

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Willard		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of the facility assessment, staff interview, and policy review, the facility failed to ensure the facility assessment evaluated residents to determine the number of staff needed in the facility. This had the potential to affect all residents. The facility census was 55. Findings include: Review of the Facility Assessment last dated 04/02/26 stated the facility determined the facility needed one full time Director of Nursing (DON), one full time Assistant Director of Nursing (ADON), nine full time licensed nurse supervisors, five as needed licensed nurse supervisors, 17 full time nursing assistants, two part time nursing assistants, and four as needed nursing assistants for nursing staff. Further review of the facility assessment revealed no evaluation was completed to determine the number of staff needed for the acuity of the residents. Interview on 07/16/26 at 9:41 A.M. with the Administrator verified the facility assessment did not evaluate resident needs to determine the number of staff needed in the facility. Furthermore, the Administrator verified the number of staff written on the facility assessment was the number of staff they currently had when they completed the assessment, and the number did not take into account the needs of the resident population. Review of the facility policy titled Facility Assessment, with a last revised date of October 2018 revealed the facility assessment included a detailed review of the resident population. This part of the assessment includes residents census data from the previous 12 months, resident capacity of the facility and its occupancy rate for the past 12 months, and factors that affect the overall acuity of the residents, such as the number and percentage of residents who need assistance with activities of daily living (ADLs), mobility impairments, incontinence, cognitive or behavioral impairments, conditions or diseases that require specialized care such as dialysis, ventilators, and wound care, religious, ethnic, or cultural factors that affect the delivery of care and services such as food and nutrition requirements, decision making and end of life care, activities, and language translation requirements.		

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of resident fund accounts, and review of facility policy, the facility failed to appropriately manage resident funds. This affected one (#02) of one resident reviewed for personal funds. The facility census was 55. Findings include: Review of the medical record for Resident #02 revealed an admission date of 10/22/25 with diagnoses that included acute respiratory failure with hypoxia, hypertension, and type II diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #02 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated the resident was alert and oriented to person, place, and time. Further review of the MDS assessment revealed Resident #02 was dependent on staff for activities of daily living (ADLs) and had a lower extremity impairment on one side. Review of the care plan dated 10/29/25 revealed Resident #02 was independent with meeting emotional, intellectual, physical and social needs, and had an ADL self-care performance deficit with interventions that included assistance with ADLs and maintain involvement as desired. Review of the Resident Fund Management Services Authorization and Agreement to handle resident funds revealed Resident #02 opened a resident funded account on 10/23/25. Review of the document revealed Resident #02 opted to have or direct deposit (recurring income source) but had no designated selection for the type of checking account (automatic transfer of funds). Review of the Social Security Administration (SSA) benefit verification letter revealed Resident #02 had a total monthly awarded benefit payment of \$1,335.00. Review of the facility's trial balance regarding resident funded accounts revealed Resident #02 had a current balance of \$0.08 with a designated established allowance of \$75.00. Review of the quarterly statements dated 10/28/25 through 12/31/25 revealed Resident #02 had one cash credit in the amount of \$600.00 on 11/28/25 and one care cost payment debit of \$600.00 on 06/25/26. Review of the quarterly statement revealed no other activity besides the interest paid credits. Review of the quarterly statement dated 01/01/26 through 03/31/26 revealed Resident #02 had no other activity besides interest paid credits. Review of the quarterly statement dated 04/01/26 through 06/30/26 revealed Resident #02 had one cash credit in the amount of \$600.00 on 06/11/26 and one care cost payment debit of \$600.00 on 12/02/25. Review of the Member Eligibility Verification Form from the Ohio Department of Medicaid (ODM) revealed Resident #02 had a patient liability of \$402.00 for the month of October 2025. Resident #02 had a patient liability of \$1,249.00 for the months of November and December of 2025, and a patient liability of \$1,260.00 January 2026 through June 2026. Interview on 07/16/26 at 8:30 A.M. with Business Office Manager (BOM) #159 revealed Resident #02 had Representative Payee (RP) who was appointed by the SSA to manage Social Security or Supplemental Security Income (SSI) benefits for him. BOM #159 revealed the facility was having trouble getting Resident #02's RP to make payments to cover the resident's patient liability, causing Resident #02 to fall behind on payments. BOM #159 revealed she obtained Resident #02's bank card and every month starting April of 2026, the BOM withdrew two cash withdrawals equaling approximately \$1,260.00 from the shared bank account for Resident #02 and the RP from the local automated teller machine (ATM). BOM #159 revealed she would then take the cash and transfer it into cashier check at the facility utilized bank. BOM #159 revealed Resident #02 had an opened account at the facility utilized bank for his funds, however, BOM #159 did not utilize that account and instead deposited the cashier checks into the facility designated account and apply the total to Resident #02's patient liability and/or care costs. BOM #159 revealed there was no documentation or