STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. Building B. Wing	08/12/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure residents were transferred using a mechanical (Hoyer) lift in a dignified manner. This affected four residents (#35, #77, #115 and #132) of five residents reviewed for dignity and respect. Findings Include: 1. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, transient cerebral ischemic attack (mini stroke), dementia, generalized anxiety disorder, altered mental status, muscle weakness and metabolic encephalopathy (disturbed brain function). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 07/08/21 revealed the resident was cognitively impaired with a Brief Interview of Mental Status (BIMS) score of six of 15 (severely cognitively impaired). Review of Resident #35's care plan, dated 07/22/21 revealed the resident needed assistance for activities of daily living (ADLs) related to cognitive communication deficits, inability to recognize his own limitations, his dependence for all needs of one to two staff, Alzheimer's dementia with behavioral disturbance and metabolic encephalopathy. Interventions included total assistance from two staff for transferring with the Hoyer lift. Further review of Resident #35's care plan dated 07/22/21 revealed the resident had a cognitive communication deficit related to Alzheimer's dementia and other unspecified dementia, inability to recognize his own needs or limitations for making decisions and was not always able to understand others or express needs. Interventions included promotion of dignity, converse with the resident and ensure privacy while providing care. Another intervention included using the residents preferred name. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/03/21 at 11:06 A.M. Resident #35 was observed being transferred from his wheelchair to his bed by State tested Nursing Assistant (STNA) #224 and STNA #225. During the observation, Resident #35 was observed to be in the bed closest to the door. The resident was in his wheelchair and was positioned in the open doorway of the room. The Hoyer lift (a portable total body lift used to help individuals with mobility challenges transfer from one place to another) was then placed over the resident in the doorway, the resident lift pad was connected to the Hoyer lift, and the resident was raised out of his wheelchair. The Hoyer lift, with Resident #35 lifted in the air, was then pulled out of the doorway, all the way into the hall where multiple staff members and other residents were located. The resident's wheelchair was removed from the doorway and placed in the hall and the resident who was suspended in the air with the Hoyer lift was then pushed back into his room and was lowered into his bed with the door to the room open. On 08/03/21 at 11:32 A.M. interview with the Director of Nursing (DON) revealed residents were regularly lifted on the Hoyer and wheeled in the hall. She stated this was due to a lack of space inside the rooms. On 08/03/21 at approximately 1:15 P.M. interview with Resident #35 revealed he did not know what a Hoyer lift was, he was unable to recall being in the hallway while suspended in the air and he was unable to report how he transferred or if he was provided a dignified transfer. The resident was asked several times using several different types of wording, however, due to the resident's cognitive deficits he was unable to provide information related to the provision of care as it related to dignity. 2. Review of the medical record for Resident #132 revealed an admitted [DATE] with diagnoses including encephalopathy, palliative care, malignant neoplasm of the colon and acute kidney failure. Review of the MDS 3.0 assessment, dated 06/29/21 revealed the resident had impaired cognition with a BIMS score of nine of 15 (moderate cognitive impairment). Review of Resident #132's care plan, dated 06/30/21 revealed the resident had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status related to encephalopathy. Interventions included anticipate the resident's need and keep the resident clean, dry, and comfortable. Promote dignity by conversing with the resident and ensuring privacy was provided while providing care. On 08/03/21 at 4:20 P.M. Resident #132 was observed being lifted from a Broda (tilt-in-space positioning chairs) wheelchair via the Hoyer lift. At the time of the observation, Resident #132's right thigh pink bordered foam dressing and incontinence brief were exposed and visible. The incontinence brief was exposed in the front and also through the hole of the Hoyer lift pad in the back buttock area. On 08/03/21 at 4:30 P.M. interview with Social Service Designee (SSD) #221 revealed Resident #132 would not have been able to make the decision to be transferred in the hall on a Hoyer lift due to her cognitive deficit. On 08/03/21 at 4:40 P.M. interview with STNA Orientee #226 confirmed Resident #132 was lifted out of her wheelchair in the middle of the hallway, wearing just a gown that was raised above her waist. