STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365730	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Euclid	3 Gateway Dr Euclid, OH 44119

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on observation, staff interview, and medical record review, the facility failed to treat residents with dignity while feeding. This affected one resident (#48) of three residents who were provided assistance with feeding. The facility census was 65. Findings Include: Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included cerebral infarction, seizures, dementia, and dysphasia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/17/24, revealed Resident #48 had severely impaired cognition. Review of Resident #48's physician orders for June 2024 revealed an order for feeding assist with all meals on 01/24/24 and the resident was ordered a dysphasia puree texture diet on 04/22/24. Observation on 06/25/24 at 12:29 P.M. revealed Resident #48 in was in a Broda chair (a chair designed to tilt and recline for comfort and mobility) with a plate of puree food on the table. Observation and interview on 06/25/24 at 12:41 P.M. revealed State tested Nurse Aide (STNA) #909 was standing beside Resident #48 while feeding her. STNA #909 confirmed she was standing and stated she knew she should sit to feed residents.

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

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on medical record review, review of resident funds accounts, and staff interview, the facility failed to make final dispersal of resident funds within 30 days of a resident's death. This affected one (#219) of one residents reviewed for final dispersal of resident funds. The facility census was 65. Findings Include: Review of Resident #219's medical record revealed the resident was admitted to the facility on [DATE] and expired on [DATE]. Review of Resident #219's resident funds account revealed a check dated [DATE] for $90.56 was sent to the Attorney General and a check dated [DATE] for $1,768.00 was sent to to cover the balance due on the resident's account. Interview on [DATE] at 2:25 P.M. with the Administrator verified Resident #219's personal funds were not disbursed within 30 days after the resident's death as required. The Administrator stated they were aware there was a problem getting the checks out within the 30 day timeframe.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 38091 Based on observation and staff interview, the facility failed to ensure all required postings were on displaying in the facility in a manner that was accessible and understandable. This had the potential to affect all 65 residents residing in the facility. The facility census was 65. Findings Include: Observation of the facility on 06/26/24 between 2:45 P.M. and 3:00 P.M. revealed no evidence of posted contact information for the State Survey Agency and other pertinent agencies and advocacy groups, including the State licensure office, adult protective services, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit, were accessible to residents and resident representatives. The Administrator verified that such required information was not posted in an interview on 06/26/24 at 3:10 P.M.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, review of self-reported incidents, staff interview, and review of a facility policy, the facility failed to report an allegation of abuse, neglect, or injury of unknown origin to the State Survey Agency as required. This affected one (#67) of two residents reviewed for abuse. The facility census was 65. Findings Included: Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), congestive heart failure, high blood pressure, and nicotine dependence. Resident #67 discharged from the facility against medical advice (AMA) on 04/17/24. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 was cognitively intact and required one person physical assistance for completing activities of daily living. Review of a progress note dated 04/16/24 at 8:00 A.M. revealed Resident #67 was observed in room during tray pass for breakfast and it was observed that Resident #67's nose and lips were swollen surrounded with small amount of dry blood. Resident #67 was asked what happened and the resident stated that a lighter was lit in his room and it blew up in his face at about 2:00 A.M. or 3:00 A.M. Resident #67 indicated he was not a snitch and refused to give staff any information Review of self-reported incidents (SRIs) submitted to the Ohio Department of Health's Enhanced Information Dissemination Collection System (EIDC) (database used for facilities to report required instances of abuse, neglect, injuries of unknown origin, and misappropriation) revealed no report was filed related to Resident #67's claim on 04/16/24 that an unknown person lit a lighter in his room and caused injuries to his face. Interview with Administrator on 06/26/24 at 10:00 A.M. verified the facility did not file a report with the State Survey Agency for Resident #67's allegations on 04/16/24 as required. Review of the policy titled, Abuse, Neglect, Exploitation, & Misappropriation of Resident Property, dated 10/01/20, revealed all incidents and allegations of abuse, neglect, and exploitation, mistreatment of a resident, or misappropriation of resident property, and all injuries of unknown source must be reported immediately to the Administrator or designee. If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the Ohio Department of Health immediately, but not no later than two (2) hours after the allegation is made.