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	06/04/2026

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure resident funds were reimbursed timely after discharge. This affected two (#77 and #78) of three residents reviewed for fund disbursement. The facility census was 64.Findings include: 1. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, hypertension, type II diabetes mellitus, lymphedema and major depressive disorder. Resident #77 passed away on 02/02/26 while still admitted to the facility. Review of the funds disbursement check for Resident #77 revealed it was dated 03/30/26. The representative of Resident #77 called the facility after receiving the check and stated it was the wrong refund amount. A second check was disbursed on 04/08/26. Interview on 06/04/26 at 3:00 P.M. with Business office Manager (BOM) #177 revealed upon investigation the first disbursement check amount was incorrect because the representative of Resident #77 came in to the office at the beginning of February and paid the month according to the rate per day in cash and there was no record of the payment. 2. Review of the medical record for Resident #78 revealed an admission date of 03/01/17 with diagnoses of hypertension, seizures, and bipolar disorder. Resident #78 discharged to another long term care facility on 12/03/25. Review of the funds disbursement check for Resident #78 revealed it was dated 02/27/26. Interview on 06/04/26 at 2:08 P.M. with Business Office Manager (BOM) #177 revealed the role of BOM was vacant from approximately the end of December 2025 until she began at the end of January 2026. BOM #177 confirmed Resident #78's funds were not paid out within 30 days due to the vacancy and the process of learning the new role. Review of the undated policy Resident Trust Fund Accounting and Records, revealed the personal needs account must be closed within thirty days of death or discharge. This deficiency represents non-compliance investigated under Complaint Numbers 2808521 and 2727019

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and policy review, the facility failed to provide adequate and timely oral care to a dependent resident. This affected one (#67) resident out of one reviewed for oral care. The facility census was 64. Findings include:Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure, traumatic subdural hemorrhage, aphasia, dysphagia, and tracheostomy.Review of the quarterly Minimum Data Set (MDS) for Resident #67 dated 03/31/26 revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive deficit. No behaviors indicated. Functional abilities included dependence on others for all activities of daily living (ADL) care. Review of revised care plan for Resident #67 dated 04/03/26 revealed staff are to provide oral care every shift and as needed. Review of physician orders entered for Resident #67 on 06/13/25 revealed oral care to be provided every shift and as needed. Observation on 06/02/26 at 5:30 A.M. revealed Certified Nursing Assistant (CNA) #118 and CNA #180 were in with Resident #67 providing incontinence care and repositioning. A white object approximately two inches in length was noted to the right upper lip of Resident #67. CNA #118 felt the object and stated it was skin. CNA #180 voiced to not pull at the object for fear of making Resident #67 bleed. Interview on 06/02/26 at 5:35 A.M. with CNA #118 and CNA #180 revealed because Resident #67 has a tracheostomy, oral care is provided by Respiratory Therapy. Both CNA #118 and CNA #180 verified they did not complete oral care at all during their overnight shift. Interview on 06/02/26 at 5:44 A.M. with Respiratory Therapist (RT) #148 revealed that RT does complete oral care once a shift and as needed. Interview on 06/02/26 at 5:50 A.M. with Registered Nurse (RN) #156 revealed RT provides oral care to residents with a tracheostomy. RN #156 verified she does not provide oral care to residents with a tracheostomy. Interview on 06/02/26 at 6:47 A.M. with the Director of Nursing (DON) revealed RT is assigned to complete oral care once a shift and as needed. CNA's, Licensed Practical Nurses (LPN) and RNs are to complete oral care as needed throughout their shifts. The DON confirmed CNAs, LPNs and RNs are educated on how to provide oral care on residents who have a tracheostomy. Interview on 06/02/26 at 7:45 A.M. with CNA #144 revealed she provides oral care to the outside of the mouth only to residents with a tracheostomy. Interview on 06/02/26 at approximately 1:00 P.M. with Regional Registered Nurse (RRN) #230 revealed CNAs, LPNs and RNs are to complete oral care as needed. RRN #230 continued to state education on oral care to residents with a tracheostomy is provided to all nursing staff upon hire. Review of CNA task documentation with RRN #230 revealed no specific task for completing oral care. Current oral care task states Dependent - helper does all of the effort. Resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity. RRN #230 verified there was no further task documentation noted for oral care. Review of the progress notes for Resident #67 revealed RT completing oral care at least once a shift. No other disciplines documented that oral care was complete. Review of the policy titled Oral Care, dated 2022 revealed it is the practice of the facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases. Review of the undated policy titled Oral Care Procedures for the Dependent Patient, revealed oral care is to be provided every shift, before and after meals as needed. This deficiency represents non-compliance investigated under Complaint Numbers 2734720 and 2727019.