

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Winchester		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>36648</p> <p>Based on interviews, and resident council meeting notes the facility failed to document in writing its responses and rationale to resident council grievances and recommendations. This had the potential to affect eight (#1, #9, #24, #14, #42, #51, #58 and # 66) residents who attend the meetings monthly. The census was 88.</p> <p>Findings include:</p> <p>Review of the Resident Council monthly meeting minutes from 12/26/23 to 11/24/24 revealed old business issues are discussed with no details documented. The meetings do discuss any concerns the residents have and are listed in the meeting minutes, however, there is no documentation from administration of addressing the residents' questions and concerns.</p> <p>Interview on 12/4/24 at 3:29 PM with Resident Council President #42 reported she is not aware of any written responses to the questions and concerns voiced at Resident Council . It is her understanding Activity Director #182 takes care of all the details.</p> <p>Interview on 12/04/24 at 3:45 P.M. with the Activity Director #182 revealed they report concerns from Resident Council in stand up administrative meetings each day . She does not receive resolutions to the reported problems in writing from the Resident Council Meetings.</p> <p>Interview on 12/04/24 at 4:10 PM interview with the Social Service Designee # 112 and the Administrator confirmed they do not have a resolution form for the concerns brought up at resident council meetings, they discuss the councils concerns during stand up meeting the following day. If an individual problem is reported, they record the concern on a grievance form and address it with the identified resident.</p> <p>The facility does not have a policy titled Resident Council Meetings.</p>

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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review, facility record review, staff interview, and facility policy review, the facility failed to provide the opportunity to view or receive resident medical records in a timely manner. This affected one (Resident #65) of one resident reviewed for medical record release. The census was 88.</p> <p>Findings Include:</p> <p>Resident #65 was admitted to the facility on [DATE]. His diagnoses were end stage renal disease, emphysema, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, alcoholic cirrhosis of liver without ascites, anemia, gout, type II diabetes. other psychoactive substance abuse, cognitive communication deficit, lack of coordination, dysphagia, congestive heart failure, atherosclerotic heart disease, pure hypercholesterolemia, low back pain, neuropathy, major depressive disorder, hyperlipidemia, adult failure to thrive, esophagitis, anxiety disorder, and allergic rhinitis.</p> <p>Review of facility Minimum Data Set (MDS) assessment, dated 09/05/24, revealed he was cognitively intact.</p> <p>Review of facility Authorization for Release of Health Information form revealed Resident #65 signed the front page of the form on 09/20/24 to release specific medical records. Then, there was a second page of the form that stated he wanted the records released to himself. He signed that page of the document on 09/25/24. There was no evidence the facility started the process of collecting medical records to give to the resident or provide the option for the resident to review his documents online, when the initial request was made on 09/20/24.</p> <p>Review of facility Invoice for Resident Records, dated 09/27/24, revealed an invoice was given to Resident #65 on 09/27/24 for \$321.00, based on the rate set forth for copies of medical records.</p> <p>Interview with Administrator on 12/05/24 at 1:50 P.M. confirmed the opportunity of allowing Resident #65 or his representatives to see his medical records was never discussed as an option. Also, he confirmed the initial request for the medical records was made on 09/20/24, but the invoice for the medical records was not given to Resident #65 until 09/27/24, which was seven days after the initial request.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility Release of Medical Records policy, dated 06/01/24, revealed upon request to access or obtain copies of the medical record, the facility should review the authorization to ascertain access rights of that person. A valid request for medical information concerning a resident, by a party other than the resident, includes the name of the resident, name and address of the facility, name and address of individuals or organizations requesting information, specific information and reports requested, period of stay for which information is to be released, date of the request, and signature of the resident or legally appointed representative authorizing release of information. Upon receipt of a request for medical record copies, the facility should notify the requesting party, in writing, of the cost for obtaining records and that records are available two days after receipt of payment for the copies.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159181.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</p> <p>Based on record review, staff interview, and policy review, the facility failed to notify the physician after a significant weight change occurred for Resident #66. This affected one (Resident #66) of five residents reviewed for nutrition. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses including type 2 diabetes, metabolic encephalopathy, and unspecified dementia.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] indicated the resident was rarely/never understood, and Section K triggered weight loss concerns without a prescribed weight-loss regimen. A brief interview for mental status (BIMS) assessment revealed a score of 8 out of 15, indicating moderate cognitive impairment.</p> <p>Review of Resident #66's care plan included maintaining adequate nutritional status and addressing weight changes, with interventions including fortified foods twice daily and boost glucose control supplementation.</p> <p>Review of the physician orders for Resident #66 revealed orders for weekly weights on Tuesdays, one time a day, starting 05/14/24, with a discontinue date of 06/06/24.</p> <p>Review of the weight history for Resident #66 revealed a weight of 174.0 pounds (lbs) on 12/26/23 and a weight of 153.4 lbs on 06/03/24, for a weight loss of 11.84% in 180 days. Additionally, Resident #66 had a weight of 153.4 lbs on 06/03/24 and a weight of 143.6 lbs on 09/04/24, with a weight loss of 6.39% in 90 days. Additionally, Resident #66 had a weight of 160.8 lbs on 03/05/24 and a weight of 143.6 lbs on 09/04/24, for a weight loss of 10.68% in 180 days.</p> <p>Review of the dietary progress notes revealed that on 12/22/23, the physician was notified of a significant weight loss with a recommendation for weekly weights. There was no evidence that any further physician notifications were made regarding the additional weight losses.</p> <p>Interview on 12/05/24 at 10:19 with Dietician #168 revealed that if there is an indication of weight loss, she will request a re-weight, and if the weight is verified as a loss, she will notify the physician of the weight change. Dietician #168 stated she does not report weight loss every time; if there is a continuous trend of weight loss, she will only notify the physician of the initial weight loss. Dietician #168 also stated that if there are any changes, she will send a weight log to the nurse practitioner. Dietician #168 reported she would send over the weight log if she had any, but did not send any information.</p> <p>Review of the notification of changes policy revealed the facility must contact the resident's physician regarding any significant changes.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</p> <p>Based on record review, staff interview, resident interview, and policy review, the facility failed to complete a timely and thorough grievance investigation and resolution for resident #9's grievances. This affected one (Resident #9) of two residents reviewed for grievance handling. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #9 revealed an admitted [DATE] and readmitted on [DATE] with diagnoses including chronic systolic heart failure, morbid obesity with alveolar hypoventilation, asthma, chronic obstructive pulmonary disease, dependence on respirator/ventilator status, obstructive sleep apnea, essential hypertension, chronic venous insufficiency, unspecified depression, anxiety disorder, gastro-esophageal reflux disease, anemia, paroxysmal atrial fibrillation, generalized muscle weakness, and stenosis of a coronary artery stent.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment revealed a brief interview for mental status (BIMS) score of 15 out of 15 indicating no cognitive impairment. Resident #9 had impaired mobility and required moderate assistance with showers but was independent with all other activities of daily living.</p> <p>Review of the care plan for Resident #9 revealed a focus on managing chronic conditions, including respiratory support, pain management, and addressing anxiety. There was no documented care plan addressing missing personal items or grievances.</p> <p>Review of the grievance logs for Resident #9 from September 2024 to December 2024 revealed three incidents on 09/24/24 with no investigation conducted for the missing items and no signature present on the investigation form. Additionally, on 09/26/24 there is another missing item on the log, but Social Worker #112 could not find the investigation report for this item and could not recall what the item missing was. On 11/21/24 there was an occurrence of a cracked phone with an investigation started via housekeeping. Social Worker #112 and the administrator reported via the investigation the phone was not on the initial items log, so the phone was not replaced or repaired with no signatures on the investigation report. On 11/26/24 there were three additional items on the log. The investigation logs had no completed investigations for all three items and the investigation logs were not signed.</p> <p>Interview on 12/04/24 at 3:38 P.M. with Social Worker #112 reported once an incident occurs the staff will complete a grievance log. She stated depending on the situation she will delegate the investigation to the appropriate department and once the investigation is complete the concern report logs are filled out, signed, and placed in the log.</p> <p>Interview on 12/04/24 at 4:09 P.M. with Social Worker #112 confirmed that the investigations for Resident #9 were not completed. Social Worker #112 and the Administrator stated they were going to make copies of all grievance logs and concern reports.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/04/24 at 4:40 P.M. the Administrator reported that he misplaced all the copies of the concern logs and could not find the originals so he could not provide me a copy of the logs.</p> <p>Interview on 12/05/24 at 7:52 A.M. with the Administrator he again confirmed that he misplaced all the logs and could not provide me a copy.</p> <p>Review of the Grievance Policy revealed social services will instruct facility staff to submit the social services director that all concerns received will be investigated within seventy-two hours following receipt of the concern. Within seven days following the receipt of the concern, the facility will inform the complainant with the results of the investigation. Additionally, it stated, when the concern is related to missing item(s), complete the missing items form. The timeframe for resolutions will remain the same as above.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, medical record review and staff interview, the facility failed to develop a comprehensive plan of care for residents. This affected three (#10,#18, and #69) of 24 sampled residents. The facility census was 88.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #10 revealed an initial admitted [DATE] with the latest readmission of 01/12/23 with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), severe protein calorie malnutrition, diabetes mellitus, congestive heart failure (CHF), depression, psychosis, dependence on respiratory ventilator, insomnia, hyperlipidemia, auditory hallucinations, allergic rhinitis, dysphagia, benign prostatic hyperplasia with lower urinary tract symptoms, schizophrenia, anemia, anxiety disorder and hypertension.