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/03/21 at 4:42 P.M. an attempted interview with Resident #132 revealed she was unable to state whether she felt her dignity was compromised when lifted out of her wheelchair in the hallway to be placed in her bed. During the interview the resident stated, I just want to make sure I have a comfortable bed, after being asked several times and several different ways if she felt her dignity was maintained. 3. On 08/03/21 at 12:30 P.M. interview with Resident #115 revealed she required a Hoyer (mechanical) lift with staff assistance to transfer. During the interview, Resident #115 revealed when staff used the Hoyer, she had to be brought into the hallway because of the space in the room. The resident revealed this made her feel undignified, especially with the gentleman resident across the hall. She also stated she lost her pride and dignity a long time ago when she came into the facility as she had to let the STNA staff do whatever they wanted because when she tried to ask for something different, the staff gave her attitude or they refused to get her up. She stated she would feel much more comfortable, getting transferred in the privacy of her room but she had always been told there was not enough room. The resident's concerns/feelings were shared with the DON on 08/03/21 at 4:00 P.M. 4. On 08/03/21 at approximately 3:00 P.M. interview with Resident #77 revealed she required a Hoyer (mechanical) lift to transfer. During the interview, the resident confirmed when staff raised her in the Hoyer, she was pulled in the hall while suspended in the air. The resident revealed this embarrassed her and she stated her legs were all spread open, but she had to cooperate with staff or they may not have gotten her up. The resident's concerns/feelings were shared with the DON on 08/03/21 at 4:00 P.M. Review of facility undated policy titled Resident Rights revealed each resident had the right to be treated with respect and dignity. This deficiency substantiates Complaint Number OH00124282.

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F 0677 Level of Harm - 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** 44068 Based on observation, record review and interview the facility failed to ensure Resident #99, who was dependent on staff for activities of daily living (ADL) care (including toileting and personal hygiene) and had moisture associated skin damage (MASD) received timely and adequate incontinence care to promote optimal hygiene and skin integrity. Actual harm occurred on 08/02/21 when staff failed to provide timely incontinence care resulting in the resident being observed crying and begging staff to help her. Initial requests for assistance were not immediately provided to the resident resulting in a delay in treatment and sustained levels of pain voiced by the resident. This affected one resident (#99) of three sampled residents. Findings Include: Review of the medical record for Resident #99 revealed an admitted [DATE] with diagnoses including psychosis, peripheral vascular disease, restlessness and agitation, urinary tract infection (UTI), encephalopathy, type two diabetes, hypertension (HTN), dementia, major depressive disorder, anxiety disorder, adult failure to thrive and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 05/20/21 revealed the resident had adequate hearing and vision, clear speech that was usually understood, and usually understood verbal communication. The resident was assessed to have moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of nine of 15. The assessment revealed the resident required total dependence from two or more staff for bed mobility and transfers and was totally dependent on one staff for dressing, toileting and personal hygiene. The assessment revealed the resident utilized a wheelchair for mobility, had a suprapubic (urinary) catheter and was always incontinent of bowel. A plan of care, dated 05/30/21 revealed the resident had a need for assistance with ADLs related to cognitive and communication deficits. Interventions included a geriatric chair when out of bed to correct posture when leaning, provide incontinence care with routine rounds and as needed (PRN). Resident #99 also had a plan of care which indicated she was incontinent of bowel and bladder. Interventions included providing incontinence care every two hours and as needed. A non-pressure skin grid, dated 07/27/21 revealed Resident #99 had MASD that had developed on 07/06/21 which the facility documented as healed as of 07/27/21. On 08/02/21 at 11:39 A.M. Resident #99 was observed in a chair sitting at the nurse's station verbalizing she wanted to lay down. The resident was heard verbalizing she was tired and had been up in chair since 6:30 A. M. The resident continued to vocalize crying and begging please help me and stating nobody will help me. At the time of the observation, Licensed Practical Nurse (LPN) #200 was observed standing at the nurses' station right in front of the resident. LPN #200's back was toward the resident. LPN #200 turned around and told the resident she would help Resident #99 shortly. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 08/02/21 at 11:45 A.M. Resident #99 remained up in the chair at the nurse's station and continued to cry out begging please. On 08/02/21 at 11:48 A.M. interview with LPN #200 revealed she was unsure what time staff had assisted Resident #99 out of bed and into the chair on this date. At the time of the interview, observation of Resident #99 revealed she continued to cry out stating, my (explicit) hurts so bad, help me, please put me cream on down there, please put cream on me, I'm in pain, On 08/02/21 at 11:54 A.M. Resident #99 continued to yell out in pain stating, if you don't hurry and put me in the bed, I'm going to throw myself, I don't care if I die, it hurts so bad, please help me, I hurt, I'm burning, I'm burning, help me please. On 08/02/21 at 11:55 A.M. (16 minutes after the surveyors initial observation), LPN #205 and LPN #99 were observed to assist Resident #99 to bed. At the time of the observation, interview with LPN #205 revealed she was not sure what time staff had assisted Resident #99 out of bed that A.M. or what time she had last been checked/changed for incontinence. On 08/02/21 at 11:58 A.M. interview with State tested Nursing Assistant (STNA) #207 revealed she had assisted with getting Resident #99 out of bed that morning and indicated it was at 7:30 A.M. During the interview, STNA #207 denied laying the resident down or checking her for incontinence since that time (over four hours earlier). The STNA later indicated she wasn't sure what time she had assisted with getting the resident out of bed, but that it was before breakfast (served at 8:30 A.M.) On 08/02/21 at 12:00 P.M. STNA #207 was observed providing incontinence care to Resident #99. The resident was observed screaming in pain during the procedure and was observed to have bright red pinpoint bleeding, reddened surrounding skin, and excoriated skin in between her thighs and buttocks. The resident had been incontinent of bowel. The resident begged for barrier cream to be applied stating she was in so much pain. The resident was observed to tighten all her muscles and was screaming out in pain while being cleansed with the washcloth. LPN #205, who was present in the room for the observation confirmed the condition of the resident's skin having pinpoint bleeding and excoriation. At the completion of care, Resident #99 remained in bed crying out in pain. On 08/03/21 at 2:10 P.M. interview with the Director of Nursing (DON) revealed it would not be appropriate for a resident to be left in bed or in their chair when they were requesting to get up or to lay down. On 08/09/21 at 11:42 A.M. interview with the DON revealed incontinent residents were checked and changed every two hours during rounds, as needed, upon request and per the resident's preference. This deficiency substantiates Complaint Number OH00124357.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on record review and interview the facility failed to ensure Resident #124, who had a diagnosis of dementia received appropriate treatment to maintain her highest practicable level of well-being. This affected one resident (#124) of three residents reviewed for medication administration. Findings Include: Review of the medical record for Resident #124 revealed an admitted [DATE] with diagnoses including dementia, adult failure to thrive, muscle weakness, major depressive disorder, cognitive communication deficit, malignant neoplasm of the vulva, polyneuropathy (multiple peripheral nerve damage that causes pain) and schizoaffective disorder. Review of the hospital discharge summary revealed the resident was to continue taking Donepezil (Aricept) 10 milligrams (mg) at bedtime, Neurontin 300 mg at bedtime and Remeron 15 mg at bedtime. Review of an order, dated 07/15/21 at 12:22 P.M. revealed Physician #215 agreed to admit the resident to skilled nursing care, reviewed and approved all orders and the plan of care (POC). Review of the admission Minimum Data Set (MDS) assessment, dated 07/20/21, revealed Resident #124 had adequate vision and hearing, had clear speech that was understood, and understood verbal communication. The resident had impaired cognition with a Brief Interview of Mental Status (BIMS) score of three of 15 (severely cognitively impaired). The resident had difficulty focusing attention and disorganized thinking that fluctuated. Review of the nursing progress notes, dated 