written (continued on next page)		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agreements that authorized her to utilize Resident #02's and/or the RP's bank card, to withdraw cash from the ATM, obtain cashier checks and then deposit it into the facility's account instead of Resident #02's personal account. BOM #159 revealed she obtained receipts for every transaction but could not provide authorization of bank transaction statements due to not being able to speak with bank staff at the inside counter because she was not listed on Resident #02's bank account. BOM #159 revealed all transactions were completed at ATMs and although all transactions were [NAME], she could not verify that the amounts withdrawn were the only funds taken from Resident #02's account and she could not verify if Resident #02 received his allotted monthly allowance of \$75.00. BOM #159 confirmed at the time of the interview that she is not following the facility policy related to managing Resident #02's accounts and further verified no one would be able to track what the resident had paid toward his patient liability. Review of the undated facility policy titled Resident Trust Fund, Accounting and Records, stated the facility had the policy in place to ensure the facility establishes and maintains a system of full, complete and separate accounting of each resident's personal account funds. The policy states each resident shall receive a receipt for every transaction, provide a signature for every transaction, all revenues and expenses shall be documented for each resident on resident ledger, and the account ledger must be available at any time for the resident to review. The policy specifically stated for all funds received and deposited by the facility should be credited to the resident's individual account. The facility must have record, including the date and reason for all deposits and expenditures. Further review of the policy under the internal procedures stated that deposits cannot be comingled with operating funds and any checks containing operating and trust funds will be deposited into the trust account; a check will be written from the trust account and deposited into the operating account for the accounts receivable portion.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure advance directives were consistent throughout the medical record. This affected two (#14, #40) of two residents reviewed for advance directives. The facility census was 55. Findings include: 1. Review of the medical record for Resident #14 revealed an admission date of [DATE]. Diagnoses included hypertension, atrial fibrillation, dementia, chronic kidney disease, and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of a signed Do Not Resuscitate (DNR) Comfort Care (CC) form dated [DATE] and located in the resident's physical paper chart revealed the resident had chosen a DNRCC-Arrest (DNRCC-A) protocol (the DNR Comfort Care protocol would be implemented in the event of a cardiac or respiratory arrest). Review of a physician order in the electronic medical record, dated [DATE] and discontinued on [DATE], revealed the resident had chosen a DNRCC-A code status. Review of a nurse's note dated [DATE] revealed the resident's family wanted the resident's code status changed to a DNR-CC (immediate activation of the DNR Comfort Care protocol) and also requested a hospice consult. Review of a physician order dated [DATE] revealed an order for the resident to have a DNRCC code status. Interview on [DATE] at 12:51 P.M., Licensed Practical Nurse (LPN) #124 revealed she would first check the electronic medical record for a resident's code status. LPN #124 revealed if the electronic medical record could not be accessed, she would check for a resident's code status in the physical chart. LPN #124 verified the electronic medical record for Resident #14 stated the resident had a DNRCC code status however the paper medical record indicated Resident #14 had a DNRCC-A code status. Interview on [DATE] at 12:58 P.M., Social Worker (SW) #153 revealed Resident #14 had a DNRCC-A code status until she signed onto hospice services and then had elected a DNR-CC code status. SW #153 revealed the resident's family discontinued hospice services after one day, but the DNRCC code status remained in effect. SW #153 revealed the resident's electronic medical record had been updated but the paper medical record had not. SW #153 revealed she had forgotten to update the DNR form in the physical paper chart with the code status change. 2. Review of Resident #40's medical record revealed an admission date of [DATE]. Diagnoses (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included cystitis, hemiplegia and hemiparesis follow cerebral infarction affecting the left non-dominant side, hyperlipidemia, chronic obstructive pulmonary disease (COPD), and type two diabetes mellitus without complications. Review of Resident #40's Medicare five-day MDS assessment dated [DATE] revealed Resident #40 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11. Review of Resident #40's care plan dated [DATE] revealed Resident #40 had chosen Do Not Resuscitate (DNR) status with interventions that included to not perform cardiopulmonary resuscitation (CPR) if Resident #40 was in cardiac arrest and to have a physician signed DNR identification form to be placed in Resident #40's chart and the physician order written in the medical record. Review of Resident #40's Electronic Medical Record (EMR) physician orders revealed an order dated [DATE] for Resident #40's advanced directives to be a Do Not Resuscitate Comfort Care (DNRCC). Observation on [DATE] at 12:06 P.M. of Resident #40's paper chart revealed the signed DNR order was for a Do Not Resuscitate Comfort Care Arrest (DNR-CCA). Interview on [DATE] at 3:08 P.M. with LPN #125 verified Resident #40's EMR advanced directive was a DNR-CC and Resident #40's paper chart advanced directive was a DNR-CCA. Review of the facility policy titled Residents' Rights Regarding Treatment and Advanced Directives, with a last revision date of [DATE] revealed upon admission, should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated to the staff.