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on medical record review and staff interview, the facility failed to electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) assessment data to the Centers for Medicare and Medicaid (CMS) system within 14 days of completing the assessment. This affected one (#2) of three residents reviewed for discharge. The facility census was 65. Findings: Review of the medical record for Resident #2 revealed a discharge MDS assessment dated [DATE] had been completed but not transmitted as of 06/24/24. Resident #2 was discharged from the facility after he failed to return from an authorized leave of absence (LOA) on 01/01/24. During interview on 06/26/24 at 1:15 P.M., the Director of Nursing (DON), Licensed Practical Nurse (LPN) #905, and Social Worker #922 confirmed Resident #2 left on an authorized leave of absence and did not return. Follow up interview on 06/26/24 at 1:40 P.M., the DON confirmed Resident #2's discharge MDS assessment had not been transmitted until 06/26/24.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review and staff interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level I screen was completed after a resident remained in the facility longer than 30 days as required. This affected one (#13) of two residents reviewed for PASARR. The facility census was 65. Findings Include: Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, chronic obstructive pulmonary disease, and high blood pressure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact and required minimum assistance for completing his activities of daily living. Review of the medical record revealed a PASARR was completed for Resident #13's stay in the facility on 04/09/24. Social Worker (SW) #922 verified Resident #13's PASARR was not completed timely as required in an interview on 06/26/24 at 1:30 P.M.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38091 Based on observation and staff interview, the facility failed to ensure daily nursing staffing information was up-to-date and posted in a prominent place readily accessible to residents and visitors. This had the potential to affect all 65 residents residing in the facility. The facility census was 65. Findings Include: Observation of the posted nursing staff information on 06/24/24 at 8:45 A.M. revealed the posted nursing staff information was located on a bulletin board inside a staffing information area near the front desk that was not visible to residents and visitors. Further observation revealed the posted nursing staffing information was dated 06/14/24. Receptionist #955 verified the posted nursing staffing information was not current and not visible to residents or visitors in the facility during an interview on 06/24/24 at approximately 8:45 A.M.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review and staff interview, the facility failed to timely act upon pharmacist recommendations to address any medication irregularities in the medical record. This affect one (#40) of five residents reviewed for unnecessary medications. The facility census was 65. Findings Include: Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses that included visual hallucinations, repeated falls, and bipolar disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired and required the assistance of one staff person for completing her activities of daily living. Review of a pharmacist recommendation dated 03/04/24 revealed Resident #40 had a physician's order dated 03/16/23 for the medication carvedilol (medication used to treat high blood pressure) with instructions to give 6.25 milligrams (mg) by mouth two times a day for hypertension (high blood pressure) and hold for systolic blood pressure (SBP) below 100 millimeters of mercury (mmhg) and/or a heart rate below 60 beats per minute. The pharmacist noted nursing was no longer taking and documenting blood pressure and pulse prior to administration as required. The pharmacist further documented for Resident #40's physician to updated the order entry in the facility's medical record system to force nursing to document the blood pressure and pulse with each dose, and also educate nursing staff that any order with a parameter attached to it required the parameter to be checked, and the dose to be held, when the parameter(s) fall outside of the stated range. Review of Resident #40's medication administration record (MAR) for March 2024 revealed blood pressure monitoring was added and completed, but no pulse monitoring was completed as recommended by the pharmacist. Review of the pharmacist recommendation dated 04/01/24 revealed the pharmacist noted further that pulse monitoring was continuing not to take place related to Resident #40's physician order for carvedilol. The Director of Nursing verified the facility did not respond to the pharmacist's notification in a timely manner of a lack of obtaining Resident #40's pulse prior to administering carvedilol in an interview on 06/27/24 at 9:30 A.M.

