

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Pickaway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 391 Clark Drive Circleville, OH 43113	
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 - Immediate jeopardy to resident health or safety 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 record review, observation, resident and staff interviews, wound physician interview, review of wound notes, review of hospital records, review of information from the National Pressure Injury Advisory Panel (NPIAP), review of specifications for air mattresses, and policy review, the facility failed to ensure the physician ordered treatments were completed as directed and failed to ensure interventions were implemented to prevent the development of, worsening of and promote the healing of an avoidable facility acquired pressure ulcer for Resident #5. Resident #5 was at risk for pressure ulcer development and dependent on staff for activities of daily living (ADLs) including transfers, and toileting and required max assist with bed mobility, turning and repositioning, and had a known sacrum stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough, a yellowish, stringy dead tissue or eschar, a layer of dead, dry tissue that forms a dark leathery scab over the ulcer may be present on some parts of the wound bed. Often includes undermining and tunneling). This resulted in Immediate Jeopardy and actual harm when the facility failed to implement effective interventions to prevent the development of and adequately treat an avoidable facility acquired pressure ulcer to right lateral thigh. On 08/14/25, Resident #5 developed a facility acquired deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) pressure ulcer to right thigh. This was assessed and staged by Licensed Practical Nurse (LPN) #1010. On 08/21/25 the deep tissue injury (DTI) to right thigh progressed to stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). The facility continued incorrect treatment orders for the pressure ulcer areas resulted in declining of both areas of sacrum and right thigh, and hospitalization on 09/23/25 for osteomyelitis. Due to continued incorrect treatments, the wound deteriorated, and Resident #5 was hospitalized again on 10/23/25 for ongoing osteomyelitis and sepsis to a stage IV wound on the sacrum. Resident #5 had increased pain to right hip/thigh and the pressure wound increased drastically in size, developed necrosis (death of tissue) of right lateral thigh stage III pressure ulcer, and myositis (muscle inflammation caused by injury or infection). Resident #5 was still being treated for both pressure ulcer areas. Actual Harm occurred to Resident #41, who was at risk for pressure ulcer development and/or alteration in skin integrity when the facility failed to provide the necessary care and services for the prevention and development and then worsening of a Stage III pressure ulcer. Resident # 41 assessed by LPN #1010 with an in-house facility acquired avoidable coccyx pressure ulcer, with no staging on 08/26/25. On 08/28/25, Wound Physician #1127 assessed and staged the coccyx pressure ulcer as a stage III. In addition, harm also occurred on 09/22/25 when Resident #41 was assessed with a blister to the left heel by LPN #1110. On 09/25/25, Wound Physician #1127 assessed the left heel as an in-house facility acquired avoidable deep tissue injury progressing to a stage III then unstageable due to incorrect treatments and care. Lastly, the facility did not ensure pressure ulcer prevention measures and care were in place and accurate for Residents #99 and #82. This affected four residents (Residents #5, #41, #99, (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and #82) of five residents reviewed for pressure ulcer care. The facility census was 84. On 01/14/26 at 10:14 A.M., the Administrator, Regional Clinical Services (RCS) Registered Nurse (RN) #1128, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 08/14/25 when the facility failed to provide correct treatment orders, accurate assessments, and necessary interventions to Resident #5 to prevent an avoidable facility acquired pressure ulcer to right thigh and the declining of that pressure ulcer as well as a known stage IV pressure ulcer to sacrum resulting in hospitalization on 09/22/25 for osteomyelitis/sepsis. Resident #5 returned to the facility 09/26/25 and was sent back to the hospital on [DATE] with continued inaccurate treatments and necessary interventions to prevent worsening of the pressure ulcers and was found to have possible osteomyelitis of the sacrum stage IV pressure ulcer and soft tissue necrosis and myositis to the right lateral thigh unstageable pressure ulcer. Resident #5 returned to the facility on [DATE] and continued to have inaccurate treatments and necessary interventions to prevent worsening of the pressure ulcers as of 01/07/26. The Immediate Jeopardy was removed on 01/14/26 when the facility implemented the following corrective actions: -On 01/13/26 at 2:00 P.M., Skin sweeps initiated by Unit Manager LPN #1010, Unit Manager LPN #1032, Assistant Director of Nursing (ADON) and Registered Nurse (RN) #1001 on all residents in house. All skin sweeps were completed by 5: 30 P.M. with any new areas noted and reported to the provider. Results of skin sweeps revealed seven residents with skin issues: one skin tear, one venous ulcer, one scratch, one excoriation, two deep tissue injuries (DT)2I, one stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister) and one blister. Residents with areas found on skin sweep included Residents #57, #29, #36, #76, #69, #5 and #9. -On 01/13/26 at 2:43 P.M. the DON spoke via phone with Wound Physician #1127 and went over all current treatment orders for residents under her care. All treatment orders currently ordered are correct. Total of seven residents including Residents #5, #87, #77, #83, #5 and #57 had orders clarified. -On 01/13/26 at 2:45 P.M. the DON educated via phone, Wound Physician #1127on writing treatment orders more specific. - On 01/13/26 at 2:50 P.M. the DON reviewed air mattress manuals for setting information. - On 01/13/26 at 3:00 P.M., education started by the DON for licensed nurses when clarifying wound orders to ensure documentation to support the notification, air mattress settings are correct, orders entered and care planned, pressure reducing interventions are in place, LPN's cannot stage pressure ulcers or assess them, they must be completed by an RN and assessments need to be completed on admission for wounds to include measurements length, width, and depth and a description of wound. Five of ten RNs were educated in person, and five of ten RNs were educated via phone. 