</p> <p>Review of the plan of care dated 01/12/23 revealed the resident utilized a non-invasive ventilator dependent related to respiratory failure with hypercapnia and COPD. Interventions included keep call bell within reach at all times, keep head of bed elevated above 30 degrees unless providing care or resident request, maintain spare tracheostomy supplies and suction at the bedside, maintain ventilator settings as ordered, observe for changes in respiratory rate or depth, observe for indications of airway obstruction and suction as needed, obtain oxygen saturation while resident is on mechanical ventilator support and/or during weaning process per facility policy, provide nutrition as ordered, provide oral care per facility policy, reposition resident every 2 hours, review all lab work and report abnormal findings to the physician and/or nurse practitioner (NP) and observe for signs/symptoms of hypoxia.</p> <p>Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident received oxygen therapy and utilized a non-invasive ventilator.</p> <p>Review of the resident's monthly physician orders for December 2024 identified orders dated 10/17/24 one to five liters of oxygen via nasal cannula as needed for oxygen saturation lower than 90% and 12/03/24 ventilation support settings: AVAPS. AE, AVAPS Rate 3, TV 500, max pressure 12, PS 6/8, EPAP 4/6, RR14, nursing to assist resident with placement of therapy and once daily and as needed wash interface and tubing in warm soapy water, rinse and dry every night shift for respiratory assistance.</p> <p>On 12/02/24 at 2:33 P.M., observation of the resident's nasal cannula oxygen delivery tubing revealed no date indicating when the nasal cannula was last changed.</p> <p>On 12/05/24 at 9:23 A.M., interview with the Director of Nursing (DON) verified the resident's plan of care lacked a care plan addressing the resident's oxygen use.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #69 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebral infraction due to occlusion or stenosis of right middle cerebral artery, diabetes mellitus, severe protein calorie malnutrition, hyperlipidemia, metabolic encephalopathy, occlusion and stenosis of right carotid artery, personal history of malignant neoplasm of larynx, hypothyroidism, tracheostomy, hypertension, aphasia, chronic kidney disease, retention of urine, gastro-esophageal reflux disease and gastrostomy.</p> <p>Review of the resident's plan of care dated 05/14/24 revealed the resident had an alteration in respiratory status/difficulty breathing related to tracheostomy and history of malignant neoplasm of larynx. Interventions included administer medication/puffers as ordered, monitor for effectiveness and side effects, observe/document changes in orientation, increased restlessness, anxiety, and air hunger, observe for signs/symptoms of respiratory distress and report to physician and/or NP as needed, observe/document/report abnormal breathing patterns to physician and/or NP, position resident with proper body alignment for optimal breathing pattern and provide oxygen as ordered.</p> <p>Review of the plan of care dated 04/19/23 revealed the resident had a tracheostomy and was at risk for complications including respiratory distress, increased secretions, weight loss and infection. Interventions included keep call light within easy reach, observe skin at tracheostomy site to prevent breakdown, provide alternative forms of communication (pad/pencil, slate, etc), provide mouth care every shift and as needed and suction as necessary.</p> <p>Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident received oxygen therapy, suctioning and tracheostomy care.</p> <p>Review of the resident's monthly physician orders for December 2023 identified orders dated 04/19/23 change aerosol bottle/humidifier canister every Monday, Wednesday, Friday and as needed, tracheostomy care every shift and as needed, clean non-disposable inner cannula daily and as needed, pulmonary consult as needed, Respiratory Therapy (RT) to evaluate and treat, use sterile water for aerosol bottle, tracheostomy suction every shift and as needed for excessive secretions, change tracheostomy ties weekly on Sunday on night shift and as needed, 05/15/23 cool air mist via tracheostomy every shift, 07/03/23 #6 Boniva laryngectomy tube, 08/20/23 titrate oxygen to maintain oxygen saturation rate greater or equal to 92%, notify physician if less than 92%, 12/04/23 change corrugate tubing weekly on Mondays, respiratory to change, nursing staff to change as needed, 01/08/24 change suction tubing and canister and change oxygen tubing weekly on Monday by RT and as needed.</p> <p>On 12/02/24 at 2:39 P.M., observation of Resident #18 revealed a tracheostomy present with humidified oxygen being provided via tracheostomy mask.</p> <p>On 12/05/24 at 9:23 A.M., interview with the DON verified the lack of a comprehensive plan of care for the resident's tracheostomy.</p> <p>3. Review of the medical record for Resident #18 revealed an initial admitted [DATE] with the most recent admission of 10/11/24 with the diagnoses including but not limited to diabetes mellitus, neuromuscular dysfunction of bladder, fibromyalgia, arthritis, major depressive disorder with psychotic features, obstructive sleep apnea, gastro-esophageal reflux disease, paraplegia, pain, constipation, osteoarthritis, dysphagia and urinary tract infection (UTI).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care dated 09/05/24 revealed the resident required assistance for activities of daily living (ADL) related to fibromyalgia and paraplegia. Interventions included apply house moisture barrier cream after each incontinence episode, assist in choosing appropriate clothing as needed, encourage and allow resident to complete self care as able, inspect skin condition daily during personal care and report any impaired areas to charge nurse, observe for changes in ADL ability and adjust assistance as needed, resident requires weight-bearing assistance with transfers, dressing, bathing, toilet hygiene, putting on and taking off footwear, personal hygiene, lying to sitting and sit to stand and staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly.</p> <p>Review of the resident's 360 ancillary consent form dated 08/24/24 revealed the resident consented to receive all ancillary services including dental.</p> <p>Review of the resident's admission assessment with baseline care plan revealed the resident had his own teeth in good/fair repair.</p> <p>Review of the resident's readmission assessment dated [DATE] revealed the resident had broken/chipped or carious teeth.</p> <p>Review of the resident's readmission assessment dated [DATE] revealed the resident had broken/chipped or carious teeth.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no mouth or facial pain/discomfort or difficulty with chewing.</p> <p>Review of the resident's oral assessment dated [DATE] revealed the resident had no issues with his natural teeth and his oral status does not effect his eating.</p> <p>On 12/02/24 at 11:32 A.M., observation of the resident's natural teeth revealed the resident's teeth were in poor repair with obvious carried teeth.</p> <p>On 12/04/24 at 12:14 P.M., interview with the DON verified the admission assessment was not accurate and the resident had no plan of care addressing the resident's poor dental status.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648</p> <p>Based on observations, interviews and policy and procedure review the facility failed to invite residents' family and or resident representative to a residents' Care Conference. This had the potential to affect two residents (#50 and #70) . The census was 88 .</p> <p>Findings include:</p> <p>1. Review of the medical record for the Resident #50 revealed an admitted [DATE] with sever cognitive deficits. Diagnoses included Alzheimer's disease, chronic kidney disease, depression and anxiety. Resident #50 requires one person assist with activities of daily living.</p> <p>Review of Resident #50 Care Conference Summary on 07/11/24 revealed Resident #50's Health Care Power of Attorney was not invited to the care conference.</p> <p>Interview on 12/02/24 at 2:05 P.M. with Resident #50's family representative revealed she has not been invited to Resident #50's Care conferences. She confirmed she is the Health Care and Financial Power of Attorney.</p> <p>Interview on 12/04/24 with the Social Services Designee # 112 confirmed she has no documentation indicating Resident #50's representative had been invited to participate in care conference on 07/11/24 and or his last conference 10/2024.</p> <p>51068</p> <p>2. Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including anterior displaced Type II dens fracture, hypertension, glaucoma, blindness in both eyes, other health conditions such as dementia, dysphagia, vitamin deficiencies, and alcohol abuse.</p> <p>Review of the Minimum Data Set (MDS) assessment created on 10/31/24 revealed that Resident #70 had a BIMS score of 12 (indicating mild cognitive impairment) out of 15, and the resident is blind. The MDS did not indicate any specific documentation related to the interdisciplinary team's involvement in care planning or coordination of services.</p> <p>Review of the Multidisciplinary Care Conference assessments revealed care conferences were held on 04/26/24 and 09/18/24. There was no record of who was invited or attended the care conference. Additionally, the care conference assessments were unlocked and relocked on 12/4/24. Additionally, Social Worker #112 provided a scratch piece of paper she took notes on that confirmed there is no evidence of who attended the care conference.</p> <p>Interview on 12/04/24 at 9:05 AM with Social Worker #112 confirmed that the care conferences were unlocked to review information, but no changes were made. Social Worker #112 also confirmed that the only documentation of the care conferences was in the PointClickCare system.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/04/24 at 11:26 A.M. with Social Worker #112 reported that the information in PointClickCare is the only information regarding the care conferences.</p> <p>Review of facility policy titled Care Planning-Resident Participation, dated 6/1/24 , revealed the facility will notify the resident and / or resident representative, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care, as well as changes to the plan of care .The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of day for the resident/resident's representative.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Winchester		STREET ADDRESS, CITY, STATE, ZIP CODE 36 Lehman Dr Canal Winchester, OH 43110	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, medical record review, staff interview and facility policy review, the facility failed to ensure one resident (#10), who was dependent on staff received routine nail care. This affected one resident (#10) of four resident reviewed for activities of daily living (ADL). The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #10 revealed an initial admitted [DATE] with the latest readmission of 01/12/23 with the diagnoses including but not limited to COPD, severe protein calorie malnutrition, diabetes mellitus, CHF, depression, psychosis, dependence on respiratory ventilator, insomnia, hyperlipidemia, auditory hallucinations, allergic rhinitis, dysphagia, benign prostatic hyperplasia with lower urinary tract symptoms, schizophrenia, anemia, anxiety disorder and hypertension.</p> <p>Review of the plan of care dated 11/03/22 revealed the resident required assistance with activities of daily living (ADL) related to new admission, weakness, depression, cognition. Interventions included inspect skin condition daily during personal care and report any impairment to charge nurse, keep call light in reach while in bed, observe for changes in ADL ability and adjust assistance as needed and president is totally dependent and does not participate in any aspect of the following tasks, toileting, bathing, transfers, bed mobility, dressing, hygiene, putting on/taking off footwear and locomotion.</p> <p>Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit.</p> <p>On 12/02/24 at 2:25 P.M., observation of Resident #10 revealed his nails were long, jagged and dirty with a brown substance.