STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Winchester	36 Lehman Dr Canal Winchester, OH 43110

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 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. Based on interview and record review, the facility failed to ensure discharge Minimum Data Set (MDS) 3.0 assessments were completed accurately and a correction was submitted timely to reflect Resident #90's disposition. This affected one resident (#90) out of four residents reviewed for MDS assessments. The facility census was 94.Findings include:Review of the medical record for Resident #90 revealed an admission date of 06/17/19, with diagnoses including hypertension, cognitive communication deficit, depression, polyneuropathy, chronic pain, dementia, gastroesophageal reflux disease (GERD), benign prostatic hyperplasia, acquired absence of the right leg above the knee, and schizoaffective disorder.Review of a progress note dated 03/02/25 revealed Resident #90 was enroute to a local hospital by critical transport, and the power of attorney was notified of the intended location.Review of the Discharge Minimum Data Set (MDS) 3.0 assessment, completed on 03/02/25, revealed the discharge status was coded as discharge - return anticipated and marked as an unplanned discharge.Review of an appointment form dated 03/03/25 revealed the resident was discharged to the hospital with the intention of going home on hospice services. Interview conducted on 08/05/25 at 11:36 A.M. with Registered Nurse (RN) MDS Coordinator #260 revealed a correction to the MDS assessment was not completed to reflect the discharge disposition of discharge - return not anticipated. RN MDS Coordinator #260 revealed a correction assessment would be submitted to ensure MDS data reflected an accurate record.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview and record review the facility failed to ensure pressure reducing devices were free from soil. This affected one (Resident #33) out of three residents reviewed for pressure reducing measures. The facility census was 94. Findings include:Review of the medical record for Resident #33 revealed an admission date of 05/06/25 with diagnoses of acute respiratory failure with hypoxia, type two diabetes mellitus, severe protein-calorie malnutrition, severe sepsis with septic shock, metabolic encephalopathy and a stage 2 pressure ulcer on the left heel.Review of the care plan dated 05/07/25 revealed Resident #33 has an actual area of skin impairment with interventions including use of an air mattress, encouragement to wear boots on both feet, evaluation for pain, completion of wound treatments, nursing observation of the wound dressing to ensure it remains intact, monitoring for clinical changes in the wound and completion of skin observations on shower days and as ordered.Review of physician orders dated 05/08/25 revealed the resident is to wear boots on both feet while in bed as tolerated for prevention. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed 05/13/25 revealed Resident #33 is moderately cognitively impaired, dependent on staff assistance for bathing and hygiene and has one stage three pressure ulcer present upon admission.Review of the skin grid pressure assessment completed 07/30/25 revealed Resident #33 has a skin impairment on the left heel, present upon admission. The wound is classified as unstable measuring 5.5 centimeters (cm) by 2.3 cm with 30% granulation and 70% slough, moderate serosanguinous and yellow/green drainage with slight odor. The wound showed noted improvement.Observation on 08/04/25 at 3:30 P.M. during wound care with the Assistant Director of Nursing (ADON) #276, Licensed Practical Nurse (LPN) #274 and Certified Nursing Assistant #273 revealed Resident #33 had a pressure ulcer located on the left heel. Prior to beginning wound care, both boots were noted to have staining on the exterior bottom portion of the heel-elevating boots. The staining appeared scattered with ring-like formations indicative of dried fluid and light pink discoloration. Additionally, the interior portion of the right boot, specifically in the toe area, showed shadowing or discoloration, slightly darkened but without definitive staining or wetness. LPN #274 began the dressing change by removing the resident's left boot, noting the dressing was saturated with pale yellow drainage. LPN #274 confirmed a large amount of drainage but denied dressing seepage through to the boot. The boot was placed at the bedside. No concerns were noted during wound care and once completed, the boot was replaced with the staining present. Observations on 08/05/25 at 6:34 A.M. and 11:03 A.M. of Resident #33's boots revealed both remained soiled with the same staining present.Interview on 08/05/25 at 11:30 A.M. with LPN #238 confirmed the staining on the exterior bottom portion of Resident #33's heel-elevating boots. LPN #238 denied performing Resident #33's wound dressing change but stated new heel boots are needed and the old boots will be laundered.Interview on 08/05/25 at 12:40 P.M. with the Director of Nursing (DON) confirmed Resident #33's pressure-reducing boots were soiled on the exterior portion.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean, safe, and comfortable living environment for residents. This had the potential to affect all residents in the facility. The facility census was 94. Findings include: An observation on 08/04/25 from 8:57 A.M. to 9:12 A.M. was conducted throughout multiple hallways and common areas. Upon entrance to the building, a large stain was noted on the ceiling tile above the second door on the right. In Hallway G, light fixtures two, six and seven contained debris and light shades on fixtures six and seven were cracked. Peeling ceiling drywall was observed after light fixture three. Outside Resident #74's room, the ceiling showed damaged paint and unfinished ceiling texture. Outside Resident #72's room, peeling ceiling was identified around the fire sprinkler and a ceiling stain was visible above the beauty shop door.Continued observation revealed in Hallway H, damaged drywall shaped like a removed hand sanitizer dispenser was observed before the emergency doors. Light fixture one had a cracked shade. Light fixtures two, three, four and five contained bugs and debris. Ceiling cracks and staining were identified outside the clean linen room. In Hallway F, ceiling vents near light fixtures one, two, four, six and seven had visible dust accumulation clinging to the ceiling surface. Light fixtures three and eight had cracked shades. Outside Resident #42's room, damaged drywall shaped like a removed hand sanitizer dispenser was observed. Light fixtures six, seven and eight had light shades containing significant amounts of debris. In Hallway E, located in the resident lounge, the ceiling was unfinished and had a ceiling curtain track along the side of the wall. In Hallway E, light fixtures one, two, three, four, six and eight contained debris. Light fixture seven was missing its light shade. Ceiling vents located outside rooms two, three and eight had heavy dust accumulation.Observation conducted on 08/04/25 from 2:42 P.M. to 2:55 P.M. revealed all concerns identified remained unaddressed.Interview conducted on 08/04/25 at 2:24 P.M. with the Administrator confirmed environmental and maintenance concerns are present. The Administrator reported the Director of Maintenance was out on leave, and a new assistant was just hired and currently in orientation. The Administrator stated the new maintenance assistant had minimal resources to provide or follow up on maintenance concerns or complaints at the current time. Interview and observation on 08/05/25 at 10:55 A.M. of all previously observed locations was conducted with the Director of Housekeeping (DOH) #257 and the Assistant Director of Housekeeping (ADOH) #600. During this walkthrough, both DOH #257 and ADOH #600 confirmed the presence of all identified issues. They acknowledged debris inside light fixtures G two, G six, G seven, H two, H three, H four, H five, F six, F seven, F eight and E one, E two, E three, E four, E six and E eight, cracked shades on G six, G seven, H one, F three and F eight and the missing shade on E seven. They confirmed the presence of peeling and stained ceilings at G three, above the beauty shop door, outside room [ROOM NUMBER] and outside the clean linen room, damaged drywall in hallway G outside Resident #74 room, before the emergency doors and in F hallway outside Resident #42 room and visible dust buildup on ceiling vents at F one, F two, F four, F six, F seven and E outside rooms two, three and eight. DOH #257 and ADOH #600 stated cleaning of light fixtures and vents falls under housekeeping's responsibilities while issues involving drywall and ceiling damage are referred to maintenance for resolution. Review of the policy Safe and Homelike Environment dated 06/01/24 revealed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.