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, and policy review, the facility failed to ensure timely and accurate pressure ulcer wound assessments, failed to ensure wound treatments were completed and accurately documented per physician orders. Additionally, the facility failed to ensure pressure ulcer prevention treatments were in place per physician orders. This affected two (#74, #2) of four residents reviewed for pressure ulcers. The facility identified seven residents with pressure ulcers. The facility census was 64. Findings include:1. Review of the medical record for Resident #74 revealed an admission date of 01/19/26 and a discharge date of 01/27/26. Diagnoses included acute and chronic respiratory failure with hypoxia, tracheostomy status, gastrostomy status, hypertension, abnormal weight loss, and type two diabetes mellitus. Review of an admission summary progress note dated 01/19/26 at 7:38 P.M. revealed the resident had an existing buttock wound and the dressing was dry and intact. Review of a skin risk assessment completed 01/19/26 revealed the resident was at high risk for skin breakdown. Review of the admission skin assessment dated [DATE] revealed the resident has a pressure ulcer to the coccyx. There was no assessment of the wound, no wound measurements, and the wound was not staged. Review of a physician order dated 01/20/26 revealed to cleanse the coccyx with normal saline, pat dry, apply nystatin cream, apply zinc oxide cream, leave open to air every shift for wound care.Review of the Treatment Administration Record (TAR) dated 01/20/26 revealed the wound treatment had been completed on the 12-hour day shift and 12-hour night shift by two different nurses. Review of a nurse's note dated 01/21/25 at 2:52 P.M. revealed the resident had asked the nurse to check his coccyx due to increased pain. The nurse observed a dressing dated 01/11/25 in place on the resident's coccyx which had not looked like an in-house facility dressing. The nurse removed the old dressing, and redness was observed around the area. The nurse then completed the wound treatment per physician orders. Review of a nurse practitioner wound care progress note dated 01/22/26 at 8:09 A.M. revealed the resident had a fungal rash to the bilateral buttocks and a new wound treatment was initiated. Interview on 06/03/26 at 11:55 A.M., Licensed Practical Nurse (LPN) #168 revealed when she went to complete the resident's wound treatment on 01/21/26, she found the resident had a dressing on his coccyx dated 01/11/26. LPN #168 revealed the area had not appeared infected. LPN #168 revealed she reported the incident to the Director of Nursing at the time. Interview on 06/03/26 at 1:44 P.M., the Director of Nursing (DON) revealed staff should have removed the hospital dressing, assessed, and measured the residents' wound upon admission to the facility then obtained treatment orders. The DON revealed the resident had no pressure ulcers prior to discharge to the hospital. The DON revealed the wound care provider saw the resident on 01/22/26 and noted the area was a fungal infection and not a pressure ulcer. Further interview with the DON revealed the nurses had incorrectly documented completing the resident's wound treatment on 01/20/26. 2. Review of the medical record for Resident #2 revealed an admission date of 05/16/25. Diagnoses included heart failure, anoxic brain injury, and contractures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was never understood. The resident was dependent on staff for toileting, repositioning, and personal hygiene. The resident was at risk for skin breakdown. Review of the skin integrity care plan dated 05/20/25 revealed an intervention for heel boots per physician orders, and to float heels as tolerated. Review of a physician order dated 05/21/25 revealed an order for heel boots for protection every shift. Review of the TAR on 06/02/26 at 2:22 P.M. revealed Resident #2's heel boots for protection had been documented as in place.Observation on 06/02/26 at 2:22 P.M. during wound care for a stage three pressure ulcer to the coccyx and urinary catheter care for Resident #2 with Licensed Practical Nurse (LPN) #218 and Registered Nurse (RN) #119 revealed the resident had no heel boots in place. The resident's heels were observed resting directly on the mattress. Interview on 06/02/26 at 2:22 P.M., RN #119 verified the resident had no heel boots in place. RN #119 also verified she had (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incorrectly documented the resident's heel boots were in place. Review of the facility policy Wound Treatment Management, dated 01/08/25 revealed wound treatments would be provided per physician orders. The effectiveness of treatments would be monitored though ongoing assessment of the wound. There were no guidelines on assessing a wound. Review of the facility policy Pressure Injury Prevention Guidelines, dated 10/01/23, revealed interventions would be implemented in accordance with physician orders, including the type of prevention devices to be used and for task the frequency for performing them. The effectiveness of interventions would be monitored through ongoing assessment of the resident's wound. This deficiency represents non-compliance investigated under Complaint Number 2727019.