STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366073	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Swanton	214 S Munson Rd Swanton, OH 43558

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews, and review of facility policy, the facility failed to ensure the residents received timely incontinence care and received appropriate incontinence care by the facility policy. This affected one (Resident #505) of one resident observed for incontinence care. The facility census was 63. Findings include:Review of the medical record for Resident #505 revealed they were admitted on [DATE]. Diagnoses included Lewy body dementia, hypertension, anxiety, muscle weakness, and abnormal posture.Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #505 was cognitively impaired and did not display any behaviors at the time of the assessment. He was always incontinent of bowel and bladder.Review of the physician orders for Resident #505 revealed the absence of an order for brief liners.Review of the care plan dated 01/09/25 for Resident #505 revealed an intervention for incontinence care every two hours and as needed.Observation on 01/05/26 at 10:45 A.M. of incontinence care for Resident #505 provided by Certified Nurse Assistants (CNA) #102 and CNA #103 revealed the resident appeared to have a dry brief. Continued observation revealed the resident had two briefs on, one on top of the other, and the brief next to his skin was saturated with urine.Interview on 01/05/26 at 10:50 A.M. with CNA #102 revealed she was unsure how long Resident #505 had a wet brief against his skin as she was unaware the resident had two briefs on. She indicated her every two-hour brief checks since beginning her shift at 7:00 A.M. consisted of checking the outer brief. CNA #102 verified the facility policy prohibited double briefing residents and brief liners could only be used if ordered by a physician.Interview on 01/05/26 at 11:05 A.M. with the Director of Nursing (DON) confirmed double briefing residents was not permitted and brief liners could only be utilized if ordered by a physician. The DON confirmed Resident #505 did not have an order for brief liners.Review of the facility policy titled Perineal Care dated 01/08/25 revealed the facility would provide perineal care to incontinent residents to promote cleanliness, prevent infection, and prevent skin breakdown.This deficiency represents non-compliance investigated under Complaint Number 2647291.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, review of facility policy, the facility failed to ensure residents were free from significant medication errors when they incorrectly transcribed physician orders and failed to administer medication as physician ordered. This affected one (Resident #501) of three residents reviewed for medication administration. The facility census was 63. Findings include:Review of the medical record for Resident #501 revealed they were admitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia, emphysema, and rheumatoid arthritis.Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #501 was cognitively intact. 1. Review of Resident #501's hospice physician orders dated 10/16/25 revealed an order for 0.25 milliliter (mL), equal to five milligrams (mg), of morphine solution 20 mg per one mL, to be administered by mouth every four hours.Review of the medication administration record for October 2025 for Resident #501 revealed an order was incorrectly entered on 10/16/25 for 0.25 mL of morphine solution 20 mg per five mL, equivalent to one mg per dose instead of the ordered five mg per dose, to be administered by mouth every four hours.Review of the controlled medication count sheet for October 2025 for Resident #501's morphine revealed a printed pharmacy label indicating morphine solution of 20 mg per five mL was dispensed to the facility to be administered at 1.25 mL per dose; equivalent to five mg per dose as ordered. The dose printed on the pharmacy label had been changed by hand to 0.25 mL per dose. The controlled medication count sheet revealed this dispensed medication was administered at 0.25 mL per dose, equivalent to one mg per dose instead of the ordered five mg per dose, on 14 occasions on 10/16/25, 10/17/25, and 10/18/25.Interview on 01/06/26 at 9:00 A.M. with the Director of Nursing (DON) confirmed Resident #501 was given one mg of morphine, instead of the ordered five mg of morphine, on 14 occasions on 10/16/25, 10/17/25, and 10/18/25.2. Review of hospice physician orders for Resident #501 revealed an order dated 10/18/25 for 0.5 mL, equal to ten mg, of morphine solution 20 mg per one mL, to be administered by mouth every two hours.Review of the medication administration record for October 2025 for Resident #501 revealed an order was incorrectly entered on 10/18/25 for 0.5 mL of morphine solution 20 mg per five mL, equivalent to two mg per dose instead of the ordered ten mg per dose, to be administered by mouth every two hours.Review of the controlled medication count sheet for October 2025 for Resident #501's morphine revealed a printed pharmacy label indicating morphine solution 20 mg per five mL was dispensed to the facility. Further review of this controlled medication count sheet revealed this dispensed medication was administered at 0.5 mL per dose, equivalent to two mg per dose instead of the ordered ten mg per dose, on 14 occasions on 10/18/25, 10/19/25, and 10/20/25.The progress note dated 10/20/25 for Resident #501 written by Registered Nurse #106 revealed Resident #501 was administered incorrect doses of morphine at two mg instead of the ordered ten mg.Interview on 01/06/26 at 9:00 A.M. with the DON confirmed Resident #501 was given two mg of morphine, instead of the ordered ten mg of morphine, on 14 occasions on 10/18/25, 10/19/25, and 10/20/25.Review of the facility policy titled Medication Administration dated 08/22/22 revealed the facility would administer medications as ordered by the physician.This deficiency represents non-compliance investigated under Complaint Number 2647291.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews, review of facility policies, and review of protocols from Centers for Disease Control and Prevention, the facility failed to ensure infection prevention measures were maintained during wound care. This affected one (Resident #503) of one resident observed for wound care. The facility census was 63.Findings include:Review of the medical record for Resident #503 revealed they were admitted on [DATE] with diagnoses including surgical aftercare on the respiratory system, pulmonary embolism, and traumatic subdural hemorrhage.Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #503 was cognitively impaired and did not display any behaviors at the time of the assessment. He was bedbound and dependent on staff for all care.Review of the physician order dated 12/04/25 for Resident #503 revealed a wound care order to cleanse the distal midline abdominal wound with normal saline, pat dry, apply alginate, and cover with an absorbent silicone dressing once daily and as needed.Observation on 01/05/26 at 10:10 A.M. revealed Licensed Practical Nurse (LPN) #101 performed the dressing change for Resident #503. LPN #101 did not change her gloves after removing the soiled dressing and cleansing the wound before applying the clean dressing. LPN #101 did not disinfect the scissors prior to cutting the alginate and placing it in the wound bed.Interview on 01/05/26 at 10:15 A.M. with LPN #101 confirmed she did not change her gloves after removing the soiled dressing and before applying the clean dressing to Resident #503's abdominal wound, nor did she disinfect the scissors prior to cutting the alginate and placing it in the wound bed.Interview on 01/05/26 at 10:30 A.M. with the Director of Nursing (DON) revealed gloves should be changed after removing a soiled dressing and before applying a clean dressing to a wound, and scissors should be disinfected prior to cutting any dressing items during wound care.Review of the facility policy titled Wound Treatment Management dated 12/01/21 revealed the facility would provide wound treatments in accordance with current standards of practice.Review of the facility policy titled Infection Prevention and Control Program dated 01/07/25 revealed the facility would maintain an infection prevention program that would help prevent infections. All reusable equipment would be cleaned.Review of Centers for Disease Control and Prevention (CDC) protocols revealed bandage scissors should be disinfected prior to use and gloves should be changed when moving from a dirty site to a clean site.This was an incidental finding discovered during the course of the complaint investigation.