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure adequate monitoring for psychotropic medication effectiveness and adverse effects/side effects. This affected three (#03, #09, and #25) of five residents reviewed for unnecessary medications. The facility identified 47 residents receiving psychotropic medications. The facility census was 55. Findings include: 1. Review of the medical record for Resident #03 revealed an admission date of 05/06/26 and a readmission date of 07/10/26. Diagnoses included depression, anxiety, chronic kidney disease, chronic obstructive pulmonary disease, and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the plan of care initiated 05/07/26 revealed the resident was at risk for episodes of anxiety. Interventions revealed to administer medications as ordered and monitor for side effects and effectiveness. Review of the plan of care initiated 07/10/26 revealed the resident exhibited depressive behaviors related to a depression diagnosis. Interventions included administering medications as ordered and for staff to observe for medication effectiveness and adverse reactions. Also, for staff to monitor for increased side effects if the psychotropic medications had been increased or decreased and to notify the physician. Review of the physician orders dated 05/07/26 revealed an order for paroxetine 40 milligrams (mg) daily for major depressive disorder and an order for buspirone five mg, two times a day for anxiety. Review of the nurse's notes revealed the resident discharged to the hospital on [DATE] with chest pain. The resident returned to the facility on [DATE]. Review of the physician orders dated 07/10/26 revealed an order for buspirone five mg, two times a day for anxiety and an order for paroxetine 40 mg daily for depression. There were no orders for monitoring for the effectiveness, adverse effects, and side effects of the medication. Review of the Treatment Administration Records (TAR) dated 06/01/26 through 07/12/26 revealed no documentation the staff were monitoring for effectiveness, side effects, and adverse effects of the psychotropic medications. 2. Review of the medical record for Resident #25 revealed he was admitted to the facility on [DATE] with diagnoses that included acute congestive heart failure, dissection of ascending aorta, anxiety disorder and hemorrhagic condition. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 14 that indicated the resident was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #25 required some assistance from staff for activities of daily living (ADLs). Review of the care plan dated 04/21/26 revealed Resident #25 had an ADL self-care performance deficit and used anti-anxiety medications with interventions that included assistance with care, administer anti-anxiety medications as ordered by physician, and monitor for side effects, effectiveness, and adverse reactions related to anti-anxiety medication. Review of the physician orders dated 04/17/26 revealed an order for Hydroxyzine Pamoate oral capsule 25 mg, one capsule to be given by mouth three times a day for anxiety. Review of the physician orders revealed no orders for monitoring for medication effectiveness, adverse effects and side effects. Review of the progress notes dated 04/17/26 through 07/16/26 revealed no documentation Resident #25 was monitored for medication effectiveness, adverse effects and side effects of anti-anxiety medication. Review of the medication administration records and treatment administration records dated 04/17/26 through 07/16/26 revealed no documentation Resident #25 was monitored for medication effectiveness, adverse effects and side effects of anti-anxiety medication. 3. Review of Resident #09's medical record revealed an admission date of 10/27/25. Diagnoses included dementia, Parkinson's disease, dysphagia, depression, anxiety, and adjustment disorder with anxiety. Review of Resident #09's modification of quarterly MDS assessment dated [DATE] revealed Resident #09 had moderately impaired cognition with a BIMS score of 10. Furthermore, Resident #09 required the use of antipsychotic and anticonvulsant medications. Review of Resident #09's care plan dated 05/01/26 revealed Resident #09 used anti-anxiety and antipsychotic medications with interventions that included to administer medications as ordered by the physician, and to monitor for side effects and effectiveness every shift. Review of Resident #09's physician orders revealed an order for Zyprexa five mg with instructions to give one tablet by mouth every morning and at bedtime related to the diagnoses of dementia with agitation. Review of Resident #09's TAR dated 06/01/26 through 07/12/26 revealed no documentation the staff were monitoring for effectiveness, side effects, and adverse effects of the psychotropic medication. Interview on 07/15/26 at 9:49 A.M., the Director of Nursing (DON) verified there was no documentation for Residents #03, #09 and #25 that the nursing staff had been monitoring the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications for effectiveness, side effects and adverse effects. Review of the facility policy Use of Psychotropic Medication, dated 10/01/25 revealed the effect of psychotropic medications would be evaluated on an ongoing basis in accordance with nurse assessments and medication monitoring parameter, consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interview, and facility policy review, the facility failed to implement a dental care plan for a resident. This affected one (#35) of one resident reviewed for dental services. The facility census was 55. Findings include: Review of the medical record for Resident #35 revealed she was admitted to the facility on [DATE] with diagnoses that included volvulus, intestinal obstruction, and epilepsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #35 required some assistance from staff for activities of daily living (ADLs). Review of the care plan dated 05/02/26 revealed Resident #35 required assistance with ADLs, was at risk for weight loss, chewing problems, and had oral and/or dental health problems with interventions that included refer to dental services, be free from pain, infection and/or bleeding, and coordinate arrangements for dental care. Review of the physician orders 