07/20/21 at 11:29 A.M. and completed by Physician Assistant (PA) #214 revealed Resident #124 had significant dementia with memory impairment but was not being medicated for her dementia. The note also revealed the resident had much anxiety. Adult failure to thrive was not listed on the PA note. Record review revealed an order, dated 07/22/21 (seven days after the resident's admission) at 10:56 A.M. for Donepezil HCl 10 mg by mouth at bedtime for dementia (which was ordered by PA #214). In addition, an order was also noted for Remeron 15 mg once a day at bedtime on this date, also ordered by PA #214. Review of the nursing progress note, dated 07/22/21 at 9:04 P.M. by PA #214 for Resident #124 revealed the resident had adult failure to thrive that was previously noted and was managed with Remeron. The PA reinitiated the Remeron 15 mg nightly. He also reinitiated Aricept 10 mg nightly for her dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pre-Admission Screen and Resident Review (PASRR) completed by Licensed Social Worker (LSW) #218 and reported on 07/23/21 revealed the assessment occurred on 07/20/21. The resident's nurse on the day of the assessment was Licensed Practical Nurse (LPN) #213. The resident was seeing things that were not seen by others and noted the resident was not receiving Aricept or Remeron she had been taking while hospitalized . LSW #213 documented the medications were not being administered by the facility in error and the facility nurse, LPN #213 informed LSW #218 a medication review would occur. Review of the plan of care, dated 07/26/21 revealed Resident #124 was at risk for exhibiting behaviors due to depression and dementia with behaviors. Interventions included establishing a routine to reduce confusion for the resident, redirecting the resident if a behavior occurred, orienting the resident to her surroundings and reporting the behaviors that could affect the resident's quality of life. Further review of the care plan revealed Resident #124 had the potential for alteration in comfort related to polyneuropathy. Interventions included encourage the resident to request pain medication and offer analgesics per medical doctor (MD) orders. The care plan revealed the resident needed assistance for activities of daily living (ADL's) related to cognitive impairment and pain. Interventions included praise for ADL self-performance and provide assistive devices to increase ADL self-performance. Review of medication administration records (MAR) for July 2021 revealed Resident #124 did not receive any medication for her dementia or adult failure to thrive until 07/22/21. She also did not receive any medication for her polyneuropathy. On 08/03/21 at 1:14 P.M. Resident #124 was observed sitting up in a chair and watching television. Interview with the resident at the time of the observation revealed the resident made comments including someone is trying to kill me, they already killed two girls. Not in here, out there. She was unable to state who was trying to harm her or why she felt they were trying to harm her. The resident was unsure of the year, month, season, or place and was oriented only to herself. On 08/03/21 new orders were noted from PA #214 to increase the resident's Remeron to 30 mg by mouth at bedtime for failure to thrive. A new order for Abilify 10 mg by mouth one time a day for schizoaffective disorder was also ordered by PA #214. Review of the nursing progress note, dated 08/03/21 at 6:59 P.M. by PA #214 revealed Resident #124 had lost six pounds since being in the facility and her Remeron was increased to 30 mg nightly to stimulate her appetite. The PA also indicated the resident was experiencing visual hallucinations, was likely having psychosis secondary to her dementia. She was started on Abilify 10 mg daily to treat her hallucinations. There was no mention of the lack of transcription of medications from the hospital discharge medication list or the failure to administer the medications upon her initial admission to the facility. On 08/09/21 at 1:20 P.M. information from the Director of Nursing (DON) revealed no clarification related to the hospital discharge order for Neurontin for Resident #124. The DON revealed she was not sure if the physician or PA #214 had addressed the need to continue or discontinue the Neurontin medication at the time of admission. Attempts to obtain additional information as to why the medications, Aricept, Neurontin and Remeron were not continued at the time of admission were unsuccessful (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/21 at 3:33 P.M. email communication from Regional Registered Nurse (RN) #230 to the surveyor revealed staff were able to speak with the surveyor regarding the medications from the hospital discharge summary for Resident #124. However, after providing surveyor contact information, no additional information was provided as no contact was made. This deficiency substantiates Complaint Number OH00124357.