes and needed a shower. Interview on 08/17/22 at 10:18 A.M. with STNA #602 and Resident #69 revealed Resident #69 was afraid of the shower bed but stated she would like a shower using the shower chair. STNA #602 stated OK she would try the shower chair. When STNA #602 was asked why the shower chair had not been attempted previously STNA #602 stated it because Resident #68 was lying in bed a lot. Interview on 08/17/22 at 2:40 PM with STNA #602 revealed she gave Resident #69 a bed bath today. STNA #602 stated she did not give Resident #69 a shower today because she did not make it back to her room to give a shower. STNA #602 stated she did not run out of time to give Resident #69 a shower, she probably could have fit it in, but quite frankly it was not Resident #69's shower day. STNA #602 stated she remembered talking with Resident #69 about using the shower chair. Review of the facility policy, Activity of Daily Living, Supporting, dated 03/2018, included appropriate care and services would be provided for residents who were unable to carry out Activity of Daily Living independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene (bathing dressing, grooming, and oral care). This deficiency substantiates Complaint Number OH00134587, Complaint Number OH00134911, and Complaint Number OH00134375. This is an example of continued non-compliance from the survey dated 07/13/22.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 42013 Based on observation, interview, record review, and review of facility policy, the facility failed to provide appropriate supervision of one cognitively impaired resident (Resident #53), who was at high risk for elopement and required supervision with activities of daily living, resulting in the resident leaving the facility without staff knowledge on 08/16/22. This resulted in Immediate Jeopardy when Resident #53 was last observed on 08/16/22 at 7:00 P.M. sitting on the bed in his room by Registered Nurse (RN) #515 and State tested Nursing Assistant (STNA) #414 and was not identified as missing until Resident #53's wife called the facility at 8:05 P.M. and informed RN #515 that Resident #53 had left the facility and was at a local drugstore located on the corner of two busy roads approximately a quarter of a mile away from the facility. Resident #53 passed through two secured doors inside the facility to reach the outside and walked along a busy road and passed by a busy shopping area on his way to the drugstore. The local police escorted Resident #53 back to the facility. Resident #53 had no known injuries. This affected one resident (Resident #53) out of three residents reviewed for elopement. On 08/25/22 at 4:09 P.M. Senior Administrator #606, Licensed Nursing Home Administrator (LNHA) #607 and the Director of Nursing were notified Immediate Jeopardy began on 08/16/22 at 7:00 P.M. when Resident #53 who was at risk for elopement was last observed by facility staff and was not identified as missing until Resident #53's wife called the facility at 8:05 P.M. Resident #53 passed through two secured doors inside the facility to reach the outside and walked along a busy road and passed by a busy shopping area on his way to the drugstore. The Immediate Jeopardy was removed on 08/19/22 when the facility implemented the following corrective action: A head count was completed by the nurse (Registered Nurse (RN) #515), on 8/16/2022, at 8:10 P.M. and reported to the Director of Nursing (DON), and the Administrator (Senior Administrator (SA) #606). Confirmation of the head count was completed. On 8/16/2022 at 8:16 P.M. Resident #53 returned to the facility with no negative effects. Resident #53's attending physician was notified by RN #515, on 8/16/2022 at 9:00 P.M. The Medical Director was notified of the elopement by the Administrator (SA #606) on 8/17/22 at 9:00 A.M. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	By 8/16/2022, all residents were assessed for elopement by the DON. As a result of the assessments, no other residents were identified as high risk for elopement. An elopement binder at each nurse's station had all residents identified as an elopement risk for staff review. On 8/16/2022 at 8:30 P.M., all staff in the building, including agency staff, were educated by the nursing supervisor in person to review the elopement binders at the start of each shift. This education was provided to the following staff members on shift which included one housekeeping aide, three nurses and 13 STNAs. On 08/17/2022 the remainder of the staff members were educated by the DON or LNHA (Licensed Nursing Home Administrator) either in person or over the phone which included the following staff members, 40 STNAs, seven dietary personnel, eight housekeeping personnel, one medtech, 13 administration, 12 nurses and eight agency nurses. The DON or designee would audit three residents weekly for three months. Audits would be reviewed by Quality Assurance and Performance Improvement (QAPI) monthly with recommendations for changes to be made as necessary. On 8/16/2022 at 8:30 P.M., all staff in the building, including agency staff, were educated by the nursing supervisor in person on the facility elopement procedures and ensuring that no residents were following while leaving unit, and the door closed completely before walking away. This education was provided to the following staff members on shift which included one housekeeping aide, three nurses and 13 STNAs. On 08/17/2022 the remainder of the staff members were educated by the DON or LNHA either in person or over the phone which included the following staff members, 40 STNAs, seven dietary personnel, eight housekeeping personnel, one medtech, 13 administration, 12 nurses and eight agency nurses. On 8/16/2022, a wander guard (alarmed monitoring device) was placed on Resident #53 upon return to the facility at 8:16 P.M. Exit door alarms were tested by the Nursing supervisor and were found to be working properly on 8/16/2022 at 8:30 P.M. Exit doors would be tested daily by Maintenance