STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365343	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Willard	370 E Howard St Willard, OH 44890

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 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** Based on closed medical record review, interview, and review of the facility policy, the facility failed to ensure medications were administered as physician ordered. This affected one (#54) of three residents reviewed for medication administration. The facility census was 53.Findings include:Review of the closed medical record for Resident #54 revealed an admission date of 02/27/26 and a discharge date of 05/24/26. Diagnoses included malignant neoplasm of pancreas, paranoid schizophrenia, and Type II diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition as evidence by a Brief Interview for Mental Status (BIMS) score of 06. This resident was assessed to require substantial assistance with activities of daily living (ADLs).Review of the hospice admission orders dated 02/27/26 revealed Resident #54 had orders for Cardizem (treats cardiovascular conditions) 120 milligrams (mg) daily, insulin glargine 100 units (u) per milliliter (ml) inject 40 units into the skin two times daily, insulin lispro 100 u/ml follow sliding scale, levothyroxine (used to treat hypothyroidism) 25 micrograms (mcg) take one tablet by mouth daily, lisinopril (treats high blood pressure) 10 mg take one tablet by mouth daily, Latuda (antipsychotic) 40 mg take one tablet by mouth daily, Prilosec 20 mg take one capsule by mouth daily, pantoprazole 40 mg take one tablet by mouth two times daily, risperidone (antipsychotic) three mg take one tablet daily, and rivaroxaban (used to treat and prevent blood clots) 20 mg take one tablet by mouth daily.Review of the physician orders for February 2026 revealed Resident #54 had no orders in place for Cardizem, insulin glargine, insulin lispro, levothyroxine, lisinopril, Latuda, Prilosec, pantoprazole, risperidone, or rivaroxaban.Review of the Medication Administration Record (MAR) revealed no evidence Resident #54 was administered Cardizem, insulin glargine, insulin lispro, levothyroxine, lisinopril, Latuda, Prilosec, pantoprazole, risperidone, or rivaroxaban on 02/27/26, 02/28/26, 03/01/26, or 03/02/26.Interview on 05/28/26 at 10:20 A.M. with the Director of Nursing (DON) revealed Resident #54 admitted to the facility from home. The DON stated Hospice was involved due to his terminal pancreatic cancer diagnosis. Further interview with the DON revealed on 02/27/26, the resident's date of admission, Licensed Practical Nurse (LPN) #218 did not transcribe the medications because there was confusion over discontinued orders by Hospice. The DON verified Resident #54 did not receive any physician ordered medications on 02/27/26, 02/28/26, 03/01/26, or 03/02/26.Interview on 05/28/26 at 11:00 A.M. with Resident #54's Power of Attorney (POA) revealed the resident was removed from his home due to not being able to take care of himself. Resident #54 admitted to the facility to have a Hospice consult due to his terminal diagnosis of pancreatic cancer. Resident #54's POA further stated the resident was on medications; however, she was unsure of what medications he was on before admission to the facility. Resident #54's POA was not aware the resident was not given any medication from 02/27/26 through 03/02/26.Interview on 05/28/26 at 1:01 P.M. with Social Services (SS) #507 revealed Resident #54 was admitted to the facility from home. She was notified of Resident #54 needing placement on 02/25/26. SS #507 further stated when Resident #54 came to the facility, he did not bring any outside medications; however, he had a medication list from his oncologist. SS #507 stated the facility nurse and Hospice went through the (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications together and the facility filled out a checklist, which included medication orders needing verified by the physician and transcribed into the Electronic Medical Record (EMR). SS #507 confirmed Resident #54 came to the facility with physician orders for Cardizem, insulin glargine, insulin lispro, levothyroxine, lisinopril, Latuda, Prilosec, pantoprazole, risperidone, and rivaroxaban.Interview on 05/28/26 at 1:39 P.M. with Hospice Registered Nurse (HRN) #219 revealed she was the nurse who admitted Resident #54 onto Hospice services. HRN #219 stated the medications that were ordered were based off Resident #54's oncologist's medication list. HRN #219 stated she verified the medication orders with LPN #218 and confirmed Resident #54 should have received the ordered medications the day he admitted to the facility.Review of the facility policy titled, admission Order Procedure, undated, revealed residents who were admitted to the facility may come with discharge orders from the community physician. Any nurse may transcribe the orders, however, the nurse completing the admission was responsible for verifying the orders were transcribed correctly. admission orders should be written on the preprinted physician order sheet as soon as possible after the resident arrived on the unit and faxed to the pharmacy. admission orders were to be verified with the attending physician and a notation made by the nurse. The pharmacy may be notified by phone that new admission orders were being faxed. The pharmacy should be notified of the next scheduled dose of diabetic medications.This deficiency represents noncompliance investigated under Complaint Number 2993954.

