

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Andover Village Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 486 S Main St Andover, OH 44003	

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 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. (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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy revealed the facility did not ensure pressure ulcer injuries were assessed and documented timely and accurately when identified. This affected one Resident (#64) out of three residents reviewed for pressure ulcers. This had the potential to affect seven Residents (#8, #9, #10 #14, #18, #29, and #43) the facility identified with pressure ulcers. The facility census was 63. Findings Include: Review of closed medical record for Resident #64 revealed an admission date of 07/10/25 and she was discharged home with home health on 08/19/25. She later readmitted back to the facility on [DATE] and then was sent to the hospital on [DATE]. Her diagnoses included fracture of right femur, malignant neoplasm of breast, malignant neoplasm of lung, malignant neoplasm of the bone, and hypertension. Review of July 2025 physician orders for Resident #64 revealed an order dated 07/25/25 to pad and protect the right heel with skin prep, and foam dressing three times a week and as needed. Review of care plan dated 07/10/25 revealed Resident #64 had impaired skin integrity and was at risk related to cancer, pain, impaired mobility and poor nutrition. The care plan revealed she refused to turn and reposition, wear her prevalon boots (boots with cushioned bottom that float the heels off the surface of the mattress), incontinence care, and showers. Interventions included two-hour time limit while in wheelchair, skin checks with showers and report abnormalities, low air loss mattress, encourage resident to elevate heels off surface of mattress and side to side turns. Review of nursing notes from 07/10/25 to 07/28/25 for Resident #64 revealed no documentation of her right heel having any skin impairment including on 07/25/25. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #64 had intact cognition and had impairment on one of her lower extremities. She was dependent of staff assistance with toileting, putting on footwear, and dressing. She required substantial to maximum assistance of staff with showers and transfers. She required partial to moderate assistance with rolling left and right. She was at risk for developing a pressure ulcer and had no unhealed pressure ulcers on admission. Observation of text message dated 07/25/25 at 5:43 A.M. sent from Licensed Practical Nurse (LPN) #616 to Resident #64's daughter revealed a picture of a heel that had a dark discolored circular area noted to the center of the heel. The text message revealed Resident #64's daughter asked who's heel that was and the message stated, mom's and that Certified Nursing Assistant (CNA) #602 had found it. Review of nursing note dated 07/28/25 at 8:54 A.M. and completed by LPN #616 revealed Resident #64's skin was checked prior to her leaving for the appointment and she did not have any new areas. Review of nursing note dated 07/28/25 at 10:50 A.M. and completed by LPN #616 revealed Resident #64 returned from the appointment and a skin check was completed. There was a new area to her right heel that was purple and non-blanching. Review of Wound Assessment- V1 dated 07/28/25 and completed by LPN/ Wound Nurse #612 revealed Resident #64 had a new pressure ulcer to her right heel that was identified as a community acquired pressure ulcer as it was present on return from her appointment. The pressure ulcer measured a length of 2 centimeters (cm), width of 2 cm and had no depth. The pressure ulcer was suspected to be a deep tissue injury and was described with 100 percent epithelial tissue. The assessment revealed the treatment was to clean the area with normal saline, apply skin prep and foam dressing three times a week. Interview on 09/30/25 at 8:00 A.M. with Resident #64's daughter revealed on 07/25/25 at 5:43 A.M. she received a text message as well as a picture from LPN #616 that Resident #64 had a pressure ulcer to her right heel. She revealed the area was dark purple in color. She revealed she used to work at the facility as a Registered Nurse (RN) and was upset as the facility did not document the pressure ulcer on 07/25/25 and they had falsified the documentation on 07/28/25 stating the pressure ulcer was found upon Resident #64's return from her appointment which was not accurate. Interview on 11/24/25 at 11:48 A.M. with LPN #616 revealed on 07/25/25 when she first came on duty CNA #602 had come up to her and reported she found an area to Resident #64's right heel. She revealed she assessed the area and took a picture of the heel. She described the heel as a small discolored dark area that appeared as a deep tissue injury. She verified she had sent a text message and the picture to Resident #64's daughter on 07/25/25 informing her of the new area and the area was