Director #503 or designee beginning 8/16/2022. Results would be reviewed in QAPI monthly. The Administrator or designee would conduct random audits starting 8/22/2022, of three staff, three times per week for four weeks to test staff knowledge of elopement procedures and how to prevent an elopement. Results will be reviewed in QAPI monthly. Newly admitted residents would continue to have an elopement assessments completed upon admission. The DON or designee would review the elopement assessment for accuracy and would continue indefinitely. On 08/17/22 family member and responsible parties were educated via an electronic communication system that when leaving the facility to ensure that no residents leave with them or behind them. On 8/17/2022 Administrator #606 attempted to contact all legible visitors on the log to interview them regarding when they left facility. No visitors contacted gave any valuable information regarding how elopement occurred. On 8/17/2022, sign placed at secured unit to remind visitors when leaving to ensure no residents follow and that door is secure before walking away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/2022, a whole house audit was completed by Maintenance Director #503 to ensure all facility windows were secured. No negative outcome. On 8/17/2022, Resident #53's care plan was reviewed by the Clinical Reimbursement Specialist to ensure all appropriate interventions were in place due to his risk for elopement. All like residents care plans were reviewed and revised if necessary on 08/17/2022. The facility had Corporate Maintenance Staff ensure proper function of all facility doors on 8/19/2022. The Contracted Alarm Company was in the facility on 8/18/2022 to ensure proper function of all facility door alarms. Company was previously, contracted to check them at least four times per year On 8/26/2022, facility would start elopement drills on each nursing shift on a weekly basis. Although the Immediate Jeopardy was removed on 08/19/22, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure continued compliance. Findings include: Review of Resident #53's medical record revealed an admitted [DATE] and diagnoses included vascular dementia, major depressive disorder and anxiety disorder. Review of Resident #53's physician orders dated, 05/17/22, revealed Resident #53 may go leave of absence with supervision. Review of Resident #53's Wandering and Elopement assessment dated [DATE] revealed Resident #53 was cognitively impaired with poor decision-making skills, had dementia, anxiety disorder, depression and ambulated independently. Resident #53 wandered aimlessly and there were significant changes in Resident #53's status. The assessment revealed Resident #53 liked to wander and roam throughout and was at a high risk for elopement. The assessment further revealed appropriate interventions were initiated and included Resident #53 was on a secured unit, his photo was in the elopement risk book, and staff were aware of Resident #53's elopement risk. Review of Resident #53's care plan dated, 05/18/22, revealed Resident #53 was at high risk for elopement. Resident #53 had a diagnosis of dementia and had impaired cognition. Resident #53 would remain safe within the facility unless accompanied by staff or other authorized persons through next review. Interventions included if Resident #53 was missing from the facility, follow elopement protocol, notify physician and family immediately and document. If Resident #53 was wandering in a potentially unsafe area or situation, redirect to safer area. Review of Resident #53's progress notes on 05/18/22 at 4:00 A.M. included Resident #53 had impaired decision making, disorganized thinking and trouble concentrating. The note revealed Resident #53 stood at the exit door and held bar at times. Resident #53 was distracted with snacks and fluids. Resident #53 was redirected when trying to wander into other resident rooms and had difficulty remembering where his room was. (continued on next page)

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	366114	A. Building B. Wing	09/01/2022

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Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #53's Admission Minimum Data Set (MDS) 3.0 assessment dated , 05/24/22 revealed Resident #53 had severe cognitive impairment, required supervision with Activities of Daily Living, and walking was not steady, but resident could stabilize without staff assistance. Review of Resident #53's progress notes on 06/27/22 at 3:09 P.M. revealed Resident #53 was exit seeking. Review of Resident #53's progress notes on 08/10/22 at 3:55 A.M. revealed Resident #53 had difficulty remembering where his room was and needed redirection at times. Observation on 08/16/22 at 8:41 A.M. revealed a double door leading into the secured memory care unit from another hall inside the facility had a red button located on the wall. The red button needed to be pressed to gain entry to the secured unit. Once the button was pressed the door was able to be opened. One side of the double doors opened, and the secured unit could be entered. After entering the secured unit observation revealed one door prevented the other door from closing and locking to secure the unit. The door alarm sounded and after approximately 30 seconds State tested Nursing Assistant (STNA) #538 walked up the hall, pressed the red button on the wall outside the secured unit and forcefully pulled the door closed so it latched. The door alarm stopped sounding. STNA #538 stated the door had to be forcefully pulled shut to properly close and lock the doors and the door had been like that awhile. Review of Resident #53's Call Summary Report from the local police department revealed on 08/16/22 at 7:51 P.M. a call was placed from the local drugstore to the police requesting an officer be dispatched due to older male seemed confused. The [AGE] year-old male was wearing a green hat, black jacket, and black pants and stated he was walking back from the VA (Veteran Affairs). The officer spoke to the older male's wife and was identified as Resident #53 and had dementia. Resident #53 was transported back to the facility at 8:24 P.M. by the police officer and returned to his unit. Review of Resident #53's Behavior Note assessment dated [DATE] at 9:14 P.M. revealed Resident #53 was observed outside the facility. Resident #53 was brought back into the facility. Resident had no signs or symptoms of injury observed. No complaints of pain. Vital signs were temperature 97.8 Fahrenheit, pulse 80, respirations 18, blood pressure 120/72 with pulse oximeter (oxygen saturation) of 98% on room air. The Director of Nursing and Administrator were notified. The physician and family made aware of the current incident and plan of care at this time. Facility staff checked on patient frequently throughout the night patient resting in bed no signs and symptoms of distress noted. Review of the Self-Reported Incident Form (SRI), tracking number 225452, dated 08/16/22 included at 8:05 P.M. the nurse received a call stating Resident #53 was at the local drugstore with the police. Resident #53 was escorted back to the facility with no visible injuries noted. The SRI further included no staff let Resident #53 off the floor, all doors were functioning properly. Staff statements do not indicated neglect occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Witness Statement written on 08/16/22 by Registered Nurse (RN) #515 revealed Resident #53 was in his bed at 7:00 P.M. RN #515 stated she received shift change report from the day shift nurse and began medication administration to the residents. At 8:05 P.M. RN #515 received a call from Resident #53's wife telling her Resident #53 was at the local drugstore and the police were with him. Resident #53 was escorted back to the facility by the police, and he was evaluated for injury. The DON was notified regarding the elopement. The statement further revealed after 7:00 P.M. Licensed Practical Nurse (LPN) 607 left the unit, the laundry aide and dietary aides entered and left the unit. No residents exited the unit at these times. The front door did not alarm in the lobby. An in-service was given for staff and a count of all residents was done with no other residents missing. The second State tested Nursing Assistant assigned to the secured unit arrived at 8:00 P.M. Interview on 08/17/22 at 4:14 P.M. with Maintenance Director (MD) #503 revealed he began working for the facility on 08/01/22. MD #503 confirmed the door to the secured unit did not close without being forcefully pulled shut and needed to be fixed. MD #503 stated he had a lot of work to catch up on since he started, and the previous maintenance director did not leave details regarding work needing to be done. Review of MD #503's Witness Statement dated, 08/19/22, included Traveling Maintenance Director (TMD) #608 assisted with maintenance and adjustment of the facility doors. Observation on 08/25/22 at 7:50 A.M. of the door leading into the secured unit revealed it closed and latched without being forcefully closed after it was opened to allow entry into the unit. Interview on 08/25/22 at 7:56 A.M. with State tested Nursing Assistant (STNA) #538 revealed the door to the secured unit was fixed either 08/18/22 or 08/19/22, it took all day because the latching mechanism needed fixed. STNA #538 stated the code was changed when the door was fixed. Interview on 08/25/22 at 7:56 A.M. with Licensed Practical Nurse (LPN) #607 revealed on 08/16/22 Resident #53's wife took Resident #53 out of the facility for about three hours and brought him back at dinner time. LPN #607 stated Resident #53's wife did not stay after she brought him back to the facility. LPN #607 indicated after his wife left Resident #53 was a little more difficult to redirect and kept trying to leave the facility via the courtyard door. LPN #607 stated typically Resident #53 was at the exit doors frequently around dinner time and always messes with the exits around 6:00 P.M. to 7:00 P.M. LPN #607 stated visitors would hold the door open; the alarm would sound and Resident #53 would push buttons on the key pad and had often been seen trying to get out of the secured unit. LPN #607 confirmed Resident #53 tried to get out the emergency door leading to the outside and the secured door leading to the hall by the conference room. LPN #607 stated the door leading to the outside would sound an alarm when first pushed and could be opened after it was pushed on continuously for 15 seconds. LPN #607 stated if the emergency door alarm sounded for less than a minute the code on the keypad could turn the alarm off. LPN #607 stated if the alarm lasted more than a minute the emergency door alarm could only be turned off by using a special key and pressing a code on the keypad by the door. The key was only located on the charge nurse's key ring and the Administrator and MD #503 had keys as well. Observation on 08/25/22 at 7:56 A.M. revealed Resident #53's room was two doors away from the secured door leading to the hall by the conference room. This was the door which had to be forcefully closed when it was opened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/25/22 at 8:31 A.M. with Senior Administrator (SA) #606 revealed on 08/16/22 at 8:05 P.M. Registered Nurse (RN) #515 received a call that Resident #53 was found at a local drugstore, the police brought him back to the facility, he was evaluated and had no injuries. SA #606 stated RN #515 and STNA #414 saw Resident #53 in bed at 7:00 P.M. SA #606 indicated she believed a family member walked out of the secured unit and out the facility with Resident #53 and did not realize he was a resident. SA #606 indicated after Resident #53 eloped from the facility family members were educated to check with a staff member if they did not know a person attempting to leave the secured unit. SA #606 stated she did not feel the staff were neglectful and unsubstantiated the SRI. SA #606 stated visitors to the facility on [DATE] were