</p> <p>On 12/03/24 at 1:35 P.M., observation of the resident's nails revealed they remained long, jagged and dirty with a brown substance.</p> <p>On 12/04/24 at 9:15 A.M., observation of the resident's nails remain long, jagged and dirty with a brown substance.</p> <p>On 12/04/24 at 9:35 A.M., interview with Licensed Practical Nurse (LPN) #127 verified the resident's nails were long, jagged and dirty with a brown substance.</p> <p>Review of the facility policy titled, Resident Care, dated 06/18 revealed facility staff will provide general care as necessary for each resident per their preferences when able and per physician orders. Typical personal hygiene for a resident will include but not limited to care of the skin to include routine and as needed bathing, foot care, shampooing and grooming of the hair per resident preferences, oral hygiene, shaving and trimming per resident preferences, removal of women's facial hair when requested and cleaning and cutting of fingernails and toenails.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review, staff interview, and facility policy review, the facility failed to follow physician orders for as needed pain medication administration. This affected one (Resident #65) of three residents reviewed for opioid use. Also, the facility failed to follow wound care orders. This affected one (Resident #70) of three residents reviewed for wound care. The census was 88.</p> <p>Findings Include:</p> <p>1. Resident #65 was admitted to the facility on [DATE]. Her diagnoses were end stage renal disease, emphysema, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, alcoholic cirrhosis of liver without ascites, anemia, gout, type II diabetes. other psychoactive substance abuse, cognitive communication deficit, lack of coordination, dysphagia, congestive heart failure, atherosclerotic heart disease, pure hypercholesterolemia, low back pain, neuropathy, major depressive disorder, hyperlipidemia, adult failure to thrive, esophagitis, anxiety disorder, and allergic rhinitis.</p> <p>Review of facility Minimum Data Set (MDS) assessment, dated 09/05/24, revealed he was cognitively intact.</p> <p>Review of Resident #65 physician orders revealed an order for Oxycodone five milligrams (mg) as needed three time daily. Within the same order, it states that the facility will administer a half tablet (2.5 mg) for pain levels one to five, and two half tablets (five mg) for pain levels six to ten. This physician order was from 09/28/24 to 11/06/24.</p> <p>Review of Resident #65 Medication Administration Records (MAR) and Controlled Drug Receipt/Records/Disposition form, dated 09/28/24 to 11/06/24, revealed the following administrations that did not follow the physician order: on 09/28/24, 10/01/24, 10/02/24, 10/03/24, 10/05/24, 10/06/24, and 10/13/24, Resident #65 had pain levels that were between six to ten, and the facility administered one half tablet (2.5 mg) of Oxycodone when they should have administered two half tablets (5 mg). On 10/09/24, 10/16/24, 10/22/24, and 11/05/24, Resident #65 had pain levels between one to five, and the facility administered two half tablets (five mg) of Oxycodone when they should have administered one half tablet (2.5 mg).</p> <p>Interview with Licensed Practical Nurse (LPN) #602 on 12/05/24 at 2:11 P.M. confirmed as needed pain medications would be counted on the narcotics sheet to verify the dose that was given. She confirmed the number of tablets/dose should be accurate from the physician orders to the number of tablets documented as being administered from the narcotic sheet.</p> <p>Interview with Director of Nursing (DON) on 12/05/24 at 2:39 P.M. confirmed pain medications were given outside the parameters for Resident #65; the dose did not match the order for the pain level the resident had.</p> <p>51068</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including anterior displaced Type II dens fracture, hypertension, glaucoma, blindness in both eyes, other health conditions such as dementia, dysphagia, vitamin deficiencies, and alcohol abuse.</p> <p>Review of the Minimum Data Set (MDS) assessment created on 10/31/24 revealed that Resident #70 had a BIMS score of 12 out of 15 (indicating mild cognitive impairment), and the resident is blind. The MDS did not indicate any specific documentation related to the interdisciplinary team's involvement in care planning or coordination of services.</p> <p>Review of the progress note on 12/02/24 at 4:37 P.M., a progress note documented that Resident #70 returned from Ohio State University Main Hospital at 4:00 P.M. The resident was alert, oriented, and able to verbalize needs. Dry necrotic tissue was noted on the right foot's great and second toes, but no wound care orders were placed at that time.</p> <p>Interview on 12/04/24 at 10:57 A.M. with the director of nursing (DON) verified when a resident returns from the hospital a complete head to toe assessment is conducted and any findings are reported to the physician. The staff will review the hospital records and address any orders noted on the discharge summary within 24 hours. DON confirmed that the wound on Resident #70's foot was not addressed upon return from the hospital and there were no new orders in place for wound care. The DON confirmed that the orders should be in the chart at that time, and she is unsure why the wound care orders have not been put into place.</p> <p>Review of the progress note on 12/04/24 at 11:31 A.M. revealed the wound nurse assessed Resident #70's foot/toe wound. Upon assessment Resident #70's right food second toenail was loose, dried blood noted around the toenail. The right foot's second toenail was still intact. The skin in between the toes was clean, dry, and intact. Podiatry services were set up for 12/18/24 and the resident was aware of the new orders.</p> <p>Review of the physician orders for Resident #70 revealed new orders for wound care were put into place including, monitor right foot second toenail every shift. Notify medical director of any changes every shift with a start date of 12/04/24. Additionally, right foot second toenail: paint with betadine daily until resolved every night shift for 30 days with a start date of 12/4/2024 7:00 P.M. and an end date of 01/03/2025.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159181.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, medical record review and staff interview, the facility failed to ensure off-loading skin interventions were in place as physician ordered for one resident. This affected one resident (#10) of two residents reviewed for pressure ulcers. The facility census was 88.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #10 revealed an initial admitted [DATE] with the latest readmission of 01/12/23 with the diagnoses including but not limited to COPD, severe protein calorie malnutrition, diabetes mellitus, CHF, depression, psychosis, dependence on respiratory ventilator, insomnia, hyperlipidemia, auditory hallucinations, allergic rhinitis, dysphagia, benign prostatic hyperplasia with lower urinary tract symptoms, schizophrenia, anemia, anxiety disorder and hypertension.</p> <p>Review of the plan of care dated 11/03/22 revealed the resident required assistance with activities of daily living (ADL) related to new admission, weakness, depression, cognition. Interventions included inspect skin condition daily during personal care and report any impairment to charge nurse, keep call light in reach while in bed, observe for changes in ADL ability and adjust assistance as needed and president is totally dependent and does not participate in any aspect of the following tasks, toileting, bathing, transfers, bed mobility, dressing, hygiene, putting on/taking off footwear and locomotion.</p> <p>Review of the resident's plan of care dated 11/25/22 revealed the resident had the potential for alteration in skin integrity related to decreased mobility, incontinence diabetes mellitus and history of pressure ulcers. Interventions included assist to trim fingernails, educate resident/family on skin breakdown risk factors and preventative measures, education provided to be aware of surroundings when in wheelchair, encourage res to be mindful of his surroundings while turning in wheelchair, encourage res to not wear briefs inserts, encourage to float heels while in bed, encourage to turn and position as tolerated, evaluate resident's specific risk factors, pressure reducing boots to bilateral feet as tolerated, pressure reducing cushion to chair, provide assistance with hygiene, including peri-care as needed, record meal intake percentages per facility policy and use barrier cream with showers and with incontinent episode.</p> <p>Review of the resident's Braden scale dated 07/24/24 revealed a score of 15 indicating the resident was at low risk for skin breakdown.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care dated 10/24/24 revealed the resident had an actual area of skin impairment related to pressure ulcer to the right outer ankle and the right and left ischium. Interventions included bariatric pressure reducing mattress to bed, educate resident to be aware of surroundings while in wheelchair, education and demonstration provided to resident to release hand from wheelchair when propelling to reduce friction for skin integrity, encourage resident to lay down in between smoke breaks as tolerated, encourage resident to limit time in wheelchair to 60 minutes at a time, encourage resident to turn and reposition, encourage resident to wear prevalon boots as much as tolerated, gel cushion to wheelchair as tolerated, initiate wound treatment, continue treatment as ordered by physician, observe and document character of wound weekly, observe for clinical changes, skin observation and document on bath/shower days, administer diet as ordered and record percentage of intake every meal, administer supplements as ordered and record percentage taken, weekly skin assessments, when transferring, turning and repositioning, use proper techniques to avoid friction and shear, assist with transfers as needed, dietician to review nutritional status quarterly and inspect for any reddened areas during daily care.</p> <p>Review of the weekly pressure skin grid dated 10/24/24 revealed the resident was found to have a deep tissue injury (DTI) to the right outer heel measuring 4.0 centimeters (cm) by 2.0 cm. The wound was described as dark purple.</p> <p>Review of the resident's Braden scale dated 10/24/24 revealed a score of 11 indicating the resident was at high risk for skin breakdown.</p> <p>Review of the weekly pressure skin grid dated 10/30/24 revealed the deep tissue injury (DTI) to the right outer heel measured 2.3 centimeters (cm) by 3.3 cm. The wound was described as dark purple. The facility determined the wound had improved.</p> <p>Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was frequently incontinent of bladder and always incontinent of bowel. The assessment indicated the resident was at risk for skin breakdown and had one stage III and one unstageable pressure ulcer not present on admission. The assessment indicated the resident had no other skin issues. The facility implemented pressure reducing device to bed/chair, pressure ulcer/injury care and application of ointments/medications other than to feet. The assessment indicated the resident had no functional limitation in range of motion.</p> <p>Review of the weekly pressure skin grid dated 11/06/24 revealed the deep tissue injury (DTI) to the right outer heel measured 2.2 centimeters (cm) by 3.0 cm. The wound was described as dark purple. The facility determined the wound had improved.</p> <p>Review of the weekly pressure skin grid dated 11/13/24 revealed the deep tissue injury (DTI) to the right outer heel measured 2.0 centimeters (cm) by 3.0 cm. The wound was described as dark purple. The facility determined the wound had improved.</p> <p>Review of the weekly pressure skin grid dated 11/20/24 revealed the deep tissue injury (DTI) to the right outer heel measured 2.0 centimeters (cm) by 3.0 cm. The wound was described as dark purple. The facility determined the wound had improved.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the weekly pressure skin grid dated 11/27/24 revealed the deep tissue injury (DTI) to the right outer heel measured 2.0 centimeters (cm) by 2.5 cm. The wound was described as dark purple. The facility determined the wound had improved.