found per CNA #602. She revealed she notified the Director of Nursing (DON) of the area as well as showed the DON the picture and she was told let's see if it resolves. She revealed the DON did not want anything charted regarding the pressure area. LPN #616 verified the DON did not come out and directly say not to document but that she knew what it meant by let's see if it resolves and she had known from the past the facility does not want any</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and facility staff interview the facility failed to ensure the medical record was accurate. This affected one, Resident #64, of three reviewed for wounds. The facility census was 63. Findings Include: Review of closed medical record for Resident #64 revealed an admission date of 07/10/25 and she was discharged home with home health on 08/19/25. She later readmitted back to the facility on [DATE] and then was sent to the hospital on [DATE]. Her diagnoses included fracture of right femur, malignant neoplasm of breast, malignant neoplasm of lung, malignant neoplasm of the bone, and hypertension. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #64 had intact cognition and had impairment on one of her lower extremities. She was dependent of staff assistance with toileting, putting on footwear, and dressing. She required substantial to maximum assistance of staff with showers and transfers. She required partial to moderate assistance with rolling left and right. She was at risk for developing a pressure ulcer and had no unhealed pressure ulcers on admission. Review of care plan dated 07/10/25 revealed Resident #64 had impaired skin integrity and was at risk related to cancer, pain, impaired mobility and poor nutrition. The care plan revealed she refused to turn and reposition, wear her prevalon boots (boots with cushioned bottom that float the heels off the surface of the mattress) Interventions included two-hour time limit while in wheelchair, skin checks with showers and report abnormalities, low air loss mattress, encourage resident to elevate heels off surface of mattress and side to side turns. Review of July 2025 physician orders for Resident #64 revealed an order dated 07/25/25 to pad and protect the right heel with skin prep, and foam dressing three times a week and as needed. Review of nursing notes from 07/10/25 to 07/28/25 for Resident #64 revealed no documentation of her right heel having any skin impairment including on 07/25/25. Observation of text message dated 07/25/25 at 5:43 A.M. sent from Licensed Practical Nurse (LPN) #616 to Resident #64's daughter revealed a picture of a heel that had a dark discolored circular area noted to the center of the heel. The text message revealed Resident #64's daughter asked who's heel that was and the message stated, mom's and that Certified Nursing Assistant (CNA) #602 had found it. Review of nursing note dated 07/28/25 at 8:54 A.M. and completed by LPN #616 revealed Resident #64's skin was checked prior to her leaving for the appointment and she did not have any new areas. 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Interview on 09/30/25 at 8:00 A.M. with Resident #64's daughter revealed on 07/25/25 at 5:43 A.M. she received a text message as well as a picture from LPN #616 that Resident #64 had a pressure ulcer to her right heel. She revealed the area was dark purple in color. She revealed she used to work at the facility as a Registered Nurse (RN) and was upset as the facility did not document the pressure ulcer on 07/25/25 and they had falsified the documentation on 07/28/25 stating the pressure ulcer was found upon Resident #64's return from her appointment which was not accurate. Interview on 11/24/25 at 11:48 A.M. with LPN #616 revealed on 07/25/25 when she first came on duty CNA #602 had come up to her and reported she found an area to Resident #64's right heel. LPN #616 revealed she assessed the area and took a picture of the heel. She described the heel as a small discolored dark area that appeared as a deep tissue injury. She confirmed she had sent a text message and the picture to Resident #64's daughter on 07/25/25 informing her of the new area and the area was found per CNA #602. LPN #616 revealed she notified the Director of Nursing (DON) of the area as well and showed the DON the picture and she was told let's see if it resolves. LPN #616 stated the DON did not want anything charted regarding the pressure area, clarifying, the DON did not come out and directly say not to document the area, but that she knew what it meant when the DON stated let's see if it resolves. LPN #616 stated she had known from the past the facility does not want any pressure ulcers identified as facility acquired. She revealed the DON had had given the directive when Resident #64 returned from her appointment on 07/28/25 to document the wound was identified on her return from the</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and review of facility policy, the facility failed to ensure proper infection control measures were maintained