10/06/25 revealed Resident #35 had an order to see ancillary providers including the dentist. Review of the physician orders 10/07/25 revealed Resident #35 had an order for dental consultations as needed. Review of the facility's previous dental visit revealed Resident #35 was last seen by the dentist on 04/02/26. Review of the upcoming dental visit of verified residents to be seen on 07/17/26 revealed Resident #35 was not a designated resident to be seen. Review of the progress note dated 06/22/26 at 7:20 P.M. revealed Resident #35 requested pain medication, hydrocodone-acetaminophen oral tablet 325 milligrams (mg) to be given every six hours as needed for pain, for tooth pain. Review of the progress note dated 06/23/26 at 9:55 P.M. revealed Resident #35 complained of toothache with a pain level of four out of 10 (zero equals no pain and 10 equals the worst pain) and stated, whole mouth hurts. Review of the progress note dated 07/10/26 at 9:05 P.M. revealed Resident #35 requested hydrocodone-acetaminophen with a pain level of 10 out of 10 for tooth pain due to a broken tooth. Review of the progress note dated 07/11/26 at 6:34 A.M. revealed Resident #35 requested hydrocodone-acetaminophen for toothache. Review of the progress note dated 07/11/26 at 6:40 P.M. revealed Resident #35 requested hydrocodone-acetaminophen for tooth pain. Review of the progress note dated 07/12/26 at 6:19 A.M. revealed Resident #35 requested hydrocodone-acetaminophen for tooth. Review of the email correspondence dated 07/13/26 at 12:54 P.M. with the Director of Social Services (DSS) #153 and the dental office, revealed Resident #35 was not listed to be seen for the upcoming visit scheduled on 07/17/26. Review of the email correspondence dated 07/13/26 at 2:01 P.M. with the DSS #153 and the dental office revealed DSS #153 requested to have Resident #35 added to the list to be seen on 07/17/26. Review of the email correspondence dated 07/13/26 at 4:06 P.M. with the DSS #153 and the dental office revealed Resident #35 was not enrolled to be seen by the dental provider and a request for her face sheet and enrollment forms were requested. Interview on 07/13/26 at 10:51 A.M. with Resident #35 revealed she had mouth and back pain and that she had already informed her assigned nurse. Resident #35 revealed the nurse assigned to her had not returned yet with the requested pain medication. Interview on 07/13/26 at 11:30 A.M. with Licensed Practical Nurse (LPN) #124 revealed she was aware of Resident #35's request for pain medication due to tooth pain. LPN #124 revealed she was unaware if Resident #35 was on the upcoming list to be seen by the dentist. Follow-up interview on 07/14/26 at 8:39 A.M. with LPN #124 revealed Resident #35 recently verbalized tooth pain due to a chipped tooth the previous day and that it had been (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, and policy review, the facility failed to ensure wound treatments were administered per physician orders. This affected two (#14, #10) of two residents reviewed for pressure ulcers. The facility identified seven residents with pressure ulcers. The facility census was 55. Findings include: 1. Review of the medical record for Resident #14 revealed an admission date of 05/29/26. Diagnoses included hypertension, atrial fibrillation, dementia, chronic kidney disease, and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. The resident had a stage three pressure ulcer present on admission. The resident was dependent on staff for toileting and transfers. The resident required substantial/maximal assistance for bed mobility. Review of the care plan initiated 05/29/26 revealed the resident was admitted to the facility with a stage three pressure ulcer to the sacrum. Interventions included for staff to complete wound treatment per physician orders. Review of a physician order dated 05/29/26 revealed to cleanse the coccyx with wound cleanser, pat dry, apply calcium alginate with silver, and cover with border foam. Change daily on day shift for wound care. The order was not discontinued until 07/13/26. Review of a wound care progress note dated 06/10/26 revealed the resident had a stage three pressure ulcer to the sacrum measuring 3.5 centimeters (cm) in length, four cm in width, with a depth of 0.1 cm. The wound had 60 percent granulation tissue and 40 percent epithelial tissue with moderate serosanguinous drainage. The surrounding skin was moist and fragile. Review of a physician order dated 06/10/26 revealed a new physician order to cleanse the wound with wound cleanser, apply saline moistened collagen to the wound bed, and cover with silicone super absorbent dressing. Change daily and as needed. Review of the weekly wound care progress notes dated 06/17/26, 06/24/26, and 07/01/26 revealed the stage three pressure ulcer was improving as evidenced by decreases in the size of the wound. Review of the Treatment Administration Record (TAR) dated 06/11/26 through 07/12/26 revealed the nurses had documented completing both the wound treatment using calcium alginate and the wound treatment using collagen. Interview on 07/14/26 at 1:56 P.M., Licensed Practical Nurse (LPN) #125 revealed she thought the two orders were the same and thought it was weird there were two orders. LPN #125 revealed she treated the wound with calcium alginate and had not applied the collagen to the wound bed. LPN #125 revealed one of the orders should have been discontinued. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/14/26 at 2:37 P.M., LPN #128 revealed she had been using calcium alginate for the wound treatment. LPN #128 revealed she had incorrectly documented completing both wound treatments and should have gotten the wound treatment orders clarified. Observation on 07/14/26 at 2:48 P.M. of wound care for Resident #14 with LPN #128 revealed the resident had a small pressure ulcer to the sacrum approximately one cm in length, 0.5 cm in width, with a depth of less than 0.1 cm. The wound bed had 100% granulation tissue. There were no signs of infection. The surrounding skin was reddened. LPN #128 cleansed the wound and applied the wound treatment per physician orders. Interview on 07/14/26 at 3:10 P.M., Registered Nurse (RN) #150 revealed the wound should have been treated with collagen and not the calcium alginate. RN #150 revealed the physician order should have been clarified. RN #150 verified she had documented completing both treatments but had only completed the order for the calcium alginate wound treatment. Interview on 07/15/26 at 9:56 A.M., RN #107 verified she had documented completing both wound treatments but had not completed the wound treatment using the collagen. RN #107 revealed the physician should have been contacted to clarify the two different wound care orders. Interview on 07/15/26 at 10:34 A.M., the Director of Nursing (DON) revealed the nurse who entered the new wound care orders should have discontinued the previous wound care orders. Interview on 07/16/26 at 12:47 P.M., LPN #122 revealed she had not noticed there were two different physician orders for wound care and probably assumed they were the same order. LPN #122 revealed she was not sure what treatment she had administered. LPN #122 revealed the orders should have been clarified with the physician. 2. Review of Resident #10's medical record revealed an admission date of 12/30/25. Diagnoses included bipolar disorder with psychotic features. chronic obstructive pulmonary disease (COPD), hypertension, anxiety, muscle weakness, pressure ulcer of the sacral region, hypertensive chronic kidney disease, mild persistent asthma, age-related osteoporosis, and urinary incontinence. Review of Resident #10's quarterly MDS assessment dated [DATE] revealed Resident #10 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11. Furthermore, Resident #10 had one unstageable pressure ulcer. Review of Resident #10's care plan dated 06/24/26 revealed Resident #10 had an actual area of impaired skin integrity as evidenced by an unstageable pressure ulcer at the sacrum that extended to the bilateral buttocks, an abrasion from 06/04/26, and pressure areas to the bilateral heels with interventions that included to keep shoes off, provide non-skid socks to Resident #10, to measure and complete skin grids weekly, and to complete treatments as ordered. Review of Resident #10's physician orders revealed an order with a start date of 07/07/26 with instructions to cleanse the right heel with wound wash, pat dry, apply skin prep and leave open to air twice a day every shift for skin impairment. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/13/26 at 9:07 A.M. of Resident #10's feet revealed bilateral dressings in place. The kerlix dressings on Resident #10's bilateral feet appeared soiled as evidenced by yellow discoloration to both dressings. Furthermore, the bilateral dressings were dated 07/12/26. Interview on 07/13/26 at 9:12 A.M. with Licensed Practical Nurse (LPN) #125 verified there were wound dressings on Resident #10's bilateral feet and the dressings appeared to have yellow discoloration. Observation on 07/13/26 at 12:17 P.M. of wound care for Resident #10 completed by LPN #125 and assisted by Certified Nurse Aide (CNA) #200 revealed LPN #125 removed the wound dressing dated 07/12/26. LPN #125 used a saline flush to wash the wound, applied a saline moistened calcium alginate AG dressing to the right foot wound, applied a bordered dressing, and wrapped the foot with kerlix. Interview on 07/13/26 at 12:36 P.M. with LPN #125 verified she applied the saline moistened calcium alginate AG dressing to Resident #10's right foot, applied a bordered dressing, and wrapped the foot with kerlix. Interview on 07/13/26 at 4:33 P.M. with LPN #125 verified Resident #10's physician orders did not match the dressing she applied to Resident #10. LPN #125 stated the wound Nurse Practitioner (NP) gave her a verbal order to begin the same wound dressing as the left heel for the right heel if the right heel wound opened. LPN #125 verified there was no documentation in Resident #10's medical record regarding this order. Interview on 07/15/26 at 3:48 P.M. with RN #107 verified she had completed Resident #10's heel wound dressing change on 07/12/26. RN #107 verified the order read to cleanse the right heel with wound wash, pat dry, apply skin prep and leave open to air twice a day every shift for skin impairment. RN #107 verified she applied the same dressing as the left foot to the right foot because the right foot heel wound opened. RN #107 stated she should have updated the physician to obtain an order for a new wound dressing. Review of the facility policy titled Wound Treatment Management with a revision date of 12/01/25 revealed wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes. In the absence of treatment orders, the licensed nurse would notify the physician to obtain treatment orders. Further review of the policy revealed treatments would be documented on the treatment administration record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, medical record review, staff interview, review of the manufacturer's instructions for the mechanical lift slings, and policy review, the facility failed to ensure monitoring was in place for mechanical lift slings utilized in the facility. This affected two (#01 and #34) of two residents reviewed for mechanical lift slings. The facility identified 12 residents requiring the use of slings for mechanical lift transfers. The facility census was 55. Findings include: 1. Review of Resident #01's medical record revealed an admission date of 01/09/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, type two diabetes mellitus, aphasia, muscle weakness, and hypertension. Review of Resident #01's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 had severely impaired cognitive skills for daily decision making. Furthermore, Resident #01 was dependent for chair to bed and bed to chair transfers. Review of Resident #01's care plan dated 07/13/26 revealed Resident #01 required assistance for activities of daily living (ADL's) related to hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side with interventions that included to use two staff for mechanical lift transfers, and resident was dependent for all ADLs. Review of Resident #01's physician orders revealed an order with a revision date of 01/10/25 that instructed staff to use a mechanical lift for all transfers. 