called and none remembered anyone leaving the facility at the same time they did and the visitors stated door alarms did not sound. SA #606 stated Resident #53 did not have a wander guard because he showed no elopement tendencies and memory care unit residents did not have wander guards because it was a secured unit. SA #606 stated staff at the drugstore saw Resident #53, he looked confused, so they called the police. Interview on 08/25/22 at 9:22 A.M. with Maintenance Director (MD) #503 revealed the door leading to the secured unit by the conference room was fixed on 08/19/22. MD #503 stated TMD #608 helped him replace the hinges. MD #503 stated the hinges were shot and the Assisted Living Maintenance Director told him the previous Maintenance Director might have bent the hinges when he worked on the door. MD #503 stated one door would hit the other door and would be unable to close, the door was not sitting correctly in the door frame and the door had to be pulled hard to close it so it locked. MD #503 stated the code was changed and the door hinges were replaced and now the door closed and locked without having to be forcefully pulled shut. Interview on 08/25/22 at 10:01 A.M with STNA #414 revealed she worked second shift on 08/16/22 and was present when Resident #53 eloped from the facility. STNA #414 stated around 7:00 P.M. she saw Resident #53 sitting on his bed. STNA #414 indicated after she saw Resident #53, she sat at the nurse's station to catch up on her charting. STNA #414 stated Registered Nurse (RN) #515 arrived at 7:00 P.M. for her shift, received report from LPN #607 and after report was given LPN #607 left the unit. STNA #414 stated she was the only STNA present in the secured unit and RN #515 was the only nurse present from 7:00 P.M. to 8:05 P. M. STNA #414 indicated a little after 8:00 P.M. a female called into the unit for the nurse, RN #515 answered the call and was told Resident #53 was at the drugstore. STNA #414 stated a head count was immediately done to make sure all other residents were accounted for. STNA #414 stated she did not get up from her seat at the nurse's station until the phone rang at 8:05 P.M. because she had a lot of charting to do. STNA #414 indicated she did not hear a door alarm from 7:00 P.M. to 8:05 P.M. STNA #414 stated Resident #53's room was two doors away from the exit leading to the hall by the conference room, the door was hard to pull close and that was how Resident #53 likely left the secured unit. STNA #414 stated Resident #53 probably caught the door before it was locked and the alarm sounded. STNA #414 stated the red button on the wall outside the secured unit needed to be pushed to keep the alarm from sounding when the door was opened, and Resident #53 probably slipped out when the door was not locked. STNA #414 stated the door had to be pulled hard to close and sometimes there was a few second delay before the alarm would sound. STNA #414 stated she would have to run down the hall help close the doors for guests who did not know the door was broken. STNA #414 stated the door was broken for a while, she did not know how long, but it could have been a couple months. STNA #414 revealed the door was fixed after Resident #53 eloped, and indicated it was hard to understand how Resident #53 was able to walk through two secured doors and leave the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/25/22 at 10:23 A.M. with SA #606 and the DON revealed the receptionist for the facility left at 7:00 P.M. and after she left no one was assigned to sit at the front desk. SA #606 stated the door alarms were checked and all worked appropriately. SA #606 stated some visitors knew the code to get out of the facility and if they did not know the code, they would need to ask a staff member to open the door for them. SA #606 stated if any of the doors leading to the outside were pushed an alarm would sound and if the door was pushed for 15 seconds it would open but would still alarm and a code would need to be entered into the keypad by the door. Observation on 08/25/22 at 10:57 A.M. with the DON and SA #606 revealed a fence surrounded the facility property on three sides and the route to the drugstore included a walk on a sidewalk near a busy road past an entrance to a busy shopping area. The drugstore was located on the corner of two roads with high traffic and was approximately one quarter mile distance from the facility. Interview on 08/25/22 at 11:14 A.M. with Resident #53's wife revealed it was very upsetting to get a call from police Resident #53 was wandering around outside. Resident #53's wife stated he might not be as lucky as this time if he gets out again. Resident #53's wife stated the intersection could be dangerous where police found him, and her first concern was a safety issue. Resident #53's wife stated he could have been really hurt or worse. Interview on 08/25/22 at 12:25 P.M. with Nurse Practitioner (NP) #609 revealed she was notified Resident #53 eloped from the facility. NP #609 stated she saw Resident #53 unofficially after he eloped from the facility but did not document the visit or charge him for a visit. NP #609 stated Resident #53 was high risk for not knowing how to get back to the facility and not able to take care of himself. NP #609 stated Resident #53 possibly might try to cross the street, but she thought he might be too scared to attempt it. Review of the facility policy titled Elopement Policy, revised 07/25/18 revealed the facility would identify residents with potential and or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility would implement its policies and procedures immediately to locate the resident in a timely manner. Residents identified at risk of elopement would have interventions immediately implemented to reduce the resident's risk of elopement. Residents identified at risk would have their picture and face sheet placed in a binder that was kept in an area accessible by staff. This deficiency substantiates Master Complaint Number OH00135250.