during tracheostomy (a surgical opening in the neck to provide direct airway into the windpipe) care. This affected one Resident (#53) out of one resident observed for tracheostomy care. This had the potential to affect 11 Resident (#2, #4, #9, #10, #21, #38, #43, #48, #53, #59, and #66) identified by the facility with tracheostomies. The facility census was 63. Findings included: Review of medical record for Resident #53 revealed an admission date of 12/12/22 with diagnoses to included chronic respiratory failure with hypoxia, cerebral infarction, and presence of tracheostomy. Review of care plan dated 12/13/22 revealed Resident #53 was at risk for respiratory distress due to respiratory failure, tracheostomy and oxygen. Interventions included administer oxygen as ordered, maintain tracheostomy as ordered, suction as ordered, and monitor for signs of respiratory distress. Review of quarterly minimum data set (MDS) dated [DATE] revealed Resident #53 was identified in a persistent vegetative state and had no discernable consciousness. He had a tracheostomy, used oxygen and needed suctioned. Review of November 2025 physician orders revealed Resident #53 had the following orders: change daily and as needed his disposable inner cannula (a sterile single-use tube that fits inside the tracheostomy tube's outer cannula to help prevent infection and keep the airway clear of mucus), and tracheostomy care every shift and as needed. Observation on 11/25/25 at 7:15 A.M. revealed Respiratory Therapist (RT) #600 applied a gown and walked into Resident #53's room. She proceeded to wash her hands, applied gloves and walked over to his bedside where the room was not well lit as she did not turn on the over- the- bed light. She removed Resident #53's split gauze dressing under his tracheostomy, and his inner cannula. She disposed of the gauze and inner cannula, removed her gloves and proceeded to wash her hands. RT #600 then applied sterile gloves from the tracheostomy kit and proceeded to take a gauze pad that was soaked in normal saline and wiped underneath his tracheostomy and stated, oh. RT #600 reached up with her right gloved hand and pulled the light switch cord. She stated she had thought the area was red and wanted to take a closer look but stated the site was not red. RT #600 proceeded to take another gauze dressing soaked with normal saline with the same right gloved hand and proceeded to clean above the tracheostomy. RT #600 used a single sweep on each side with the gauze. RT #600, then took a new disposable cannula from the container and inserted using her right-gloved hand. RT #600 proceeded to doff her gloves, gown and washed her hands. Interview on 11/25/25 at 7:25 A.M. with RT #600 verified she had applied sterile gloves and started cleaning his tracheostomy site but during the care she had reached up and pulled on the light cord above the bed to turn on the light with her right gloved hand. She verified she continued to wear the same gloves and proceeded to complete the tracheostomy care and replaced his disposable inner cannula without washing her hands and re-gloving after touching the light cord. She stated, I was not thinking and turned on the light and verified she contaminated her clean sterile gloves when she touched the light cord. Interview on 11/25/25 at 7:35 A.M. with Director of Nursing (DON) verified the RT and/or nurse needed to maintain a sterile clean field and not cross contaminate her gloves during tracheostomy care and replacing the inner cannula. She revealed touching other items including pulling the light cord during the care would be an infection control issue. Review of facility policy labeled, Tracheostomy Care dated August 2013 revealed the purpose of the procedure was to guide tracheostomy care and the cleaning of. The general guidelines included aseptic technique must be used when tracheostomy tube changes (either reusable or disposable) were completed. The policy revealed gloves must be worn on both hands during any manipulation of the tracheostomy and sterile gloves must be used during aseptic procedures. The staff was to remove and dispose of the inner cannula and replace with another sterile inner cannula. In addition, the policy revealed for tracheostomy site and stoma care the staff was to apply clean gloves and clean with saline soaked gauze pads using a single sweep for each side, then rinse and dry in same manner. There was nothing in the policy regarding ensuring to maintain aseptic technique including not touching other items or surfaces during care including pulling the light cord. Review of facility competency test labeled, Trach Care Competency dated 04/18/25 and completed by RT #600 with the DON overseeing revealed the staff was to wash their hands, don gown, gloves and mask (if applicable). The staff was to remove and dispose of the trach dressing while observing the condition of the surrounding skin. The competency revealed the staff was to remove gloves, wash hands and don sterile gloves and proceed to clean the skin under the flange</p>		