</p> <p>Review of the resident's monthly physician orders for December 2024 identified orders dated 02/25/23 foam cushion to wheelchair as tolerated, 01/15/24 house barrier cream every shift and as needed for incontinence/moisture for skin integrity prevention, 02/02/24 wear prevalon boots as tolerated while in bed every shift for skin integrity, 02/25/24 apply anti-fungal cream after each incontinent episode and as needed, 10/24/24 encourage resident to wear prevalon boots as much as tolerated every shift, encourage resident to turn and reposition every two hours as tolerated every shift, 11/22/24 pressure reducing mattress to bed, encourage resident to lay down in between smoke breaks as tolerated. chart effectiveness and compliance every shift, limit time sitting up in wheelchair for 60 minutes per Wound Physician, document compliance and non-compliance with wound care every shift and 11/27/24 paint right outer heel with betadine daily until resolved.</p> <p>On 12/02/24 at 2:30 P.M., observation of the resident revealed the physician ordered Prevalon boots were not in place.</p> <p>On 12/03/24 at 10:35 A.M., observation of the resident revealed the physician ordered Prevalon boots were not in place.</p> <p>On 12/04/24 at 9:35 A.M., interview with Licensed Practical Nurse (LPN) #127 verified the Prevalon boots were not in place as physician ordered.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure appropriate enteral feeding services were provided Resident #189. This affected one (Resident #189) of one resident reviewed for tube feeding services. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #189 revealed an admitted [DATE] with diagnoses including unspecified fracture of the fourth lumbar vertebra, Type 2 diabetes mellitus with hyperglycemia, severe protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), dysphagia, and other complex conditions.</p> <p>Review of Resident #189's Minimum Data Set (MDS) 3.0 assessment indicated severe cognitive impairment and the need for maximum assistance with activities of daily living (ADLs), including dressing, toileting, and mobility.</p> <p>Review of the physician orders for Resident #189 revealed orders to clean the peg tube site with normal saline and apply split gauze daily starting 11/19/24. Additionally, Enteral feeding was ordered once daily via PEG tube, with a specified rate of 50 milliliters (ml) an hour of Glucerna 1.5 for a total of 1000 ml a day, via Kangaroo pump, starting 11/19/24 at 2:00 PM. Additionally, flushes were ordered at 50 ml an hour for 20 hours daily to provide a total of 1000 ml of free water per day. Tube placement was to be checked every shift using a 10 cc air bolus before medication administration, feedings, and flushes. The feeding should be delivered via a Kangaroo pump, with the order specifying that the feeding bag should be replaced daily at 6:00 P.M.</p> <p>Observation on 12/05/24 at 9:38 A.M. revealed the Glucerna bag was not replaced until 12/05/24 at 1:00 A.M.</p> <p>Interview on 12/05/24 at 9:43 A.M. with Licensed Practical Nurse (LPN) #128 confirmed the Glucerna bag was not replaced until 12/05/24 at 1:00 A.M. and should have been replaced on 12/04/24 at 6:00 P.M. to start Resident #189's enteral feeding services. This resulted in Resident #189 going for 7 hours (from 6:00 P.M. on 12/04/24 to 1:00 A.M. on 12/05/24) without any nutrition.</p> <p>Interview on 12/05/24 at 9:57 A.M. with LPN#128 verified she did not have a proper hand off from night shift nursing and there were no notes in the chart for Resident #70 justifying why the Glucerna bag was not replaced until 12/05/24 at 1:00 A.M. LPN #128 confirmed Resident #189 will typically go from 2:00 P.M. to 6:00 P.M. without the feeding services and new feed will start at 6:00 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care and Treatment of Feeding Tubes policy revealed feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided. Direction for staff regarding how to manage and monitor the rate of flow will be provided. The facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complications and risk factors.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, medical record review, staff interview and facility policy review, the facility failed to ensure provision of appropriate equipment was at the bedside for immediate access for two residents (#9 and #69) and failed to ensure one resident's (#10) nasal cannula oxygen delivery equipment was dated. This affected three residents (Resident #9,#10 and #69) of three residents reviewed for respiratory care. The facility census was 88.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #10 revealed an initial admitted [DATE] with the latest readmission of 01/12/23 with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), severe protein calorie malnutrition, diabetes mellitus, congestive heart failure (CHF), depression, psychosis, dependence on respiratory ventilator, insomnia, hyperlipidemia, auditory hallucinations, allergic rhinitis, dysphagia, benign prostatic hyperplasia with lower urinary tract symptoms, schizophrenia, anemia, anxiety disorder and hypertension.</p> <p>Review of the plan of care dated 01/12/23 revealed the resident utilized a non-invasive ventilator dependent related to respiratory failure with hypercapnia and COPD. Interventions included keep call bell within reach at all times, keep head of bed elevated above 30 degrees unless providing care or resident request, maintain spare tracheostomy supplies and suction at the bedside, maintain ventilator settings as ordered, observe for changes in respiratory rate or depth, observe for indications of airway obstruction and suction as needed, obtain oxygen saturation while resident is on mechanical ventilator support and/or during weaning process per facility policy, provide nutrition as ordered, provide oral care per facility policy, reposition resident every 2 hours, review all lab work and report abnormal findings to the physician and/or nurse practitioner (NP) and observe for signs/symptoms of hypoxia,</p> <p>Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident received oxygen therapy and utilized a non-invasive ventilator.</p> <p>Review of the resident's monthly physician orders for December 2024 identified orders dated 10/17/24 one to five liters of oxygen via nasal cannula as needed for oxygen saturation lower than 90% and 12/03/24 ventilation support settings: AVAPS. AE, AVAPS Rate 3, TV 500, max pressure 12, PS 6/8, EPAP 4/6, RR14, nursing to assist resident with placement of therapy and once daily and as needed wash interface and tubing in warm soapy water, rinse and dry every night shift for respiratory assistance.</p> <p>On 12/02/24 at 2:33 P.M., observation of the resident's nasal cannula oxygen delivery tubing revealed no date indicating when the nasal cannula was last changed.</p> <p>On 12/03/24 at 1:35 P.M., observation of the resident's nasal cannula oxygen tubing revealed the oxygen delivery tubing remained undated.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/04/24 at 9:15 A.M., observation of the resident's nasal cannula oxygen tubing revealed the oxygen delivery tubing remained undated.</p> <p>12/04/24 at 9:35 A.M., interview with Licensed Practical Nurse (LPN) verified the facility scheduled nasal cannula oxygen delivery tubing changes on the night shift and are to be dated at the time of the change.</p> <p>On 12/05/24 at 9:23 A.M., interview with the Director of Nursing (DON) verified the resident's plan of care lacked a care plan addressing the resident's oxygen use.</p> <p>2. Review of the medical record for Resident #69 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebral infraction due to occlusion or stenosis of right middle cerebral artery, diabetes mellitus, sever protein calorie malnutrition, hyperlipidemia, metabolic encephalopathy, occlusion and stenosis of right carotid artery, personal history of malignant neoplasm of larynx, hypothyroidism, tracheostomy, hypertension, aphasia, chronic kidney disease, retention of urine, gastro-esophageal reflux disease and gastrostomy.</p> <p>Review of the resident's plan of care dated 05/14/24 revealed the resident had an alteration in respiratory status/difficulty breathing related to tracheostomy and history of malignant neoplasm of larynx. Interventions included administer medication/puffers as ordered, monitor for effectiveness and side effects, observe/document changes in orientation, increased restlessness, anxiety, and air hunger, observe for signs/symptoms of respiratory distress and report to physician and/or NP as needed, observe/document/report abnormal breathing patterns to physician and/or NP, position resident with proper body alignment for optimal breathing pattern and provide oxygen as ordered.</p> <p>Review of the plan of care dated 04/19/23 revealed the resident had a tracheostomy and was at risk for complications including respiratory distress, increased secretions, weight loss and infection. Interventions included keep call light within easy reach, observe skin at tracheostomy site to prevent breakdown, provide alternative forms of communication (pad/pencil, slate, etc), provide mouth care every shift and as needed and suction as necessary.</p> <p>Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident received oxygen therapy, suctioning and tracheostomy care.</p> <p>Review of the resident's monthly physician orders for December 2023 identified orders dated 04/19/23 change aerosol bottle/humidifier canister every Monday, Wednesday, Friday and as needed, tracheostomy care every shift and as needed, clean non-disposable inner cannula daily and as needed, pulmonary consult as needed, Respiratory Therapy (RT) to evaluate and treat, use sterile water for aerosol bottle, tracheostomy suction every shift and as needed for excessive secretions, change tracheostomy ties weekly on Sunday on night shift and as needed, 05/15/23 cool air mist via tracheostomy every shift, 07/03/23 #6 Boniva laryngectomy tube, 08/20/23 titrate oxygen to maintain oxygen saturation rate greater or equal to 92%, notify physician if less than 92%, 12/04/23 change corrugate tubing weekly on Mondays, respiratory to change, nursing staff to change as needed, 01/08/24 change suction tubing and canister and change oxygen tubing weekly on Monday by RT and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 at 7:54 A.M., observation of Licensed Practical Nurse (LPN) provide the physician ordered tracheostomy care revealed he washed his hands, donned PPE (gloves, gowns, mask and goggles). The LPN placed a barrier on the resident's bedside table and set-up the required supplies. The LPN applied a pulse oximetry to the resident's right index finger to monitor the resident oxygen saturation rate during the procedure. The LPN removed the soiled split drain sponge from the resident's tracheostomy stoma. The LPN sanitized his hands and donned a pair of sterile gloves, the LPN then removed the tracheostomy using his left hand. The LPN then poured hydrogen peroxide and normal saline (NS) in the sterile tray. The LPN then cleansed the tracheostomy using the sterile brush from the kit. The LPN then used NS and a 4X4 and cleansed the tracheostomy stoma. The LPN then placed the tracheostomy cannula in the resident's tracheostomy stoma and changed the tracheostomy ties. The LPN then placed a split drain sponge around the tracheostomy stoma. The surveyor and the LPN was not able to locate a spare tracheostomy cannula and found the ambu bag in the resident's second drawer of his night stand.</p> <p>On 12/05/24 at 8:23 A.M., interview with LPN #142 verified the resident did not have a spare tracheostomy cannula at bedside for emergency use and the ambu bag was not easily accessible for emergency use.</p> <p>Review of the facility policy titled, Tracheostomy Care, dated 06/02/23 revealed tracheostomy care will be provided according to eh physician's orders, comprehensive and individual care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate. General considerations include provide tracheostomy care at least twice weekly and maintain a suction machine, supply of suction catheters, correctly sized cannulas and an ambu bag easily accessible for immediate emergency care.