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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** 38091 Based on medical record review, staff interview, and review of a facility policy, the facility failed to adequate monitoring was completed as ordered prior to the administration of a medication. This affected one (#40) of five residents reviewed for unnecessary medications. The facility census was 65. Findings Include: Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses that included visual hallucinations, repeated falls, and bipolar disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 was moderately cognitively impaired and required the assistance of one staff person for completing her activities of daily living. Review of a physician order dated 03/16/23 revealed Resident #40 was ordered carvedilol (medication used to treat high blood pressure) with instructions to give 6.25 milligrams (mg) by mouth two times a day for hypertension (high blood pressure) and hold for systolic blood pressure (SBP) below 100 millimeters of mercury (mmhg) and/or a heart rate below 60 beats per minute. Review of Resident #40's medication administration records from September, October, November, and December 2023, and January and February 2024 revealed no documented blood pressures or pulse measurements were taken as ordered prior to giving the medication. Review of a pharmacist recommendation dated 03/04/24 revealed the pharmacist noted nursing was no longer taking and documenting blood pressure and pulse prior to administration as required. The pharmacist further documented for Resident #40's physician to updated the order entry in the facility's medical record system to force nursing to document the blood pressure and pulse with each dose, and also educate nursing staff that any order with a parameter attached to it required the parameter to be checked, and the dose to be held, when the parameter(s) fall outside of the stated range. Interview with the Director of Nursing on 06/27/24 at 9:30 A.M. verified the nursing staff did not obtain Resident #40's blood pressure or pulse prior to administering carvedilol as ordered in September 2023 through February 2024. Review of the policy titled, Administering Medications, dated 04/01/19, revealed medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35768 Based on observation, staff interview, and policy review, the facility failed to ensure insulin was dated when opened, was stored in the container for the resident it was ordered for, and was disposed of once expired. This affected five (#13, #15, #26, #33, and #40) of thirteen residents who receive insulin. The census was 65. Findings include: 1. Observation on [DATE] at 3:14 P.M. revealed a used injector pen of Humalog insulin for Resident #33 was stored in a medication cart. The pen was open and in use with no date written when use began. Interview during the observation with Licensed Practical Nurse (LPN) #905 stated all insulin pens should be dated when initially opened and verified Resident #33's insulin injector pen was not dated. 2. Observation on [DATE] at 3:23 P.M. revealed a used injector pen of Lispro insulin for Resident #13 and Resident #15 were stored in a medication cart. The pens were open and in use with no date written when use began. Further observation of the medication cart revealed an open vial of Lispro insulin for Resident #26 that was dated [DATE], and an opened vial of Humalog insulin for Resident #40 that was stored in a box labeled for Resident #15. Interview during the observation of the medication cart on [DATE] at 3:23 P.M., Assistant Director of Nurse (ADON) #930 stated all insulin pens should be dated when initially opened and insulin generally expires 28 days after opening and should be removed from the medication cart. ADON #930 verified Resident #13 and Resident #15's insulin was not dated, verfiied Resident #26's Lispro insulin was past expiration, and verified Resident #40's vial of Humalog insulin was stored in a box labeled for Resident #15. Review of the facility policy titled, Insulin Storage and Dispensing Information, dated 2021, revealed Lispro and Humalog insulin is good for 28 days.

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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. 35768 Based on observation, staff interview, and policy review, the facility failed to store food in a safe and sanitary manner. This affected six (#3, #10, #44, #48, and #172) of 31 residents residing on the 300 and 400 units. The census was 65. Findings include: Observation on 06/24/24 at 3:14 P.M. revealed four containers of applesauce that were not dated and a container of pudding dated 06/20/24 were sitting in the top drawer of the medication cart. The containers were warm to the touch. Another container of applesauce dated 06/20/24 was currently provided to residents who had difficulty swallowing medications. Interview on 06/24/24 at 3:20 P.M. with Licensed Practical Nurse (LPN) #905 stated the containers of applesauce and pudding were in the medication cart when she arrived, so she used them. LPN #905 removed all containers from the cart and stated the containers should have been dated. The facility identified six (#3, #10, #44, #48, and #172) residents who utilized applesauce or pudding with medication administration on the 300 and 400 units. Review of the facility policy titled, Dating for Food Storage, dated 2021, revealed staff were to date foods that were time and temperature controlled (applesauce and pudding) when made and document the use by date as well. The foods should also be kept for designated days and be stored at 41 degrees Fahrenheit or lower.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38091 Based on record review, staff interview, and review of the Centers for Disease Control and Prevention (CDC) guidance for water management, the facility failed to provide evidence of water testing conducted to monitor and prevent the growth of Legionella (a bacteria that causes Legionnaire's disease) in the building water system. This had the potential to affect all 65 residents in the facility. The census was 65. Findings Include: During the entrance conference, the facility was asked to provide a copy of the Legionella water management program and evidence of water testing being conducted. The facility provided the policy titled, Legionella Water Management Program, revised September 2022; however, the facility had no evidence to support that regular testing for Legionella was being done in the building. Interview on 06/27/24 at 12:50 P.M. with the Administrator verified the facility had no documented evidence of water testing related to Legionella prevention. During a follow up interview on 06/27/24 at 1:00 P.M., Maintenance Director (MD) #915 indicated the facility did conduct water testing from different water sources in the facility and send the samples out; however, the results do not return for two to three weeks. MD #915 stated the facility had been unable to locate the previous maintenance director's records and were unable to provide evidence of routine water testing. Review of the CDC document titled, Overview of Water Management Programs, dated 03/15/24, revealed water management programs require regular monitoring of key areas for potentially hazardous conditions. 36307