2. Review of Resident #34's medical record revealed an admission date of 02/02/23. Diagnoses included flaccid hemiplegia affecting the left dominant side, muscle weakness, chronic kidney disease stage two, and developmental disorder of speech and language. Review of Resident #34's quarterly MDS assessment dated [DATE] revealed Resident #34 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 13. Furthermore, Resident #34 was dependent for chair to bed and bed to chair transfers. Review of Resident #34's care plan dated 05/02/26 revealed Resident #34 required assistance for ADLs related to left hemiplegia and lumbar disc disorder with an intervention that included to utilize the mechanical lift for transfers. Review of Resident #34's physician orders revealed an order with a date of 05/31/24 that instructed staff to use a mechanical lift for all transfers. Observation on 07/15/26 at 10:46 A.M. of a mechanical lift transfer for Resident #34 completed by Certified Nursing Assistant (CNA) #110 and CNA #101 revealed Resident #34's mechanical lift sling was worn and discolored on the fabric of the sling that supported the weight of the resident and where the sling attached to the mechanical lift. Interview on 07/15/26 at 10:48 A.M. with CNA #110 and CNA #101 verified the mechanical lift sling was worn and discolored on the fabric of the sling that supported the weight of the resident and where the sling attached to the mechanical lift. Observation and concurrent interview on 07/15/26 at 11:09 A.M. with Laundry Attendant (LA) #148 verified four mechanical lift slings that were cleaned and hanging in the laundry room had worn straps and were discolored. One of the slings had a hole in the fabric. LA #148 verified the CNAs in the facility should be monitoring the slings prior to each use. LA #148 stated she was unaware of any documentation regarding the monitoring of the mechanical lift slings in the facility and stated slings would be disposed of if they noticed any damage to them. Observation and concurrent interview on 07/15/26 at 11:31 A.M. with CNA #139 verified the mechanical lift sling under Resident #38 was frayed and discolored from use. Interview on 07/15/26 at 1:37 P.M. with the Director of Nursing (DON) verified laundry was responsible for monitoring the mechanical lift slings. Furthermore, the DON verified there was no documentation in the facility regarding the monitoring of slings and the facility did not have any documentation regarding what size (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slings should be used for each resident.Observation and concurrent interview on 07/15/26 at 2:53 P.M. with Licensed Practical Nurse (LPN) #124 verified the mechanical lift sling under Resident #01 had a hole in it and it was worn and discolored on the fabric of the sling that supported the weight of the resident and attached the sling to the mechanical lift.Review of the manufacturers owner's operator and maintenance manual revealed after each laundering (in accordance with instructions on the sling) slings are to be inspected for wear, tears, and loose stitching. Furthermore, bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury and are to be discarded immediately.Review of the facility policy titled Safe Resident Handling/Transfers, revised on 10/01/25 revealed the staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy. The facility will ensure that there are appropriate amounts of varying sizes of slings to accommodate residents, and that residents will be measured correctly as per the manufacturer's instructions on proper sling sizes. Slings will be laundered according to the manufacturer's instructions, and any damaged, broken, or unsafe slings will be removed from service or replaced.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure oxygen orders specified liters per minute (lpm). This affected one (#10) of three residents reviewed for respiratory care. The facility census was 55. Findings include: Review of Resident #10's medical record revealed an admission date of 12/30/25. Diagnoses included bipolar disorder with psychotic features, chronic obstructive pulmonary disease (COPD), hypertension, anxiety, muscle weakness, pressure ulcer of the sacral region, hypertensive chronic kidney disease, mild persistent asthma, age-related osteoporosis, and urinary incontinence. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11. Furthermore, Resident #10 required the use of oxygen therapy. Review of Resident #10's care plan dated 06/24/26 revealed Resident #10 had altered respiratory status or difficulty breathing related to asthma and COPD with interventions that included to provide oxygen as ordered and to observe, document, and report abnormal breathing patterns to the Medical Director. Review of Resident #10's physician orders revealed an order dated 01/02/26 that read oxygen via nasal cannula at bedtime and as needed for shortness of breath every shift. Observation on 07/13/26 at 9:07 A.M. revealed Resident #10 to be receiving oxygen via nasal cannula at 2.5 lpm. Interview on 07/13/26 at 9:12 A.M. with Licensed Practical Nurse (LPN) #125 verified Resident #10 was receiving oxygen via nasal cannula at 2.5 lpm. Interview on 07/13/26 at 9:14 A.M. with LPN #125 verified Resident #10's physician order did not specify the liter flow of oxygen to be delivered. Review of the facility policy titled Oxygen Administration, with a revision date of 01/04/26 revealed oxygen is administered to residents who need it, consistent with professional standards of practice, comprehensive person-centered care plans, and the resident's goals and preferences.