</p> <p>51068</p> <p>3. Review of the medical record for Resident #9 revealed an admitted [DATE] and readmitted on [DATE] with diagnoses including chronic systolic heart failure, morbid obesity with alveolar hypoventilation, asthma, chronic obstructive pulmonary disease, dependence on respirator/ventilator status, obstructive sleep apnea, essential hypertension, chronic venous insufficiency, unspecified depression, anxiety disorder, gastro-esophageal reflux disease, anemia, paroxysmal atrial fibrillation, generalized muscle weakness, and stenosis of a coronary artery stent.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment revealed no cognitive impairment. Resident #9 had impaired mobility and required moderate assistance with showers but was independent with all other activities of daily living.</p> <p>Review of the care plan for Resident #9 revealed a focus on managing chronic conditions, including respiratory support, pain management, and addressing anxiety.</p> <p>Review of the physician orders for Resident #9 revealed orders indicating the need for weekly change of corrugated tubing and canisters for trach care every Thursday, and as needed, starting 11/26/24. The orders also specified weekly changes of trach ties and trach collar/mask every Tuesday on the 7 PM to 7 AM shift, and as needed, starting 09/12/24. Additionally, the resident was prescribed suctioning of the trach as needed for increased secretions.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/05/24 at 9:30 AM revealed that the resident's room was missing an Ambu bag, a necessary emergency trach supply.</p> <p>Interview on 12/05/24 at 9:31 A.M. with the resident confirmed the facility had previously used the Ambu bag, but it had not been replaced at the time of the observation.</p> <p>Interview with the Director of Nursing (DON) on 12/05/24 at 9:57 AM confirmed that the supplemental supplies, including the Ambu bag, should have been readily available in the resident's room for emergencies. The DON acknowledged that it was a lapse in the system that led to the missing equipment.</p> <p>Interview on 12/05/24 at 11:19 A.M. with Regional Registered Nurse (RRN) #250 confirmed that the Ambu bag needed to be replaced and was not in the room at that time. RRN #250 verified that the Ambu bag was replaced.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review and staff interview, the facility failed to have all dialysis communication and records were in the facility to ensure full care could be provided. This affected one (Resident #65) of one resident reviewed for dialysis. The census was 88.</p> <p>Findings Include:</p> <p>Resident #65 was admitted to the facility on [DATE]. His diagnoses were end stage renal disease, emphysema, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, alcoholic cirrhosis of liver without ascites, anemia, gout, type II diabetes. other psychoactive substance abuse, cognitive communication deficit, lack of coordination, dysphagia, congestive heart failure, atherosclerotic heart disease, pure hypercholesterolemia, low back pain, neuropathy, major depressive disorder, hyperlipidemia, adult failure to thrive, esophagitis, anxiety disorder, and allergic rhinitis.</p> <p>Review of facility Minimum Data Set (MDS) assessment, dated 09/05/24, revealed he was cognitively intact.</p> <p>Review of Resident #65 physician orders found he was scheduled to have dialysis on Tuesday, Thursdays, and Saturdays.</p> <p>Review of Resident #65 dialysis notes within the facility found the following notes without the needed weight information: 11/30/24 (no pre weight), 11/27/24 (no pre and post weight), 11/07/24 (no pre weight), 10/24/24 (no pre weight), 10/19/24 (no pre weight), 09/26/24 (no pre weight), 09/19/24 (no pre weight), and 09/05/24 (no pre weight).</p> <p>After review of the facility dialysis records for Resident #65 on 12/04/24 and informing the facility there were multiple weights not documented, the facility provided communication documentation from the dialysis center with the needed weights on 12/05/24.</p> <p>Interview with Regional Nurse #250 on 12/05/24 at 10:35 A.M. stated they had a separate medical records area that had these dialysis records; she stated they did not get them from the dialysis center recently.</p> <p>Interview with Dialysis Center Representative #601 on 12/05/24 at 10:42 A.M. confirmed they sent specific dialysis records for Resident #65 that were requested by the facility, in the afternoon of 12/04/24. She confirmed the facility stated they didn't have the needed records and needed the dialysis center to send them over. She confirmed it was communication dialysis logs that had both pre and post weights for Resident #65.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>37100</p> <p>Based on personnel record review and staff interview, the facility failed to complete staff performance evaluations as required. This had the potential to affect 88 of 88 residents.</p> <p>Findings Include:</p> <p>Review of Certified Nursing Assistant (CNA) #165 and CNA #179 personnel records found they did not have a completed 90 day performance evaluation completed.</p> <p>Interview with Visiting Administrator #600 on 12/04/24 at 10:30 A.M. confirmed they have no evidence to support the above staff had performance evaluations completed as required.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review and staff interview, the facility failed to properly monitor residents psychotropic medications to ensure the need/appropriate dose of psychotropic medications. This affected one (Resident #7) of five residents reviewed for unnecessary medications. The census was 88.</p> <p>Findings include:</p> <p>Resident #7 was admitted to the facility on [DATE]. Her diagnoses were schizoaffective disorder, asthma, type II diabetes, anxiety disorder, major depressive disorder, hypertension, dementia, lack of coordination, schizoaffective disorder, shortness of breath, osteoporosis, aphasia, dysphagia, hypertensive heart disease, moderate intellectual disabilities, hypothyroidism, hyperlipidemia, and diffuse traumatic brain injury. Review of her minimum data set (MDS) assessment, dated 10/02/24, revealed she had a severe cognitive impairment.</p> <p>Review of Resident #7 physician orders found she was prescribed the following psychotropic medications: Olanzapine 15 milligrams (mg), Depakote 250 mg twice daily, Fluphenazine five mg twice daily, and Fluphenazine Decanoate Solution intramuscularly 25 mg every 21 days for schizoaffective disorder, and venlafaxine 75 mg for depression.</p> <p>Review of Resident #7 pharmacy recommendations, dated November 2023 to November 2024, revealed one pharmacy recommendation for a gradual dose reduction (GDR) for Fluphenazine in January 2024. The physician reviewed it and determined a GDR would not be beneficial to her mental health to reduce the dosage. Other than this recommendation, no other psychotropic medication had a recommendation for a GDR as required.</p> <p>Interview with Regional Nurse #250 on 12/05/24 at 9:20 A.M. and 9:45 A.M. stated the pharmacy will review each resident's psychiatric notes (including Resident #7) and then determine if they will complete any type of recommendation for irregularity, including GDR. She confirmed the pharmacy did not complete a GDR recommendation for Resident #7 psychotropic medications in the last 12 months, other than Fluphenazine.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</p> <p>Based on record review, and staff interview, the facility failed to ensure adequate monitoring was completed for a medication as ordered for Resident #9. This affected one (Resident #9) of six residents reviewed for unnecessary medications. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #9 revealed an admitted [DATE] and readmitted on [DATE] with diagnoses including chronic systolic heart failure, morbid obesity with alveolar hypoventilation, asthma, chronic obstructive pulmonary disease, dependence on respirator/ventilator status, obstructive sleep apnea, essential hypertension, chronic venous insufficiency, unspecified depression, anxiety disorder, gastro-esophageal reflux disease, anemia, paroxysmal atrial fibrillation, generalized muscle weakness, and stenosis of a coronary artery stent.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating no cognitive impairment. Resident #9 had impaired mobility and required moderate assistance with showers but was independent with all other activities of daily living.</p> <p>Review of the care plan for Resident #9 revealed a focus on managing chronic conditions, including respiratory support, pain management, and addressing anxiety.</p> <p>Review of the physician orders for Resident #9 revealed orders for Entresto were initiated on 10/08/24 with a dosage of 24-26 milligrams (mg) twice daily for hypertension. The orders specified that Entresto should be held if the resident's systolic blood pressure (SBP) was below 110 millimeters of mercury (mmHg) or if the heart rate (HR) was below 60 beats per minute (bpm).</p> <p>Review of the Medication Administration Records (MAR) confirmed that Entresto was administered outside the prescribed parameters on multiple occasions: 11/12/24: 106/81 (12:44 A.M.) and 129/81 (10:00 A.M.), both outside the specified SBP parameter. On 11/10/24: 109/73 (8:34 A.M.) and 8:35 A.M. On 10/31/24: 106/79 at 9:30 A.M. On 10/28/24: 109/70 at 8:37 P.M. On 10/15/24: 109/77 at 9:31 A.M. and 9:32 A.M. These values indicate that Entresto was administered even when the resident's blood pressure was below the ordered threshold of 110 mmHg.</p> <p>Interview on 12/04/24 at 2:33 P.M. with the Director of Nursing (DON), revealed that the facility's practice was to administer Entresto if the readings were only one digit outside of the parameters, stating it was a known rule for nursing discretion. The DON confirmed that the Entresto was administered outside the prescribed parameters and acknowledged the need to verify the facility's practices with the physician. The DON could find no documented evidence related to the nursing discretion rule. The DON could also find no evidence of the staff notifying the physician prior to administering the medication while outside of the ordered parameters.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Additionally, the rule regarding nursing discretion was confirmed in a written statement from the physician on 12/05/24, but this was the first documented evidence of such a rule. No prior written documentation or confirmation of the nurse discretion practice could be found in the resident's medical record or facility policies.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review and staff interview, the facility failed to properly monitor resident behaviors to ensure the need/appropriate dose of psychotropic medications. This affected one (Resident #7) of five residents reviewed for unnecessary medications. The census was 88.</p> <p>Findings include:</p> <p>Resident #7 was admitted to the facility on [DATE]. Her diagnoses were schizoaffective disorder, asthma, type II diabetes, anxiety disorder, major depressive disorder, hypertension, dementia, lack of coordination, schizoaffective disorder, shortness of breath, osteoporosis, aphasia, dysphagia, hypertensive heart disease, moderate intellectual disabilities, hypothyroidism, hyperlipidemia, and diffuse traumatic brain injury.</p> <p>Review of her minimum data set (MDS) assessment, dated 10/02/24, revealed she had a severe cognitive impairment.</p> <p>Review of Resident #7 physician orders found a new order for Olanzapine 15 milligrams (mg) for schizoaffective disorder was started on 11/18/24. Prior to this order, she was on Olanzapine/Zyprexa 10 mg for schizoaffective disorder. In addition to Olanzapine for schizoaffective disorder, she was also prescribed Depakote 250 mg twice daily, Fluphenazine five me twice daily, and Fluphenazine Decanoate Solution intramuscularly 25 mg every 21 days for schizoaffective disorder, and venlafaxine 75 mg for depression.</p> <p>Review of Resident #7 psychiatry progress notes, dated 11/18/24, revealed an office visit which indicated that Resident #7 stated she was having trouble sleeping the last few nights. When asked other questions, it was documented that she was answering non-sensically when asked about her mania/hypomania. According to staff information provided to the psychiatrist, she was telling staff that she will be giving birth. There were no reports of aggression, agitation, or irritability.