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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** 42013 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure one resident's (Resident #62) insulin was not administered to another resident (Resident #86). This affected two residents (Resident #62 and #86) out of three residents reviewed for insulin administration. The facility census was 89. Findings include: Review of Resident #62's medical record revealed an admitted [DATE] and diagnoses included type two diabetes mellitus with other diabetic neurological complications, hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting the right dominant side, and dementia without behavioral disturbances. Resident #62 passed away in the facility on 08/17/22. Review of Resident #62's physician orders dated 08/10/22 revealed Humalog Solution 100 units (insulin lispro), inject as per sliding scale for blood sugar subcutaneously before meals for diabetes mellitus. Review of Resident #86's medical record revealed an admitted [DATE] and diagnoses included hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting the right dominant side, type two diabetes mellitus, and major depressive disorder. Review of Resident #86's physician orders dated 03/23/22 revealed Humalog Solution 100 units per milliliter (ml) insulin, inject 6 units subcutaneously before meals for diabetes. Observation on 08/16/22 at 9:01 A.M. of Registered Nurse (RN) #511 revealed RN #511 checked Resident #86's blood sugar, the blood sugar was 329, and RN #511 prepared to administer insulin to Resident #86. RN #511 reached into the medication cart drawer and picked up a vial of Humalog insulin 100 units per ml and withdrew 6 units insulin into a syringe. Observation of the Humalog insulin vial revealed it did not have the date it was opened and first used documented, and the insulin was labeled for Resident #62 not Resident #86. RN #511 confirmed the insulin did not have an opened date documented on it and was labeled with Resident #62's name and not Resident #86's name. RN #511 proceeded to administer the 6 units of Humalog insulin from the undated Humalog insulin bottle labeled for Resident #62 to Resident #86. RN #511 stated Resident #86 did not have Humalog insulin 100 units per ml available in the medication cart and that was why he used Resident #62's Humalog insulin. Interview on 08/23/22 at 9:53 A.M. with the Director of Nursing (DON) revealed Registered Nurse (RN) #511 should have called Resident #86's physician for guidance on how to proceed when RN #511 found Resident #86's insulin was not available in the medication cart, and the pharmacy should have been notified to have the insulin sent to the facility. (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 facility policy titled Medication Administration dated, 06/21/17 included medications would be administered by legally-authorized and trained persons in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice. Open the medication administration book/electronic medication administration record to the appropriate resident and the nurse was responsible for noting the expiration date on the package, container, and was responsible to read the label and if the medication was discontinued or outdated to remove the medication for proper disposal. The facility should follow any State specific regulatory requirements in regard to medication administration. This deficiency is an example of continued non-compliance from the survey dated 06/02/22.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of facility policy, the facility failed to administer insulin per manufacture guidelines to ensure two residents (Resident's #82 and #86) were free from significant medication error. This affected two residents (Resident's #82 and #86) out of three residents reviewed for medication administration. Findings include: 1. Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, muscle weakness, abnormalities of gait and mobility, and malignant neoplasm of the prostate. Review of Resident #82's physician orders dated 06/22/22 revealed Novolog Solution (insulin aspart), inject 15 unit subcutaneously before meals related to type two diabetes mellitus without complications. Further review on 6/20/2022 revealed Novolog 100 units per ml Solution, use per sliding scale for blood sugar and inject subcutaneously four times a day before meals and at bedtime for diabetes mellitus type two. Observation on 08/16/22 at 9:46 A.M. of Registered Nurse (RN) #511 revealed he checked Resident #82's blood sugar and the blood sugar was 240. RN #511 took a Novolog Solution Pen Injector 100 units per ml from the medication cart and withdrew 24 units of insulin from the tip of the injector. RN #511 stated he did not have any needles for the Novolog Pen Injector and had to withdraw the insulin from the tip of the pen. RN #511 stated he withdrew the standard dose of Novolog 15 units and and additional 9 units Novolog insulin from the Pen Injector for the sliding scale blood sugar. RN #511 placed the Novolog Pen Injector back in the medication cart once he had withdrawn the insulin. RN #511 proceeded to administer 24 units of Novolog Solution 100 units per ml to Resident #82. Interview on 08/23/22 at 9:53 A.M. with the Director of Nursing revealed she ordered needles for the Novolog Solution Pen Injectors (insulin aspart). Review of the manufacturer information included withdrawal of insulin from a prefilled insulin device or penfill cartridge1-9, Novo Nordisk prefilled insulin devices and PenFill cartridges was not designed for or intended for use with syringes. If your FlexTouch, FlexPen or NovoPen Echo did not work, troubleshoot the device. Verify that there was no other alternative (for example having your prescriber call in a new prescription to your pharmacy) or have a back-up vial on hand. 2. Review of Resident #86's medical record revealed an admitted [DATE] and diagnoses included hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting the right dominant side, type two diabetes mellitus, and major depressive disorder. Review of Resident #86's physician orders dated 05/26/22 revealed insulin glargine solution 100 units per ml (Lantus), inject 10 unit subcutaneously in the morning related to type two diabetes mellitus without complications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/16/22 at 9:01 A.M. of Registered Nurse (RN) #511 revealed he took a Lantus (insulin glargine) Pen Injector 100 units per ml out of the medication cart and withdrew 10 units from the Pen Injector via the tip. RN #511 stated he did not have any needles for Resident #86's Lantus Pen Injector and had to withdraw the insulin from the tip of the Injector. After RN #511 withdrew insulin from the Lantus Pen Injector he placed the Injector in the medication cart drawer. RN #511 proceeded to administer the insulin to Resident #86. Interview on 08/23/22 at 9:53 A.M. with the Director of Nursing revealed she ordered needles for the Lantus Pen Injectors (insulin glargine). Review of the manufacturers information for Lantus (insulin glargine injection) included to not use a syringe to remove Lantus from the disposable prefilled pen. This deficiency substantiates Complaint Number OH00134587 and Complaint Number OH00134911. This is an example of continued non-compliance from the survey dated 06/02/22.