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on observation, record review, facility policy and procedure review and interview the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 10.71% and included three medication errors of 28 medication administration opportunities. This affected two residents (#129 and #67) of three residents observed for medication administration. Findings Include: 1. Review of the medical record for Resident #129 revealed an admitted [DATE] with diagnoses including vascular dementia with behavioral disturbance, anxiety and hypertension (HTN). Review of the physician order, dated 08/05/20 at 5:22 P.M. for Resident #129 revealed an order for Namenda extended release (XR) 14 milligrams (mg) capsule by mouth one time a day related to vascular dementia with behavioral disturbance. Review of the physician order, dated 11/25/20 at 4:09 P.M. for Resident #129 revealed an order for to give 12.5 mg of Metoprolol tartrate by mouth two times a day for hypertension. Review of the physician order dated 02/27/21 at 3:09 P.M. for Resident #129 revealed an order that medication may be crushed and cocktailed (mixed together) unless contraindicated. Review of the plan of care dated 07/13/21 revealed Resident #129 had a cognitive deficit related to vascular dementia and was at risk for further decline in cognitive status. Interventions included administration of medications as ordered. On 08/03/21 at 9:50 A.M. Resident #129 was observed sitting in her wheelchair in her doorway. Licensed Practical Nurse (LPN) #217 asked the resident if she would like her medication crushed or whole today. The resident told LPN #217 that it did not matter to her initially but then stated crushed were easier to take. On 08/03/21 at 9:53 A.M. LPN #217 administered Resident #129's medications to her crushed with the exception of her Fish oil and pain medication. On 08/03/21 at 9:54 A.M. interview with LPN #217 confirmed no medications were cut in half nor were half tabs administered and all of the medications except the pain medication and the Fish oil were crushed. A whole 25 mg tablet of Metoprolol tartrate was administered and the Namenda XR was crushed. This resulted in two medication errors for the resident. Review of information contained on WebMD titled Metoprolol Tartrate revealed the medication needed to be taken regularly as prescribed to get the most benefit from it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of information contained on WebMD titled Namenda XR revealed the medication was to be swallowed whole. The medication was not to be chewed or crushed. Crushing or chewing the medication could release all of the drug at once, increasing the risk of side effects since it was an extended release medication. Review of facility policy titled Medication Pass Guidelines, revised 07/2018 revealed medications should not be crushed without a physician's order and without checking the do not crush medication list. Further review of the policy revealed extended or time released medication were not crushable. 2. Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including unilateral primary osteoarthritis of the left knee, pain in left knee, hypertension, secondary pulmonary hypertension, hyperlipidemia, generalized muscle weakness, other abnormalities of gait and mobility, difficulty in walking, need for assistance with personal care, dementia with behavioral disturbance, age related osteoporosis, mixed irritable bowel syndrome, insomnia, Vitamin D deficiency, hypokalemia, polyosteoarthritis, allergic rhinitis and major depressive disorder. Review of the plan of care, dated 07/26/21 revealed Resident #67 experienced pain/discomfort OR had the risk for pain/discomfort related to osteoarthritis and dementia. Interventions included administration of pain medications as ordered, observe for pain every shift, and be aware of the resident's admitting diagnosis to ensure pain medication had been ordered. Review of the nursing progress notes, dated 07/15/21 at 4:02 P.M. by PA #214 for Resident #67 revealed the resident's potassium blood test was low at 2.8 (normal range was 3.6-5.2) and the physician ordered Potassium chloride 20 milliequivalents (mEq) by mouth twice daily. Review of the physician order dated 07/29/21 at 9:27 P.M. revealed an order for Potassium Chloride 20 (MEQ) extended release (ER) tablet by mouth one time a day for hypokalemia (low potassium). On 08/03/21 at 9:58 A.M. observation of medication administration for Resident #67 revealed LPN #217 administered all of the resident's medication, including the Potassium Chloride crushed in pudding. On 08/03/21 at 10:03 A.M. interview with LPN #217 confirmed all of the medications including Resident #67's Potassium chloride 20 MEQ ER tablet were crushed and administered. This resulted in one medication error for the resident. Review of information contained on WebMD titled Potassium Chloride Tablet, Extended Release Particles/Crystals revealed the medication was not to be crushed, chewed or sucked on. Doing so could release all of the drug at once, increasing the risk of side effects since it was extended release. Review of facility policy titled Medication Pass Guidelines, revised 07/2018 revealed medications should not be crushed without a physician's order and without checking the do not crush medication list. Further review of the policy revealed extended or time released medication were not crushable. This deficiency substantiates Complaint Number OH00124357.