</p> <p>Review of Resident #7 behavior monitoring documentation, dated September 2024 to December 2024, found the behaviors the facility was monitoring for her use of antidepressants and antipsychotics were as follows: hallucinations, delusions, paranoia, sadness, withdrawn, and appetite changes. Review of those behavior logs found no behaviors were documented as being exhibited. There was no justification leading up to the increase of Resident #7 Olanzapine from 10 mg to 15 mg.</p> <p>Interviews with Regional Nurse #250 on 12/05/24 at 9:20 A.M. and 9:45 A.M. confirmed there were no behaviors documented in the Resident #7 records to support an increase in her Olanzapine. She confirmed there was an increase in Olanzapine on 11/18/24 for Resident #7 thinking she was pregnant and not sleeping for a few nights. She confirmed there should have been documentation to support these behaviors.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</p> <p>Based on record review, staff interview, resident interview, and policy review, the facility failed to ensure timely collection of a urine sample for a urinary tract infection (UTI) as ordered for Resident #81. This affected one (Resident #81) out of one resident reviewed for labs. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, type II diabetes, obesity, dependence on respirator, lack of coordination, obstructive sleep apnea, bladder-neck obstruction, obstructive and reflux uropathy, difficulty walking, edema, combined systolic heart failure, spinal stenosis, and several other chronic conditions.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (Additionally, a BIMS assessment on 12/02/24 with a score of 15), indicating no cognitive impairment. Resident #81 was dependent on a wheelchair and required assistance with toileting, bathing, and personal hygiene. The resident had an indwelling catheter and was frequently incontinent with bowel movements.</p> <p>Review of the progress notes for Resident #81 revealed on 10/20/24 at 11:21 A.M., the nursing note indicated a small amount of mucus was noted in the urine, and new orders were received for a urine culture and sensitivity, with the responsible party notified.</p> <p>Review of the physician orders for Resident #81 revealed a physician's order was placed on 10/21/24 for a urine culture and sensitivity, which was not collected promptly. The sample was collected on 10/24/24, resulting in a delay of three days before the lab results were available. This delay impacted the timely initiation of appropriate treatment for the UTI.</p> <p>Review of the progress notes for Resident #81 revealed on 10/26/24 at 6:31 P.M., a nursing note indicated that lab results were reviewed with the resident and Med One was notified for new orders to start Bactrim DS (Sulfamethoxazole-Trimethoprim) for the UTI. The resident and responsible party (RP) were informed.</p> <p>Interview on 12/04/24 at 2:55 P.M. with the Director of Nursing (DON) confirmed the collection sample was delayed and there was no justification as to why the sample was delayed by three days.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Diagnostic Testing Services Policy revealed the facility will provide appropriate diagnostic services required to maintain the overall health of its residents and in accordance with state and federal guidelines. Additionally, the policy stated the facility will maintain a schedule of diagnostic tests in accordance with the physicians' orders. No diagnostic tests will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialist orders in accordance with state law to include scope of practice laws. Qualified nursing personnel will receive and review the diagnostic test reports and communicate the results to the ordering physician within 24 hours of receipt unless the report results fall outside of clinical reference ranges and require immediate attention at which time the physician will be notified upon receipt.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, staff interview and facility policy review, the facility failed to ensure one resident (#18) oral assessments were accurate and dental services were arranged to address the resident's poor dental status. This affected one resident (Resident #18) of one resident reviewed for dental. The facility census was 88.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #18 revealed an initial admitted [DATE] with the most recent admission of 10/11/24 with the diagnoses including but not limited to diabetes mellitus, neuromuscular dysfunction of bladder, fibromyalgia, arthritis, major depressive disorder with psychotic features, obstructive sleep apnea, gastro-esophageal reflux disease, paraplegia, pain, constipation, osteoarthritis, dysphagia and urinary tract infection (UTI).</p> <p>Review of the plan of care dated 09/05/24 revealed the resident required assistance for activities of daily living (ADL) related to fibromyalgia and paraplegia. Interventions included apply house moisture barrier cream after each incontinence episode, assist in choosing appropriate clothing as needed, encourage and allow resident to complete self care as able, inspect skin condition daily during personal care and report any impaired areas to charge nurse, observe for changes in ADL ability and adjust assistance as needed, resident requires weight-bearing assistance with transfers, dressing, bathing, toilet hygiene, putting on and taking off footwear, personal hygiene, lying to sitting and sit to stand and staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly.</p> <p>Review of the resident's 360 ancillary consent form dated 08/24/24 revealed the resident consented to receive all ancillary services including dental.</p> <p>Review of the resident's admission assessment with baseline care plan dated 08/07/24 revealed the resident had his own teeth in good/fair repair.</p> <p>Review of the resident's readmission assessment dated [DATE] revealed the resident had broken/chipped or carious teeth.</p> <p>Review of the resident's readmission assessment dated [DATE] revealed the resident had broken/chipped or carious teeth.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no mouth or facial pain/discomfort or difficulty with chewing.</p> <p>Review of the resident's oral assessment dated [DATE] revealed the resident had no issues with his natural teeth and his oral status does not effect his eating.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/02/24 at 11:32 A.M., interview/observation of the resident's natural teeth revealed the resident's teeth were in poor repair with obvious carried teeth. Resident #18 stated he had requested several times to see the facility dentist and was told, you are on the list. Resident #18 revealed he wanted to make an appointment with a community dentist but the facility would not transport him to the appointment as he would have to make his own transportation arrangements.</p> <p>On 12/05/24 at 10:46 A.M., interview with Social Worker (SW) #112 verified the resident had not seen the facility contracted dentist and was present in the facility during the dentist's last visit.</p> <p>On 12/04/24 at 12:14 P.M., interview with the Director of Nursing verified the admission assessment was not accurate to reflect the resident's poor dental status of carried teeth.</p> <p>Review of the facility policy titled, Dental Services, dated 2022 revealed it was the policy of the facility to assist residents in obtaining routine and emergency dental care. The dental needs of each resident are identified through the physical assessment and MDS assessment process and addressed in each resident's plan of care.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36648</p> <p>Based on observations , and staff interviews the facility failed to ensure the steam warmer and two compartment sink was maintained in a safe and operating condition . This had the potential to affect 85 residents. The census was 88.</p> <p>Findings include:</p> <p>Observation on 12/04/24 at 10:24 A.M. of the kitchen's two compartment sink omitted a strong odor of sewage. The sink was empty. Verified by dietary Aide #105.</p> <p>Observation on 12/4/24 at 10:28 A.M. behind the serving line the steam oven was dripping water from the bottom left side of the door. The water dripped approximately 2 feet down to a 11 x 11 serving metal bin. [NAME] # 217 revealed when she uses the steamer the water drips out . The staff must empty the water filled bin every one to two hours. Dietician #168 verified the water and confirmed she reported the issue to corporate in November 2024.</p> <p>Interview on 12/04/24 03:16 P.M. with the Administrator regarding the steam oven, he confirmed it had been replaced once in the past. The maintenance man must change the seals to prevent the water from dripping.</p> <p>Interview on 12/05/24 01:08 P.M. to 1:30 P.M. with Maintenance Director #177 confirmed the steamer was not new when they got it from a sister facility. He was aware of the drip ; the seals have not been replaced. He is aware of the odor in the kitchen. He explained, Three weeks ago, he tried to snake the drains under the two compartment sink , but the odor still exists. After surveyor intervention he has called a Plumber to service the drains on 12/05/24.</p> <p>Review of the e-mail from the administrator on 12/05/24 at 3:40 P.M. confirmed after surveyor intervention corporate approved the facility to purchase a new steamer. They received a quote, and it has been approved and purchased. Arrival date is to be determined.</p> <p>Review of the work receipt by the plumber dated 12/05/24 revealed he cleaned the kitchen sink drain to remove clog. Determined the odor was coming from floor drains from grease interceptor not being properly cleaned. The drains all need to be cleaned and the pumps need to be pumped.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observations, staff interviews, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for one resident (Resident #189) who had a feeding tube in place. The facility also failed to follow infection control procedures during wound care for two residents (Residents #81 and #300) and did not follow infection control procedures during catheter care for one resident (Resident #10). The deficient practices affected four residents (#10, #81, #189, #300) of four reviewed for infection control. The facility census was 88.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #81 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, diabetes mellitus, dependence on respirator, obstructive sleep apnea, bladder neck obstruction, obstructive and reflux uropathy, congestive heart failure, spinal stenosis lumbar region, hypertension and depression.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter and was frequently incontinent of bowel.</p> <p>Review of the resident's monthly physician orders for December 2024 identified orders dated 07/24/24 catheter care every shift, 10/18/24 catheter size 16 FR 10 milliliter (ml) balloon and 11/14/24 acetic acid irrigation solution 0.25% with the special instructions to use 50 ml via irrigation every 12 hours as needed for mucous accumulation in indwelling urinary catheter.</p> <p>On 12/04/24 at 3:20 P.M., observation of Certified Nursing Assistant (CNA) #106 provide the physician ordered catheter care revealed the CNA entered the resident's room and donned a pair of disposable gloves. The CNA obtained a clear plastic graduate container and emptied the resident's indwelling urinary catheter collection bag. The CNA set the clear plastic graduate container on the floor and wiped the end of the plastic drainage tube with an alcohol wipe, clamped the tube shut and emptied the urine into the toilet. The CNA rinsed the plastic graduate container and placed in a clear plastic bag. The CNA then changed her gloves without washing or sanitizing her hands. She obtained one soapy washcloth and one wet wash cloth and cleansed the resident's groins. The CNA then rinsed the resident's groins and pat dry with a towel. The CNA then cleansed the indwelling urinary catheter with a disposable alcohol swab moving up and down the indwelling urinary catheter. The CNA then covered the resident with a sheet. The CNA washed her hands and exited the room with the dirty linen and trash.