STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365730	A. Building B. Wing	12/10/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and review of the facility policy and procedure, the facility failed to ensure a homelike environment. This affected six residents (#1, #4, #14, #16, #41, and #54) of six residents reviewed for environment and had the potential to affect all 68 residents residing in thee facility. The facility census was 68.Findings include:Observation on 12/03/25 at 11:03 A.M. of Resident #4 in his room sitting in his wheelchair wearing a coat and hat. Interview at this time with Resident #4 stated it was cold in the building, and they needed to turn on the heat.Interview on 12/03/25 at 11:16 A.M. with Resident #54 stated it was cold at night in his room and staff would get him another blanket that helped. Observation of Resident #54's room revealed long black marks and gashes in the wall near the entrance into the room. Resident #54 stated they were supposed to paint the walls and stated they had re-did the bathroom. Observation of the bathroom revealed it appeared to have been updated but was missing the baseboard along the wall. Interview on 12/03/25 at 11:24 A.M. with Resident #14 (Resident #54's roommate) revealed they were supposed to paint the wall next to his bed but was not sure when. Observation of the wall next to Resident #14's bed was a very long patched area that needed to be painted that ran near the ceiling down to the resident's bed. Interview on 12/03/25 at 2:02 P.M. with Resident #41 stated it was always cold in her room and stated she was told they fixed the heat, but it still felt cool. Observations on 12/04/25 between 10:16 A.M. and approximately 10:30 A.M. during tour with Maintenance Staff (MS) #491 of the residents' rooms. MS #491 stated he had to point the laser temperature gun at a surface to get the temperature because there were no thermostats in the resident rooms. Observation in Residents #14 and #54's room the temperature from the vent was 75 degrees Fahrenheit, the wall by window was 70 degrees Fahrenheit, and the back wall across from beds was 70 degrees Fahrenheit, and the wall by the beds was 71 degrees Fahrenheit. MS #419 verified the walls needed painting and the baseboards placed in the bathrooms. MS #419 stated he was in the process of updating the room but was moved to the assisted living building about a month ago. Observations of the temperature of Resident #4's room revealed from the vent it was 83 degrees Fahrenheit, back wall and the wall by window was 73 degrees Fahrenheit, and the back wall where the television was located was 63 degrees Fahrenheit. Resident #4 stated the room felt cold to him. Observation of Residents #1 and #41's room revealed the temperature from the vent was 56 degrees Fahrenheit, the wall by the window and the wall across from the beds was 61 degrees Fahrenheit, and wall by the beds was 64 degrees Fahrenheit. Both Resident #1 and #41 stated that their room was cold. MS #491 verified it felt cold in Resident #1 and #41's room, even with him wearing a jacket. Observation of Resident #16's room revealed the temperature from the vent was 91 degrees Fahrenheit, but it was blowing out very little and did not spread throughout room. The temperature from the wall by the window was 63 degrees Fahrenheit, the back wall by the bed was 65 degrees Fahrenheit, and the wall across from the bed was 60 degrees Fahrenheit. Further observation of Resident #16's room revealed a large area of wallpaper. During the tour, MS #491 verified the above findings and stated in regards to the repairs, that he and the maintenance director were in the process of completing the rooms, but he was then sent to the assisted living facility and that was about a month ago. MS #491 stated he was not sure what the maintenance director was doing.Observations on 12/04/25 between approximately 11:00 A.M. and 11:15 A.M. with Regional Director of Operations (RDO) #615 of Resident #1 and #41's room verified it was cool. Residents #1 and #41 stated to RDO #615 that it was cold in their room. Observation of Resident #16's room stated he could feel the heat coming from vent when he touched the vent but verified it didn't seem to move around the room. RDO #615 verified the peeling wallpaper near the window and the flooring that was in disrepair near the side of the room by the window. Observation in Resident #14 and #54's room, RDO #615 checked the vent stated he felt heat coming through. At this time Resident #54 stated to RDO #615 that it gets cold in the room at night. RDO #615 verified the walls needed painted, and the baseboard for the bathroom needed installed. Observation of Resident #4's room with RDO #615, Resident #4 stated he was cold and was wearing a coat and hat. RDO #615 stated he felt the heat from the vent but will have it looked at. During the observations RDO #615 verified the findings and stated they recently had someone out regarding the heat but would have someone back out to investigate the heat for Residents #1, #4, #14, #16, #41, and #54. Review of the undated facility policy titled Homelike Environment revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment; and comfortable and safe temperatures (71 degrees