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and policy review, the facility failed to ensure monitoring of Legionella control measures were in place. This had the potential to affect all residents. Additionally, the facility failed to wear proper personal protective equipment while caring for a resident in enhanced barrier precautions. This affected one (#67) of one resident reviewed for infection control measures. The facility census was 64. Findings include:1. Review of the facility Legionella Environmental Assessment Form, dated 02/11/26 revealed interventions to prevent Legionella were specific only to the flushing of the closed Assisted Living unit (ALU) showers and bathrooms. Interview on 06/03/26 at 4:00 P.M. with Director of Maintenance (DOM) #219 confirmed the Legionella Environmental Assessment Form was specific only to the ALU. DOM #219 confirmed he had no Legionella prevention measures listed on the Legionella Environmental Assessment Form that were specific to the nursing home. Review of Environmental Monitoring policy dated 09/2018 revealed Legionella prevention monitoring was to include flushing of hot and cold water in rooms that were vacant for ten or more days. The flushing included the running of hot and cold water for five minutes at a time for five different times to be sure the pipes were clear of standing water. Further review of the Environmental Monitoring policy revealed the Legionella prevention intervention of removing and descaling of shower heads quarterly should be in place.Follow up interview on 06/04/26 at 11:10 A.M. with DOM #219 confirmed there was no documentation of flushing of hot and cold water in empty rooms for five minutes at a time for five different times. Additionally, DOM #219 confirmed he was unable to provide documentation showing shower heads were removed and descaled quarterly. DOM #219 continued to state he was unsure where the Environmental Monitoring policy came from as he had never seen it. Interview on 06/04/26 at 3:25 P.M. with Administrator revealed the policies Environmental Monitoring, Infection Control/Water Systems and Water Safety Plan were developed by the previous administrator and it was assumed the policies were developed and shared with DOM #219. 2. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure, traumatic subdural hemorrhage, aphasia, dysphagia, and tracheostomy.Review of the quarterly Minimum Data Set (MDS) for Resident #67 dated 03/31/26 revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive deficit. The resident had no behaviors. Functional abilities included dependence on others for all activities of daily living (ADL) care. Review of physician orders dated 06/14/25 revealed gloves and gown to be worn when dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting as well as during device care or use of central line, urinary catheter, feeding tube, tracheostomy/ventilator.Review of the revised care plan for Resident #67 dated 04/03/26 revealed enhanced barrier precautions were to be in place. Observation on 06/02/26 at 5:30 A.M. revealed Certified Nursing Assistant (CNA) #118 and CNA #180 entered Resident #67's room to provide incontinence care. Gloves were applied; no further personal protective equipment (PPE) was donned. CNA's #118 and #180 continued to cleanse mucous around tracheostomy area, provide incontinence care and reposition Resident #67. Interview on 06/02/26 at 5:35 A.M. with CNA #118 and CNA #180 revealed confirmation neither wore PPE. The Enhanced Barrier Precautions (EBP) signage on the door was reviewed with both CNA #118 and CNA #180, both CNAs stated the EBP sign did not relate to Resident #67, and they were not required to wear PPE when providing care to Resident #67. CNA #180 stated the EBP sign pertained to the roommate of Resident #67, and the roommate was independent in her care. Interview on 06/02/26 at 5:41 A.M. with Licensed Practical Nurse (LPN) #159 revealed Resident #67 was in EBP due to resident having a percutaneous endoscopic gastrostomy (PEG) tube as well as a tracheostomy. LPN #159 confirmed that PPE should be worn when providing care to Resident #67.Review of the policy titled Enhanced Barrier Precautions, dated 07/13/22 revealed EBP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	refers to the use of gown and gloves during high-contact resident care activities. Further review of the policy revealed high contact areas included dressing, bathing, providing hygiene, and changing briefs.This deficiency represents non-compliance investigated under Complaint Number 2734720.