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interview, and facility policy review, the facility failed to ensure timely dental services. This affected one (#35) of one resident reviewed for dental services. The facility census was 55. Findings include: Review of the medical record for Resident #35 revealed she was admitted to the facility on [DATE] with diagnoses that included volvulus, intestinal obstruction, and epilepsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #35 required some assistance from staff for activities of daily living (ADLs). Review of the care plan dated 05/02/26 revealed Resident #35 required assistance with ADLs, was at risk for weight loss, chewing problems, and had oral and/or dental health problems with interventions that included refer to dental services, be free from pain, infection and/or bleeding, and coordinate arrangements for dental care. Review of the physician orders 10/06/25 revealed Resident #35 had an order to see ancillary providers including the dentist. Review of the physician orders 10/07/25 revealed Resident #35 had an order for dental consultations as needed. Review of the facility's previous dental visit revealed Resident #35 was last seen by the dentist on 04/02/26. Review of the upcoming dental visit of verified residents to be seen on 07/17/26 revealed Resident #35 was not a designated resident to be seen. Review of the progress note dated 06/22/26 at 7:20 P.M. revealed Resident #35 requested pain medication, hydrocodone-acetaminophen oral tablet 325 milligrams (mg) to be given every six hours as needed for pain, for tooth pain. Review of the progress note dated 06/23/26 at 9:55 P.M. revealed Resident #35 complained of toothache with a pain level of four out of 10 (zero equals no pain and 10 equals the worst pain) and stated, whole mouth hurts. Review of the progress note dated 07/10/26 at 9:05 P.M. revealed Resident #35 requested hydrocodone-acetaminophen with a pain level of 10 out of 10 for tooth pain due to a broken tooth. Review of the progress note dated 07/11/26 at 6:34 A.M. revealed Resident #35 requested hydrocodone-acetaminophen for toothache. Review of the progress note dated 07/11/26 at 6:40 P.M. revealed Resident #35 requested hydrocodone-acetaminophen for tooth pain. Review of the progress note dated 07/12/26 at 6:19 A.M. revealed Resident #35 requested hydrocodone-acetaminophen for tooth. Review of the email correspondence dated 07/13/26 at 12:54 P.M. with the Director of Social Services (DSS) #153 and the dental office, revealed Resident #35 was not listed to be seen for the upcoming visit scheduled on 07/17/26. Review of the email correspondence dated 07/13/26 at 2:01 P.M. with the DSS #153 and the dental office revealed DSS #153 requested to have Resident #35 added to the list to be seen on 07/17/26. Review of the email correspondence dated 07/13/26 at 4:06 P.M. with the DSS #153 and the dental office revealed Resident #35 was not enrolled to be seen by the dental provider and a request for her face sheet and enrollment forms were requested. Interview on 07/13/26 at 10:51 A.M. with Resident #35 revealed she had mouth and back pain and that she had already informed her assigned nurse. Resident #35 revealed the nurse assigned to her had not returned yet with the requested pain medication. Interview on 07/13/26 at 11:30 A.M. with Licensed Practical Nurse (LPN) #124 revealed she was aware of Resident #35's request for pain medication due to tooth pain. LPN #124 revealed she was unaware if Resident #35 was on the upcoming list to be seen by the dentist. Follow-up interview on 07/14/26 at 8:39 A.M. with LPN #124 revealed Resident #35 recently verbalized tooth pain due to a chipped tooth the previous day and that it had been addressed and she was on the list to be seen by dental services on 07/15/26. LPN #124 revealed Resident #35 was excited to be seen by dental due to ongoing issues (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with her teeth. LPN #124 revealed the facility was responsible for arranging visits with ancillary services such as the dentist. Interview on 07/15/26 at 8:38 A.M, with DSS #153 revealed she was responsible for arranging and scheduling all ancillary visits for residents. DSS #153 revealed if residents experienced pain and required immediate services, she would contact alternative resources, local dentists, for emergencies. DSS #153 revealed sometimes dental could see residents right away but if he could not, appointments would be scheduled with providers who accepted resident's insurance. DSS #153 revealed dental was scheduled to see residents on 07/17/26 and Resident #35 was not on the list to be seen. Follow-up interview on 07/15/26 at 9:31 A.M. with DSS #153 revealed Resident #35 was added to the list, after surveyor intervention, and was informed Resident #35's tooth had been bothering her. DSS #153 revealed she was unaware Resident #35 needed to be seen by the dentist. Review of the facility document titled Ancillary Services undated, revealed the facility had a policy in place that the facility would assist residents in obtaining routine and emergency ancillary services as needed. Review of the policy revealed routine dental services and emergency dental services such as an episode of acute pain in teeth, gums or palate, broken or otherwise damaged teeth or any other problem of the oral cavity. Review of the document revealed the facility did not implement the policy.		

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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** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure infection control standards were maintained during wound care. Furthermore, the facility failed to implement Enhanced Barrier Precautions (EBP) when the staff failed to wear the appropriate personal protective equipment (PPE) for resident care when the resident was identified as requiring EBP. This affected three (#10, #33 and #14) of three residents reviewed for infection control practices. The facility identified 13 residents in the facility requiring EBP. The facility census was 55. Findings include: 1. Review of Resident #10's medical record revealed an admission date of 12/30/25. Diagnoses included bipolar disorder with psychotic features. chronic obstructive pulmonary disease (COPD), hypertension, anxiety, muscle weakness, pressure ulcer of the sacral region, hypertensive chronic kidney disease, mild persistent asthma, age-related osteoporosis, and urinary incontinence. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11. Furthermore, Resident #10 had one unstageable pressure ulcer. Review of Resident #10's care plan dated 06/24/26 revealed Resident #10 required Enhanced Barrier Precautions (EBP) related to wounds with interventions that included for staff to wear gloves and gown when providing high-contact resident care activities such as when providing incontinence care or wound care and for staff to clean their hands prior to entering and when leaving Resident #10's room. Review of Resident #10's physician orders revealed an order with a start date of 07/07/26 with instructions to cleanse the right heel with wound wash, pat dry, apply skin prep and leave open to air twice a day every shift for skin impairment. Further review of Resident #10's physician orders for the month of July 2026 revealed no order for EBP. Observation on 07/13/26 at 9:24 A.M. of Resident #10's room and door revealed no signage posted regarding EBP. Interview on 07/13/26 at 9:26 A.M. with Licensed Practical Nurse (LPN) #125 verified Resident #10 did not have a physician order for EBP and should have due to the wounds on Resident #10's body. Furthermore, LPN #125 verified no signage was posted regarding EBP for Resident #10 on or near Resident #10's room. Observation on 07/13/26 at 9:07 A.M. of Resident #10's feet revealed bilateral dressings in place. The kerlix dressings on Resident #10's bilateral feet appeared soiled as evidenced by yellow discoloration to both dressings. Furthermore, the bilateral dressings were dated 07/12/26. Interview on 07/13/26 at 9:12 A.M. with Licensed Practical Nurse (LPN) #125 verified there were wound dressings on Resident #10's bilateral feet and the dressings appeared to have yellow (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discoloration. Observation on 07/13/26 at 12:17 P.M. of wound care for Resident #10 completed by LPN #125 and assisted by Certified Nurse Aide (CNA) #200 revealed LPN #125 and CNA #200 did not wear a gown as required during wound care. Further observation revealed LPN #125 applied gloves, removed the soiled dressing from Resident #10's right foot and with the same gloves opened an abdominal pad (ABD) and saline flush to cleanse the wound. While flushing the wound, LPN #125 touched the flush to the wound and patted the wound dry with the ABD. Without changing gloves, LPN #125 opened a calcium alginate AG dressing. LPN #125 took off the gloves and without performing hand hygiene, applied a new pair of gloves. LPN #125 used the same flush that touched Resident #10's wound to moisten the calcium alginate AG dressing and applied the dressing to the wound. LPN #125 then applied a silicone super absorbent bordered dressing and wrapped the dressing with kerlix. LPN #125 took off her gloves and without performing hand hygiene, put on another pair of gloves. LPN #125 took off Resident #10's left heel wound dressing. LPN #125 changed gloves without performing hand hygiene in between and with a new pair of gloves, opened the calcium alginate AG. LPN #125 moistened the calcium alginate AG with a saline flush and applied the dressing over an old dressing that remained on Resident #10's foot. With surveyor intervention, LPN #125 and CNA #200 removed the old dressing and applied a new clean dressing to Resident #10's heel. Interview on 07/13/26 at 12:36 P.M. with LPN #125 verified the above findings. 2. Review of Resident #33's medical record revealed an admission date of 02/25/26. Diagnoses included brief psychotic disorder, anemia, depression, hypertension, edema, and vitamin D deficiency, and muscle weakness. Review of Resident #33's quarterly MDS assessment dated [DATE] revealed Resident #33 had severely impaired cognition with a BIMS score of four. Review of Resident #33's care plan dated 07/13/26 revealed Resident #33 required isolation/quarantine related to shingles or chicken pox with interventions that included to maintain isolation/quarantine by staff during the acute infection period and to discontinue isolation/quarantine as soon as the infection no longer exists. Review of Resident #33's physician orders revealed no order for contact precautions. Further review of the physician orders revealed an order for valacyclovir HCL with instructions to administer one one-gram tablet by mouth every morning and at bedtime for shingles for two days. Interview on 07/16/26 at 10:51 A.M. with the Director of Nursing (DON) verified Resident #33 was on contact precautions related to shingles and did not have a physician order for contact precautions. 3. Review of the medical record for Resident #14 revealed an admission date of 05/29/26. Diagnoses included hypertension, atrial fibrillation, dementia, chronic kidney disease, and congestive heart failure. Review of the admission MDS assessment dated [DATE] revealed the resident had impaired (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Willard		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition. The resident had a stage three pressure ulcer present on admission. Review of the care plan initiated 05/29/26 revealed the resident was admitted to the facility with a stage three pressure ulcer. One intervention revealed for staff to maintain enhanced barrier precautions per facility protocol. Review of a physician orders dated 05/29/26 through 07/12/26 revealed no physician orders for enhanced barrier precautions. Observation on 07/13/26 at 10:18 A.M., revealed there was no sign posted on the resident's door indicating the resident was on enhanced barrier precautions. Interview on 07/13/26 at 10:18 A.M., LPN #128 verified there was no sign posted on the resident's door alerting staff of the required enhanced barrier precautions. LPN #128 revealed Resident #14 had a pressure ulcer and should have been placed on enhanced barrier precautions. Review of the facility policy Enhanced Barrier Precautions, dated 07/13/22, revealed staff would use gowns and gloves for high-contact resident care activities to prevent the transmission of novel or targeted multidrug-resistant organisms. High-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing incontinence briefs, providing toileting assistance, wound care, and device care. Further review of the policy revealed staff would obtain a physician order for residents placed on enhanced barrier precautions. Additionally, clear signage would be posted on the door or wall outside of the resident room indicating the type of precautions, the required personal protective equipment (PPE), and the high-contact resident care activities requiring the use of gowns and gloves.		