</p> <p>On 12/04/24 at 3:26 P.M., interview with CNA #106 verified the lack of personal protective equipment (PPE) while providing the physician ordered catheter care. The CNA verified a disposable gown should have been worn while providing the physician ordered catheter care. The CNA also verified the movement of the alcohol swab up and down the indwelling urinary catheter instead of going from insertion site down in a circular motion.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy titled, Catheter Care, dated 06/01/24 revealed it was the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are used. When providing catheter care to a male gently draw foreskin back if applicable, using a circular motion, cleanse the meatus with a clean cloth moistened with water and perineal cleaner (soap), with a new moistened cloth, starting at the urinary meatus moving down, cleanse the shaft, with a new moistened cloth, starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter and dry area with towel.</p> <p>2. Review of the medical record for Resident #10 revealed an initial admitted [DATE] with the latest readmission of 01/12/23 with the diagnoses including but not limited to COPD, severe protein calorie malnutrition, diabetes mellitus, CHF, depression, psychosis, dependence on respiratory ventilator, insomnia, hyperlipidemia, auditory hallucinations, allergic rhinitis, dysphagia, benign prostatic hyperplasia with lower urinary tract symptoms, schizophrenia, anemia, anxiety disorder and hypertension.</p> <p>Review of the plan of care dated 11/03/22 revealed the resident required assistance with activities of daily living (ADL) related to new admission, weakness, depression, cognition. Interventions included inspect skin condition daily during personal care and report any impairment to charge nurse, keep call light in reach while in bed, observe for changes in ADL ability and adjust assistance as needed and resident is totally dependent and does not participate in any aspect of the following tasks, toileting, bathing, transfers, bed mobility, dressing, hygiene, putting on/taking off footwear and locomotion.</p> <p>Review of the plan of care dated 10/24/24 revealed the resident had an actual area of skin impairment related to pressure ulcer to the right outer ankle and the right and left ischium. Interventions included bariatric pressure reducing mattress to bed, educate resident to be aware of surroundings while in wheelchair, education and demonstration provided to resident to release hand from wheelchair when propelling to reduce friction for skin integrity, encourage resident to lay down in between smoke breaks as tolerated, encourage resident to limit time in wheelchair to 60 minutes at a time, encourage resident to turn and reposition, encourage resident to wear prevalon boots as much as tolerated, gel cushion to wheelchair as tolerated, initiate wound treatment, continue treatment as ordered by physician, observe and document character of wound weekly, observe for clinical changes, skin observation and document on bath/shower days, administer diet as ordered and record percentage of intake every meal, administer supplements as ordered and record percentage taken, weekly skin assessments, when transferring, turning and repositioning, use proper techniques to avoid friction and shear, assist with transfers as needed, dietician to review nutritional status quarterly and inspect for any reddened areas during daily care.</p> <p>Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was frequently incontinent of bladder and always incontinent of bowel. The assessment indicated the resident was at risk for skin breakdown and had one stage III and one unstageable pressure ulcer not present on admission. The assessment indicated the resident had no other skin issues. The facility implemented pressure reducing device to bed/chair, pressure ulcer/injury care and application of ointments/medications other than to feet. The assessment indicated the resident had no functional limitation in range of motion.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the weekly pressure skin grid dated 11/13/24 revealed the stage III pressure ulcer to the sacrum wound was resolved.</p> <p>Review of the progress note dated 11/22/24 at 7:15 A.M. revealed the nurse was checking the resident's buttocks when receiving care and found bilateral buttocks having pressure sore measuring 13.0 cm by 8.0 cm by 0.5 cm on the right side and 12.0 cm by 8.0 cm by 0.5 cm on the left side. A small amount of blood was noted. The wounds were cleansed with NS, pat dry, Xerofoam applied and covered with a dry clean dressing. The intervention to turn and reposition every two hours was implemented.</p> <p>Review of the resident's primary care physician progress note dated 11/22/24 revealed the resident was being seen for regulatory visit to address chronic condition and skin breakdown. The resident was found to have excoriation to groin and the resident's bottom, superimposed candidiasis with Diflucan two doses, zinc and nystatin cream was initiated. The wound team was to follow and offloading recommended.</p> <p>Review of the resident's monthly physician orders for December 2024 identified orders dated 02/15/23 regular no added salt diet, 10/31/24 ProHeal 30 milliliters (ml) by mouth twice daily, 02/25/23 foam cushion to wheelchair as tolerated, 01/15/24 house barrier cream every shift and as needed for incontinence/moisture for skin integrity prevention, 02/02/24 wear prevalon boots as tolerated while in bed every shift for skin integrity, 02/25/24 apply anti-fungal cream after each incontinent episode and as needed, 10/24/24 encourage resident to wear prevalon boots as much as tolerated every shift, encourage resident to turn and reposition every two hours as tolerated every shift, 11/22/24 pressure reducing mattress to bed, encourage resident to lay down in between smoke breaks as tolerated. chart effectiveness and compliance every shift, limit time sitting up in wheelchair for 60 minutes per Wound Physician, document compliance and non-compliance with wound care every shift and 11/27/24 paint right outer heel with betadine daily until resolved, cleanse left and right ischium with normal saline, pat dry, apply Mesalt to wound bed, cover with dry clean dressing daily and as needed, 12/02/24 gel cushion to wheelchair as tolerated.</p> <p>On 12/05/24 at 8:31 A.M., observation of Licensed Practical Nurse (LPN) #142 provide the physician ordered treatment to the resident's left and right buttocks revealed supplies were set-up on a barrier on the resident's bedside table upon entry to the room. The LPN washed her hands and donned gloves. The resident had the prevalon boots on and was positioned with pillows. No offloading was observed with the positioning. The resident was assisted onto his right side. The left and right buttocks wounds had no dressing in place. The LPN cleansed the left buttocks wound with normal saline (NS) and a 4X4. She then washed her hands and donned a pair of gloves and cleansed the right buttocks with NS and a 4X4. The LPN then changed her gloves without washing or sanitizing her hands. She then placed Mesalt pad onto the left buttocks wound and covered the wound with bordered dressing. The LPN then placed a Mesalt pad on the right buttocks wound and covered with a bordered dressing using the same gloves she dressed the left buttocks wound with. The resident was positioned on his left side but offloading was not achieved.</p> <p>On 12/05/24 at 8:42 A.M., interview with LPN #152 verified she completed the two wounds as one instead of separating the wounds and completing separately.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Review of the medical record for Resident #300 revealed an initial admitted [DATE] with the latest readmission of 11/21/24 with diagnoses including but not limited to cirrhosis of liver, morbid obesity, asthma, diabetes mellitus, protein calorie malnutrition, chronic obstructive pulmonary disease, anemia, acute and chronic respiratory failure, insomnia, allergic rhinitis, retention of urine, dysphagia, pressure ulcer of unspecified site, depression, anxiety disorder, gastro-esophageal reflux disease, hyperlipidemia, obstructive sleep apnea, cerebral infarct and chronic kidney disease.</p> <p>Review of the plan of care dated 01/24/24 revealed the resident has an actual area of skin impairment related to pressure area to sacrum, skin tear to right iliac crest and abrasion to right buttocks and right back. Interventions included air mattress as ordered, ask resident about pain level prior to dressing change procedure, medicate if needed, enhanced barrier precautions, evaluate for pain and provide pain relieving interventions as ordered, initiate wound treatment, continue treatment as ordered by the physician, limit time out of bed, nursing to observe the wound dressing daily to ensure that the dressing remains in tact and that there are no signs/symptoms of infection or increased drainage, observe and document character of wound weekly, observe for clinical changes, pressure reducing cushion to chair, refer to dietician to determine need/no need for dietary intervention and skin observation an document on bath/shower days.</p> <p>Review of the plan of care dated 02/05/24 revealed the resident had potential for alteration in skin integrity, requires protective/preventative skin care maintenance related to bowel/bladder incontinence, decreased mobility and history of previous skin breakdown. Interventions included air mattress to bed, apply house barrier as ordered, assist with transfers as needed, dietician to review nutritional status quarterly, encourage to float heels as tolerated, inspect for any reddened areas daily during care, pressure reducing cushion to chair to promote comfort and prevent skin breakdown as tolerated, provide peri-care with each incontinence episode, review for change in continence, weekly skin assessments, when transferring, turning and repositioning, use proper techniques to avoid friction and shear, diet as ordered and dietary supplements as tolerated to aid in wound healing, administer treatment to skin tear as ordered, keep skin clean and dry, apply lotion to dry skin and notify physician of signs/symptoms of infection or ineffective treatment.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was at risk for skin breakdown and had one stage IV pressure ulcer on admission. The facility implemented the interventions pressure reducing device to bed/chair, nutrition/hydration intervention to manage skin problems, pressure ulcer/injury care and application of ointments/medications other than to feet.</p> <p>Review of the resident's monthly physician orders for December 2024 identified orders dated 11/21/24 identified orders dated 11/27/24 cleanse upper sacral wound with normal saline (NS), place gentamicin to gauze packing strips, pack into small area wound and cover with dry clean dressing daily and as needed, 12/02/24 cleanse lower sacral wound with NS, pack wound with Dakins 1/2 Strength solution Kerlix, cover with dry clean dressing daily and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/03/24 at 3:26 P.M., observation of Licensed Practical Nurse (LPN) #145 and LPN #142 provide the physician ordered treatment to the stage IV pressure ulcer to the sacrum revealed the LPN donned PPE (gown/gloves). LPN #142 applied a disposable barrier on the resident's bedside table. assembled the required supplies and set-up the supplies on the barrier. LPN #145 washed her hands and donned a pair of gloves. LPN #145 then removed the soiled dressing to the wound to the left upper buttocks and the sacral wound. The wound bed was noted to be pink in color with a small amount of bleeding around the edges. LPN #145 changed her gloves without washing/sanitizing her hands. LPN #145 then cleansed the wound to the left upper buttocks with normal saline (NS) and a 4X4. She then obtained a clean NS soaked 4X4 and cleansed the sacral wound. The LPN then pat both areas dry using a 4X4 for each area. LPN #145 then changed her gloves without washing/sanitizing her hands. The LPN then packed the left upper buttocks with gentamicin soaked iodofoam. The LPN then packed the sacral wound with half strength Dakin's soaked Kerlix. The LPN then covered the sacral wound with a foam dressing and the left upper buttocks with an ABD pad. The LPN then positioned the resident to comfort with a wedge under her left side, a pillow under her right side and her heels floating with pillows.