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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 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** Based on closed medical record review, staff interview and review of facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (#54) of three residents reviewed for medication administration. The facility census was 53.Findings include:Review of the closed medical record for Resident #54 revealed an admission date of 02/27/26 and a discharge date of 05/24/26. Diagnoses included malignant neoplasm of pancreas, paranoid schizophrenia, and Type II diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition as evidence by a Brief Interview for Mental Status (BIMS) score of 06. This resident was assessed to require substantial assistance with activities of daily living (ADLs).Review of the Hospice admission notes revealed Resident #54 was admitted to Hospice on 02/27/26. Resident #54 had orders to receive insulin glargine 100 units (u) per milliliter (ml); inject 40 units into the skin two times daily. Further review revealed an order for insulin lispro 100 u/ml; following a sliding scale of zero to twenty units.Review of the physician orders for February 2026 revealed Resident #54 had no orders for insulin glargine or insulin lispro 100 u/ml.Review of the Medication Administration Record (MAR) revealed no evidence Resident #54 was administered insulin glargine on 02/27/26, 02/28/26, 03/01/26, or 03/02/26. Further review revealed no evidence Resident #54 was administered insulin lispro or the facility completed Finger Stick Blood Sugars (FSBS) to determine whether the resident required the administration of insulin lispro or the dosage needed based on the sliding scale parameters on 02/27/26, 02/28/26, 03/01/26 or 03/02/26. Interview on 05/28/26 at 10:20 A.M. with the Director of Nursing (DON) revealed Resident #54 admitted to the facility from home. The DON stated Hospice was involved due to his terminal pancreatic cancer diagnosis. Further interview with the DON revealed on 02/27/26, the resident's date of admission, Licensed Practical Nurse (LPN) #218 did not transcribe the medications because there was confusion over discontinued orders by Hospice. The DON verified Resident #54 did not receive any insulin or have his FSBS obtained to monitor for the need of sliding scale insulin from 02/27/26 through 03/03/26.Interview on 05/28/26 at 11:00 A.M. with Resident #54's Power of Attorney (POA) revealed the resident was removed from his home due to not being able to take care of himself. Resident #54 admitted to the facility to have a Hospice consult due to his terminal diagnosis of pancreatic cancer. Resident #54's POA further stated the resident was on medications; however, she was unsure of what medications he was on before admission to the facility. Resident #54's POA was not aware the resident was not given any insulin or had his blood sugar monitored from 02/27/26 through 03/02/26.Interview on 05/28/26 at 1:01 P.M. with Social Services (SS) #507 revealed Resident #54 was admitted to the facility from home. She was notified of Resident #54 needing placement on 02/25/26. SS #507 further stated when Resident #54 came to the facility, he did not bring any outside medications; however, he had a medication list from his oncologist. SS #507 stated the facility nurse and Hospice went through the medications together and the facility filled out a checklist, which included medication orders needing verified by the physician and transcribed into the Electronic Medical Record (EMR). SS #507 confirmed Resident #54 came to the facility with physician orders for insulin.Interview on 05/28/26 at 1:39 P.M. with Hospice Registered Nurse (HRN) #219 revealed she was the nurse who admitted Resident #54 onto Hospice services. HRN #219 stated the medications that were ordered were based off Resident #54's oncologist's medication list. HRN #219 stated she verified the medication orders with LPN #218 and confirmed Resident #54 should have received insulin as ordered.Review of the facility policy titled, admission Order Procedure, undated, revealed residents who were admitted to the facility may come with discharge orders from the community physician. Any nurse may transcribe the orders, however, the nurse completing the admission was responsible for verifying the orders were transcribed correctly. admission orders should be written on the preprinted physician order sheet as soon as possible after the resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arrived on the unit and faxed to the pharmacy. admission orders were to be verified with the attending physician and a notation made by the nurse. The pharmacy may be notified by phone that new admission orders were being faxed. The pharmacy should be notified of the next scheduled dose of diabetic medications.This deficiency represents noncompliance investigated under Complaint Number 2993954.