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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. 44068 Based on observation, review of Centers for Disease Control and Prevention (CDC) guidance, review of World Health Organization (WHO) guidance for glove use and interview the facility failed to maintain adequate infection control practices to prevent the development and transmission of communicable diseases and infections. This affected three residents (#42, #127 and #95) and had the potential to affect all 129 residents residing in the facility. Findings Include: The following infection control concerns were observed during the onsite investigation: 1. On 08/02/21 at 10:48 A.M. Resident #127 was observed inside Resident #42's room. Resident #127 was observed to sit on Resident #42's bed. At the time of the observation, State tested Nursing Assistant (STNA) #203 also observed Resident #124 from outside the room with the surveyor and watched Resident #127 until he sat down on Resident #42's bed. The STNA proceeded to walk down the hall. On 08/02/21 at 10:53 A.M. interview with STNA #203 revealed residents sometimes sit on other resident's beds even though they should not. She stated on the memory care units it was often difficult to redirect residents. However, the STNA confirmed she had not attempted to redirect Resident #127 prior to the resident entering or sitting on another resident's bed. Review of the Centers for Disease Control and Prevention (CDC) guidance titled, How Infections Spread, revised 01/07/16 revealed many germs live in and on our bodies and can be transferred from one person to another through contact, sprays, splashes, inhalation and/or through a puncture. 2. On 08/02/21 at 10:57 A.M. Housekeeper #202 was observed in the common area on D hall cleaning. The housekeeper was observed wearing a surgical mask, however the mask was placed below the housekeepers nose. At the time of the observation, Physical Therapy Assistant (PTA) #220 was also observed sitting at a table in the common area on his laptop with his mask below his nose and mouth. Interview immediately following the observation at 10:58 A.M. with PTA #220 confirmed his mask was not being worn properly as it was below the nose and mouth. He confirmed the masks were to be worn covering the nose and mouth. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Guidance for Wearing Masks, updated 04/19/21 revealed masks should completely cover the nose and mouth. 3. On 08/02/21 at 11:00 A.M. Housekeeper #202 was observed cleaning Resident #95's room. The surveyor asked Housekeeper #202 for the code to exit the unit and Housekeeper #202 proceeded to exit the room and while wearing the same gloves in the room to clean, entered the code for the surveyor to exit the unit. The housekeeper then returned to the resident's room to resume cleaning. Interview immediately following the observation with Housekeeper #202 confirmed the observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. Building B. Wing	08/12/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of World Health Organization (WHO) information leaflet titled Glove use, revised 08/09 revealed gloves should be removed when an indication for hand hygiene followed a contact that had required gloves. Hand rubbing or hand washing should occur after the removal of gloves. When an indication for hand hygiene applied while the health-care worker was wearing gloves, then gloves should be removed to perform hand rubbing or handwashing. 4. On 08/02/21 at 11:31 A.M. State tested Nursing Assistant (STNA) #208 was observed on the G hall wearing gloves while carrying bagged/soiled linen. Interview immediately following the observation revealed the STNA indicated he was assisting a resident with care in the last room on the right of the hall and picked up the resident's wet blanket to bring it to the soiled utility for it to be washed. There was no indication the employee was wearing clean gloves or had changed his contaminated gloves prior to exiting the room to go to the soiled utility room. This deficiency is an incidental finding to Master Complaint Number OH00124357.