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, review of the facility policy, and review of the manufacturers instructions, the facility failed to ensure one resident's (Resident #62) insulin was labeled the date it was opened and the date it was first used. This affected two residents (Resident #62 and #86) out of three residents reviewed for medication storage. Findings include: Review of Resident #62's medical record revealed an admitted [DATE] and diagnoses included type two diabetes mellitus with other diabetic neurological complications, hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting the right dominant side, and dementia without behavioral disturbances. Resident #62 passed away in the facility on 08/17/22. Review of Resident #62's physician orders dated 08/10/22 revealed Humalog Solution 100 units (insulin lispro), inject as per sliding scale for blood sugar subcutaneously before meals for diabetes mellitus. Review of Resident #86's physician orders dated 03/23/22 revealed Humalog Solution 100 units per milliliter (ml) insulin, inject 6 units subcutaneously before meals for diabetes. Review of Resident #86's medical record revealed an admitted [DATE] and diagnoses included hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting the right dominant side, type two diabetes mellitus, and major depressive disorder. Observation on 08/16/22 at 9:01 A.M. of Registered Nurse (RN) #511 revealed RN #511 checked Resident #86's blood sugar, the blood sugar was 329, and RN #511 prepared to administer insulin to Resident #86. RN #511 reached into the medication cart drawer and picked up Humalog insulin 100 units per ml and withdrew 6 units insulin into a syringe. Observation of the Humalog insulin bottle revealed it did not have the date it was opened and first used documented and the insulin was labeled for Resident #62 not Resident #86. RN #511 confirmed the insulin did not have an opened date documented on it and was labeled with Resident #62's name and not Resident #86's name. RN #511 proceeded to administer the 6 units of Humalog insulin from the undated Humalog insulin bottle labeled for Resident #62 to Resident #86. RN #511 stated insulin was good for 30 days once it was opened and first used for a resident. Interview on 08/23/22 at 9:53 A.M. with the Director of Nursing (DON) revealed Registered Nurse (RN) #511 should have written 08/16/22 on the insulin bottle as the date the insulin was first opened and used because 08/16/22 was when the insulin was found to not have an open date documented on it. The DON stated RN #511 should have checked when the insulin was delivered to the facility and used that date as the date to determine when 28 days had passed and medication should be discarded. (continued on next page)

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	366114	A. Building B. Wing	09/01/2022

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Administration dated, 06/21/17 included medications would be administered by legally-authorized and trained persons in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice. Open the medication administration book/electronic medication administration record to the appropriate resident and the nurse was responsible for noting the expiration date on the package, container, and was responsible to read the label and if the medication was discontinued or outdated to remove the medication for proper disposal. The facility should follow any State specific regulatory requirements in regard to medication administration. Review of the manufacturers instructions for insulin lispro injection solution (Humalog) 100 units per ml revealed in-use (opened) Humalog vials, cartridges, pens and Humalog KwikPens should be stored at room temperature, below 86 degrees Fahrenheit and must be used within 28 days or be discarded even if they still contained Humalog.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, interview, and record review, the facility failed to ensure sufficient silverware was available at meals. This had the potential to affect 82 of 89 residents in the facility as seven residents (Resident #2, #3, #4, #5, #6, #34, and #76) received nothing by mouth. Findings include: Review of the medical record for Resident #91 revealed an admitted [DATE] and a discharge date if 07/28/22. Diagnoses included chronic respiratory failure, COPD, hypertension, chronic idiopathic constipation, and heart failure. Observation on 08/16/22 at 7:59 A.M. of breakfast trays being served revealed STNA #407 pull a tray from the cart that had only one fork and no other silverware. Observed on the tray was a bowl of oatmeal and on the plate that was partially uncovered revealed toast. STNA #407 verified the observation. Interview on 08/16/22 at 8:16 A.M. with STNA #523 revealed that there was not always enough silverware or the appropriate silverware to match the meal. STNA #523 stated the residents complained about the lack of silverware. Observed STNA #523 remove a tray from the meal cart that had a spoon and knife. The tray had toast and an egg dish. STNA #523 verified the observation. Observation on 08/16/22 at 8:28 A.M. of Resident #11's breakfast tray revealed she had oatmeal, toast, and an egg dish and for silverware she had only had a spoon and knife. Observation at this time was verified by STNA #523. Interview on 08/16/22 at 8:34 A.M. with Dietary Manager (DM) #625 revealed they had a resident that hoarded the silverware and staff that threw away the silverware. DM #625 stated that there will always be an issue with heaving enough silverware. Interview on 08/16/22 at 9:02 A.M. with STNA #538 stated there had been an issue with the lack of silverware and she had complained about it. Interview on 08/16/22 at 9:06 A.M. with Resident #52's revealed she had eggs, toast, and oatmeal. Observation of Resident #52's tray revealed she had eaten 100% of her meal and there was a folk and knife on her tray. When asked how she ate her oatmeal, Resident #52 stated she had her own plastic spoon. Interview on 08/16/22 at 9:09 A.M. with STNA #405 revealed there was not enough silverware, or the kitchen sent silverware that did not match the meal. STNA #405 verified the observation of Resident #52's breakfast tray that had only a knife and fork. Review of a list of resident diets revealed Resident #2, #3, #4, #5, #6, #34, and #76 did not receive food by mouth. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency substantiates Complaint Number OH00134587.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39969 Based on observation, interview, and record review, the facility failed to ensure the milk was stored in a safe manner while on the beverage cart, the condiment container was maintained in a clean and sanitary condition, and cups of juice were covered during meal service. This had the potential to affect 82 of 89 residents in the facility as seven residents (Resident #2, #3, #4, #5, #6, #34, and #76) received nothing by mouth. Findings include: Observation on 08/16/22 at 7:59 A.M. of breakfast trays being served revealed on the beverage cart orange juice, apple juice, and milk in clear pitchers that is covered. The milk was sitting on the cart not in an ice bath. Interview at this time with State tested Nurse Aide (STNA) #407 stated the milk normally came in individual cartons and verified the milk was not in an ice bath to kept it at a safe temperature. Observation on 08/16/22 at 8:16 A.M. of the yellow condiment container on top of the meal cart was dirty on the bottom with various debris. Interview at this time with STNA #523 verified the observation. Observation on 08/16/22 at 8:30 A.M. of the meal cart located outside of Resident #11's room revealed a tray of multiple pre-poured cups of orange and apple juice sitting on top of the cart uncovered. STNA #523 verified the observation and then placed the tray of the pre-poured juice inside on the bottom shelf of the meal cart. Interview on 08/16/22 at 8:34 A.M. with Dietary Manager (DM) #625 revealed they kept the juice in the freezer until the beverage cart was ready to go out. DM #625 stated the beverage cart went out first. DM #625 verified the milk went out on the beverage carts not in an ice bath. Observation on 08/16/22 at 8:59 A.M. on the memory unit was milk in clear pitcher not in ice bath and two cups of juice sitting on the cart uncovered. Interview on 08/16/22 at 9:02 A.M. with STNA #538 stated verified the observation and stated the milk was usually sent in the individual cartons sitting in ice. STNA #538 stated the two cups of juice were extras. Interview on 08/16/22 at 9:09 A.M. with STNA #405 revealed they usually had the individual cartons of milk in ice or a jug of milk in ice, but not on this day. Review of a list of resident diets revealed Resident #2, #3, #4, #5, #6, #34, and #76 received nothing by mouth. This deficiency substantiates Complaint Number OH00134587.

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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** 42013 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a glucometer used for two residents (Resident's #82 and #86) was disinfected appropriately between uses. This affected two residents (Resident's #82 and #86) out of three reviewed for disinfection of the glucometer. Findings include: Review of Resident #86's medical record revealed an admitted [DATE] and diagnoses included hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting the right dominant side, type two diabetes mellitus, and major depressive disorder. Review of Resident #86's physician orders dated 03/23/22 revealed Humalog Solution 100 units per milliliter (ml) insulin, inject 6 units subcutaneously before meals for diabetes. Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses including diabetes mellitus type two, muscle weakness, abnormalities of gait and mobility, and malignant neoplasm of the prostate. Review of Resident #82's physician orders dated 06/22/22 revealed Novolog Solution (insulin aspart), inject 15 unit subcutaneously before meals related to type two diabetes mellitus without complications. Further review on 6/20/2022 revealed Novolog 100 units per ml Solution, use per sliding scale for blood sugar and inject subcutaneously four times a day before meals and at bedtime for diabetes mellitus type two. Observation on 08/16/22 at 9:01 A.M. of Registered Nurse (RN) #511 revealed he took a glucometer from a drawer in the medication cart and walked into Resident #86's room. RN #511 checked Resident #86's blood sugar and the blood sugar was 329. RN #511 returned to the medication cart with the glucometer and without disinfecting the glucometer placed the glucometer on top of the medication cart. RN #511 prepared insulin to be administered to Resident #86, administered the insulin to Resident #86, returned to the medication cart, picked the glucometer up off the top of the medication cart and placed it back in a drawer. RN #511 did not disinfect the glucometer before placing it in the drawer in the medication cart. Observation on 08/16/22 at 9:46 A.M. of RN #511 revealed RN #511 picked up the glucometer from the medication cart he used for Resident #86, did not disinfect the glucometer and walked into Resident #82's room. RN #511 checked Resident #82's blood sugar which was 240 and returned to the medication cart. RN #511did not disinfect the glucometer, placed the glucometer on top of the medication cart and prepared insulin to be administered to Resident #82. RN #511 administered Resident #82's insulin, returned to the medication cart, picked up the glucometer and without disinfecting it placed it in a drawer in the medication cart. RN #511 confirmed he did not disinfect the glucometer before or after using it for Resident's #82 and #86. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/22 at 9:55 A.M. with the Director of Nursing (DON) revealed the glucometer needed to be sanitized between each resident. The DON stated a disposable bleach cloth or disposable cloth from a purple top container should be used. The DON indicated the glucometer should be wiped, then wrapped in a disposable cloth and remain wrapped for three minutes before taking the disposable cloth off the glucometer, then leave the glucometer open to air for two minutes to dry. The DON stated the medication carts contained at least two glucometers and the glucometers could be alternated. Review of the facility policy titled Use of Glucometer to Obtain A Blood Glucose (Sugar) revised, 03/2015 included the facility obtained blood to perform a blood sugar check per physician's order and as needed per nursing judgement. The blood sample was obtained by using a glucometer and a lancet. Each resident had their own glucometer and glucometers were not used for more than one resident. Glucometers were used, cleaned and calibrated per manufacturer's instructions. Review of the manufacturer glucometer owner's manual included the cleaning procedure was to remove dust, blood and body fluid from the surface and should be performed whenever the meter was visibly dirty. The disinfecting procedure was necessary to kill pathogens such as Human Deficiency Virus and Hepatitis B and C viruses on the device. The meter must be cleaned and disinfected after use on each patient. Thoroughly wipe the entire surface of the meter with disinfecting wipes listed to clean any possible dirt, dust, blood and other body fluids. Take another disinfecting wipe and wipe the meter thoroughly, allow the surface to remain wet for two minutes, allow to air dry. This deficiency is an example of continued non-compliance from the survey dated 07/13/22 and 06/02/22.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, record review, and interview, the facility failed to maintain a clean, sanitary, and homelike environment in good repair. This had the potential to affect all 58 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, and #58) that resided on the first floor. Findings include: Observation on 08/15/22 at 3:34 P.M. of Resident #42's room revealed the resident in bed sleeping. Observed the floor was sticky and the portion of the pillow that was view appeared soiled. Observation on 08/15/22 at 3:48 P.M. of Resident #29's room revealed various food debris in the air conditioner unit and in the windowsill was a medicine cup not labeled or dated filled with a light yellowish jelly substance. Observation on 08/16/22 at 8:24 A.M. with the Administrator revealed a small brownish stain on the outside door of room [ROOM NUMBER], the room was empty. Observation on the pole like structure on the wall entering the common dining area on the first floor located across from the nursing station, there was a small and large brownish stain. Observed in the dining area was bed linen on floor of the door in the dining area. The Administrator verified the observations and stated she would have housekeeping clean up the stains and stated the linen was placed down at the door to keep the rain from getting in. Tour on 08/16/22 from 8:47 A.M. to 8:59 A.M. with Housekeeping/Laundry Director (HLD) #612 revealed in Resident #29's room there were a moderate amount of crumbs in air conditioner unit. HLD #612 verified the observation and stated it was maintenance responsibility, but he was new to the facility. Observed in the windowsill near Resident #29's bed above this air conditioner unit was a small orange pill and a medicine cup of a yellowish jelly like substance that was not labeled or dated. HLD #612 verified the observation. Observed in the bathroom were brownish stains on bathroom floor and HLD #612 verified the observations and stated the floor needed to be stripped and that was housekeeping's responsibility. Observation of Resident #42's room revealed the resident sitting on the side of the bed eating breakfast. Observed the floor being sticky, stains, and stains on the wall along the molding. HLD #612 verified the observation and stated Resident #42 urinated on the floor and stated it was the responsibility of the aides and housekeeping. HLD #612 stated housekeeping shift ended at 3:00 P.M. and it was the aide's responsibility after 3:00 P.M. Observation of Resident #42's pillowcase appeared dingy and soiled. HLD #612 verified the observation and stated the aides were to change the pillowcases and the resident's roommate, Resident #43, bed was made but there was no pillowcase on his pillow. HLD #612 verified the observation. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/16/22 at 12:10 P.M. with the Director of Nursing (DON) stated the yellowish jelly like substance in the medicine cup in the window of Resident #29 was A&D ointment and the pill had disintegrated, unable to tell what it was. DON stated she was doing an in-service regarding the barrier creams and ointment to not be kept that way and for the nurses to watch to ensure residents were taking their medications. Observation on 08/17/22 at approximately 9:34 P.M. on the wall in the hall near Residents #39 and #40's room revealed an outlet that was missing the cover. Observation on 08/17/22 at 4:00 P.M. in Resident #53's room revealed the door of the bathroom was off and was located up against the wall across from the resident's bed near his bedside table. Interview at this time with Resident #53 stated the bathroom door fell and that was about two months ago. Interview on 08/17/22 at 4:03 P.M. with Licensed Practical Nurse (LPN) #601 verified Resident #53's bathroom door had fell and it had been that way for a couple of weeks. LPN #601 stated management was aware. Interview and observation on 08/17/22 at 4:11 P.M. with the Director of Maintenance (DOM) #503 of the door to the entrance into the memory unit near the conference room of the entrance door not closing completely. DOM #503 verified the observation and stated it needed to be fixed but staff were to manually pull the door closed in order for it to lock and not alarm. After entering the memory unit DOM #503 verified the observation of Resident #53's bathroom door and the outlet that was missing a cover near Residents #39 and #40's room. DOM #503 stated he was not made aware of the identified findings and had started at the facility two weeks ago. Review of the facility census revealed the following residents resided on the first floor where the above observations occurred: Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, and #58. Review of Resident Council meeting minutes for 06/28/22 meeting the residents felt like the floors were not being vacuumed and moped like they should be. Review of the undated facility policy titled, Room Cleaning In-Service, revealed the procedures included high dusting windowsills, molding, radiator, vents; cleaning doors, walls; and wet mop the entire room and bathroom behind closets, doors, corners, and under the beds. This deficiency substantiates Complaint Number OH00134911, Complaint Number OH00134462, and Complaint Number OH00134462.