</p> <p>On 12/03/24 at 3:49 P.M., interview with LPN #145 verified the treatments to the left upper buttocks and the sacrum was administered together instead of separate to prevent the potential spread of infection and the lack of handwashing during glove changes.</p> <p>Review of the facility policy titled, Hand Washing Guidelines, last revised 01/19 revealed it was the policy of this facility that staff washes their hands on a regular basis, including before and after providing care for a resident, when visibly soiling is present, before and after the use of gloves, and as needed to assure clean hands.</p> <p>51068</p> <p>4. Review of the medical record for Resident #189 revealed an admitted [DATE] with diagnoses including unspecified fracture of the fourth lumbar vertebra, Type 2 diabetes mellitus with hyperglycemia, severe protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), dysphagia, and other complex conditions.</p> <p>Review of Resident #70's Minimum Data Set (MDS) 3.0 assessment indicated severe cognitive impairment and the need for maximum assistance with activities of daily living (ADLs), including dressing, toileting, and mobility.</p> <p>Review of the care plan for Resident #189 revealed a focus on managing the resident's complex health conditions, including tube feeding via a PEG tube and the need for assistance with personal care.</p> <p>Review of the physician orders for Resident #189 revealed the following orders: Clean PEG tube site with normal saline (NS), pat dry, and apply split gauze to the site every shift starting 11/19/24. Additionally, Enteral feeding orders via the PEG tube, including a rate of 50 milliliters (mL) an hour of Glucerna 1.5 for 20 hours daily, starting 11/19/24. However, there were no physician orders for enhanced barrier precautions for Resident #189.</p> <p>Observation on 12/02/24 at 1:24 P.M. revealed there were no enhanced barrier precautions set up for Resident #189.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 12/03/24 at 3:54 P.M. and 12/04/24 at 8:46 AM, no enhanced barrier precautions were in place for the resident's PEG tube feeding.</p> <p>Interview on 12/04/24 at 8:50 A.M. with Registered Nurse (RN) #126 confirmed that enhanced barrier precautions are used for open wounds, catheters, feeding tubes, and similar situations.</p> <p>Observation on 12/04/24 at 3:03 P.M. revealed barrier precautions were still not in place.</p> <p>Observation on 12/05/24 at 9:29 A.M., revealed no enhanced barrier precautions were observed despite discussions with nursing staff.</p> <p>Interview on 12/05/24 at 9:43 A.M., LPN# 128, confirmed that enhanced barrier precautions should have been in place for the PEG tube but were not implemented.</p> <p>Review of the care plan for Resident #189 revealed that the care plan was updated to include enhanced barrier precautions on 12/05/24, but these precautions were not implemented prior to this date.</p> <p>Review of the Infection Prevention and Control Program revealed the policy requires adherence to standard precautions for infection control, which include proper hygiene, use of personal protective equipment (PPE), and following appropriate isolation procedures for residents with high infection risks. This directly applies to the resident with a PEG tube, who should be receiving enhanced barrier precautions to prevent contamination and infection. Enhanced Barrier Precautions are required for residents with open wounds or invasive devices, like a feeding tube, to minimize the risk of infection. The absence of these precautions violates the facility's infection control procedures.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068</p> <p>Based on record review, staff interview, and facility policy review, the facility failed to follow their antibiotic stewardship processes for Residents #81 and #43. This affected two (Resident's #81 and #43) out of three residents reviewed for antibiotic use. The facility census was 88.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, type II diabetes, obesity, dependence on respirator, lack of coordination, obstructive sleep apnea, bladder-neck obstruction, obstructive and reflux uropathy, difficulty walking, edema, combined systolic heart failure, spinal stenosis, and several other chronic conditions.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (Additionally, a BIMS assessment on 12/02/24 with a score of 15), indicating no cognitive impairment. Resident #9 was dependent on a wheelchair and required assistance with toileting, bathing, and personal hygiene. The resident had an indwelling catheter and was frequently incontinent with bowel movements.</p> <p>Review of the progress notes for Resident #81 revealed on 10/26/24 at 6:31 P.M. lab results indicated a urinary tract infection (UTI), and Bactrim was prescribed on 10/27/24.</p> <p>Review of the physician orders for Resident #81 revealed an order for Bactrim Tablet 800-160 milligram's (MG) (Sulfamethoxazole-Trimethoprim) give 1 tablet by mouth two times a day for UTI for seven days with a start date of 10/27/24 and an end date of 11/03/2024.</p> <p>Review of the Medication Administration Records (MAR) confirmed Bactrim was prescribed from 10/27/24 to 11/03/24.</p> <p>Review of the urine analysis labs revealed the organism present was proteus mirabilis with a growth of >100,000 Colony-Forming Units per Milliliter (CFU/mL). Under the antibiotic sensitivity section it indicated bacterial resistance to Bactrim (denoted as R [>2/38], confirming resistance per minimum inhibitory concentration standards).</p> <p>Interview on 12/05/24 at 2:45 P.M. with the Director of Nursing (DON) confirmed that Bactrim was prescribed despite the culture showing resistance. The DON stated that they had no justification for the antibiotic order and confirmed that there was no documentation explaining the reason for the choice of Bactrim.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Winchester		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Antibiotic Stewardship Policy revealed that Antibiotics must be selected based on culture and susceptibility data whenever available to ensure effectiveness against the identified pathogen. Clinical staff must document the rationale for the selection of an antibiotic, particularly when culture data indicates resistance to the prescribed medication. Timely review of laboratory results, including culture and sensitivity reports, is required to guide adjustments in treatment. Inappropriate antibiotic use, such as prescribing resistant antibiotics, must be avoided to minimize the risk of treatment failure and antimicrobial resistance.</p> <p>41266</p> <p>2. Review of the medical record for Resident #43 revealed an initial admitted on 10/04/24 and a readmitted on 10/14/24. Medical diagnoses included anxiety disorder, transient cerebral ischemic attack, other nontraumatic intracerebral hemorrhage, cerebral infarction, opioid abuse, and hemiplegia affecting left nondominant side.</p> <p>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 had intact cognition and scored 15 out of 15 on the Brief Interview Mental Status (BIMS) assessment. Resident #43 required varied assistance with Activities of Daily Living (ADLs) ranging from independence to substantial assistance from staff.</p> <p>Review of the infection control log revealed Resident #43 was admitted from the hospital on 11/12/24 with a urinary tract infection (UTI). There was no organism listed. The urinalysis with sensitivity was listed as unable to obtain (uto). Resident #43 did not meet McGreer's criteria for an infection. Resident #43 received Amoxicillin from 11/12/24 to 11/17/24 (five days).</p> <p>Review of the Medication Administration Record (MAR) dated November 2024 revealed Resident #43 had a physician order for Amoxicillin-Potassium Clavulanate (an antibiotic) 875-125 milligrams (mg) with instructions to take one tablet two times daily for a UTI for five days. The order was dated 11/12/24. Resident #43 received one dose on 11/12/24, two doses on 11/13/24, 11/14/24, 11/15/24, and 11/26/24, and one dose on 11/17/24. The resident received a total of ten doses of the antibiotic.</p> <p>Review of the progress notes revealed there was no evidence Resident #43 was evaluated by a physician or Certified Nurse Practitioner (CNP) after returning from the hospital to ensure the antibiotic order was appropriate. There was no evidence of Resident #43's lab results in the resident's medical record to verify the resident had a UTI.</p> <p>Interview on 12/05/24 at 2:01 P.M. with Regional Nurse (RGN) #250 confirmed Resident #43 returned from the hospital with an ordered antibiotic for a UTI. The facility was not able to obtain labs from the hospital to verify an organism or the positive UTI results. RGN #250 confirmed Resident #43 did not meet McGreer's criteria for a UTI and the resident was not seen by a physician or CNP to verify the appropriateness of the antibiotic order.</p> <p>Review of the facility policy, Antibiotic Stewardship, undated, revealed the policy stated, Providers will utilize the McGreer's Criteria when considering initiation of antibiotics. When infection is suspected review with physician the criteria that was met for use of antibiotic. At 72 hours after antibiotic initiation or first dose in the facility, each resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential. Completion of an antibiotic time-out must be recorded in the resident record.</p>		

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NAME OF PROVIDER OR SUPPLIER Embassy of Winchester		STREET ADDRESS, CITY, STATE, ZIP CODE 36 Lehman Dr Canal Winchester, OH 43110	
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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41266</p> <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on medical record review, review of immunization records, staff interview, and facility policy review, the facility failed to administer the influenza vaccine to one resident (Resident #20) and the facility failed to administer the pneumococcal vaccine to one resident (Resident #6) after the residents consented to receive the vaccinations. The deficient practice affected two residents (Residents #6 and #20) of five reviewed for immunizations. The facility census was 88.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #20 revealed an initial admitted on 01/18/24 and a readmitted on 03/08/24. Medical diagnoses included Type II Diabetes Mellitus without complications, metabolic encephalopathy, vascular dementia, essential hypertension, and cognitive communication deficit.</p> <p>Review of the Vaccine Administration Record Informed Consent for Vaccination dated 10/25/24 revealed Resident #20's representative consented for the resident to receive an influenza vaccine.</p> <p>There was no evidence in the medical record Resident #20 received the influenza vaccination after the resident's representative consented.</p> <p>2. Review of the medical record for Resident #6 revealed an admitted on 03/09/17. Medical diagnoses included secondary parkinsonism, aphasia, hemiplegia affecting left nondominant side, dementia, and psychotic disturbance, mood disturbance and anxiety.</p> <p>Review of the Vaccine Administration Record Informed Consent for Vaccination dated 10/24/24 revealed Resident #6 verbally consented to receive the pneumococcal vaccination.</p> <p>There was no evidence Resident #6 received the pneumococcal vaccination after consenting to receive the vaccine.</p> <p>Interviews on 12/05/24 at 2:17 P.M. and 2:18 P.M. with Regional Nurse (RGN) #250 confirmed Resident #20 did not receive the influenza vaccine after his representative consented for the resident to receive the vaccine. RGN #250 confirmed Resident #6 did not receive the pneumococcal vaccination after verbally consenting to receive the vaccine.</p> <p>Review of the facility policy, Infection Prevention and Control Program, revised 06/01/24, revealed the policy stated, Residents will be offered the influenza vaccine each year between October 1 and March 31 unless contraindicated or received the vaccine elsewhere during that time. Residents will be offered the pneumococcal vaccines recommended by the Centers for Disease Control (CDC) upon admission, unless contraindicated or received the vaccines elsewhere. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. Residents will have opportunity to refuse the vaccines. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.</p>		