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38091 Based on observation, staff interview, review of a State Fire Marshal report, and policy review, the facility failed to maintain a safe, clean, sanitary, and well maintained environment and equipment. This had the potential to affect all 65 residents residing in the facility. The facility census was 65. Findings Include: 1. An environmental tour was conducted on 06/26/24 between 9:30 A.M. and 9:45 A.M. with Maintenance Director (MD) #915. Observation of the carpeting throughout the facility was significant discolored and stained. The ceiling in the 400 hall dining room area was completely ripped off and plastic sheeting was covering the ceiling to prevent debris from falling. One of the walls of the dinning room was completely taken down to the wooden studs. Observation of the 300 and 400 Hall tub room had drilled out holes in the shower room that were directly in front of the room. The holes exposed rusted pipes and numerous cob webs. Observation of the ceiling light about the 100 and 200 Hall nurses' station did not have a cover. The 100 and 200 Hall tub room had a noted brown substance on the floor that was not easily removed and various other debris on the floor including an open ketchup packet. Further observation of the 100 and 200 Hall tub room revealed numerous other towels that were discolored and wet were thrown about in the room. Observation of the laundry area revealed multiple ceiling tiles completely off the ceiling along with other water damaged areas exposing the piping above the ceiling. Lights covers observed throughout the facility contained numerous dead insects inside the light covers. Further observation during the tour on 06/24/24 between 9:30 A.M. and 9:45 A.M. revealed the tube feeding pole used by Resident #4 had significant amount of dried and caked on residual tube feeding supplement at the bottom of the pole. The stand up closet next to Resident #48's bed had the back panel half off and exposing multiple nails. The room occupied by Resident #6 and Resident #21 had a large hole in the bathroom door and a significant area of stained black and brown substances on the bathroom floor. Resident #58's bathroom also had black and brown substances on the bathroom floor. The privacy curtains in the rooms occupied by Resident #11, Resident #20, Resident #25, Resident #30, and Resident #211 were stained with various unknown substances. The base board behind Resident #37 and Resident #45's beds was hanging off the wall exposing the drywall. Interview with MD #915 during the tour stated the facility had a major flood related to pipes breaking in January 2024 causing the ceiling to collapse. MD #915 further explained that repairs were just approved on 06/20/24 and work was expected to begin on sometime in July 2024. MD #915 verified all the environmental concerns at the time of discovery during the tour. Review of the State Fire Marshal report from 06/20/24 revealed (regarding the 300 hall dinning room area) the area had a water leak earlier this year and needs to be repaired as soon as possible (ASAP). There is a shock risk because there are many open junction boxes with exposed wires. The missing drywall also will allow smoke and flame spread if they would have a fire. (continued on next page)

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Embassy of Euclid	3 Gateway Dr Euclid, OH 44119

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 06/24/24 at 8:35 A.M. revealed Resident #12's electric wheelchair was in the hallway and the wheelchair had food debris and dust covering the arm rests, seat, and footrest. Interview on 06/24/24 at 8:47 A.M., with the Director of Nursing (DON) verified the observation of Resident #12's wheelchair and directed staff to clean the wheelchair. 3. Observation on 06/25/24 at 3:52 P.M. revealed Resident #56's wheelchair was missing the right armrest and the vinyl on the left armrest was cracked exposing the padding underneath. Interview on 06/25/24 at 3:55 P.M., with the DON verified the observations and directed staff to replace the wheelchair. Review of the facility policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 2024, revealed direct staff were responsible for cleaning single-resident equipment when visibly soiled. 35768