11 of 19 LPNs were educated in person and eight of 19 educated via phone. This was completed by 7:00 P.M. - On 01/13/26 at 3:00 P.M. education started by the DON for certified nursing assistants (CNA) on ensuring pressure reducing interventions are in place and not to change air mattress settings. 22 of 49 CNAs were educated in person with 27 of 49 CNA's educated via phone. This was completed by 7:00 P.M. - All staff not educated will be educated prior to the next working shift by the DON or designee. - On 01/13/26 at 3:40 P.M. Regional Nurse #1054 and Regional Clinical Services RN #1128 audited all air mattresses to ensure proper air mattress settings are in place. Any abnormalities were corrected at that time. All orders are in place, care planned and on Kardex. Floor nurses will monitor settings moving forward to ensure proper settings in place. Current residents with air mattresses included Residents #28, #57, #32, #42, #73, #82, #33, #1, #15, #39, #2, #34, #90, #31, #87, #20, #99, #85, #71, #41, #5, #77 and #72. - On 01/13/26 at 4:00 P.M. the DON reviewed via phone all other treatment orders currently ordered with the resident's' providers who included Medical Director Physician #1129, Physician #1130 and the wound clinic and all are appropriate. A total of 21 residents were reviewed. -On 01/13/26 at 4:40 P.M. the DON notified Medical Director Physician #1129 of the facility plan via phone during an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting. In attendance were the DON, Administrator, Medical Director Physician #1129 (via phone), Regional Nurse #1054 and Regional Clinical Services RN #1128. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 01/14/26 at 10:45 A.M. Regional Nurse #1054 assessed Resident #5 for new skin impairments, pressure reducing interventions in place and proper air mattress settings. No abnormalities were found. - On 01/14/26 at 11:00 A.M. Regional Nurse #1054 reviewed Kardex and care plans for those at risk via Braden score and current residents with pressure ulcers for appropriate interventions in place. - DON will oversee the wound prevention and treatment process moving forward. - ADON will go on wound rounds to ensure compliance with wound prevention and treatment process. - DON/designee will audit five resident's wound documentation and treatment orders weekly to ensure correct orders are entered, and wound assessments are being completed timely for four weeks. - DON/designee will audit five resident's air mattresses weekly to ensure proper settings are in place for four weeks. - DON/designee will audit five residents to ensure pressure reducing interventions are in place weekly for four weeks. - Audits will be reviewed in QAPI and changes made as needed. Although the Immediate Jeopardy was removed on 01/14/26, the facility remained out of compliance at Severity Level 3 (actual harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1. Review of the medical record for Resident #5, revealed an admission date of 12/03/24. Diagnoses included type 2 diabetes, central cord syndrome at cervical 5 level of cervical spinal cord, specified disorder of muscle, generalized anxiety disorder and major depressive disorder. Review of the care plan revised on 07/11/25 revealed Resident #5 was at risk for pressure injury formation with interventions including encourage resident to turn and reposition frequently as resident tolerates and low air loss mattress on bed with no mattress settings identified. Review of Resident #5's Braden Scale for Predicting Pressure Sore Risk dated 08/01/25 revealed a score of 13 which was moderate risk for skin breakdown. The scale was 6 (high risk) to 23 (no risk). Review of the medical record from 12/03/24 to 08/13/25, revealed Resident #5 was totally dependent for bed mobility, at risk for pressure ulcers and had a sacrum stage III pressure ulcer present upon admission. Review of the physician's orders through that time revealed no order for a low air loss mattress or turning and repositioning. There were incorrect treatment orders. Pressure ulcer assessment and staging were being completed by LPN #1010. and the sacrum stage III ulcer had deteriorated to a stage IV. Review of the skin and wound evaluation for Resident #5 dated 08/14/15 at 1:56 P.M. by Unit Manager LPN #1010 revealed a sacrum stage IV pressure ulcer that measured 6.7 centimeters (cm) by 6.6 cm by 4.5 cm with a wound bed composition of 90 percent granulation and 10 percent slough. Review of the skin and wound evaluation for this resident dated 08/14/25 at 3:24 P.M. by Unit Manager LPN #1010 revealed an avoidable deep tissue injury of the right lateral thigh, in house acquired that measured 4 cm by 3.3 cm. Review of the medical record for Resident #5 dated 08/14/25 revealed the wound consultant physician did not assess her that week as well as no other documentation for assessing and staging the sacrum stage IV pressure ulcer and the right outer thigh deep tissue injury by another physician and/or Registered Nurse. The orders for treatments were obtained by Physician #1130, and the wound consultant physician office was not contacted for treatment. Review of the physician order for Resident #5 dated 08/14/25 at 7:09 P.M. revealed a treatment for the right outer thigh deep tissue injury to cleanse with normal saline, paint with Betadine, a povidone-iodine, and cover with dressing every shift. Review of the physician orders for this resident dated 08/14/25 at 8:10 P.M. revealed a treatment for the sacrum stage IV pressure ulcer to cleanse with normal saline, pack with Dakin's Solution (no strength percent was mentioned in the order) moistened gauze, cover with a dressing and change every shift. Review of the physician orders and progress notes for Resident #5 from 08/14/25 through 08/20/25 revealed no clarification to a physician of the percentage of the Dakin's Solution used for the treatment of the sacrum stage IV pressure ulcer. Review of the treatment administration record (TAR) for Resident #5 dated 08/14/25 through 08/20/25 revealed the incorrect treatment order was administered for the sacrum stage IV pressure ulcer. Review of the physician order for Resident #5, dated 08/20/25 at 9:42 A.M. revealed a treatment for the sacrum stage IV pressure ulcer of Dakin's solution, 0.125 percent solution, apply (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	topically every shift to come from the pharmacy. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 08/21/25 with no time stamp. Resident #5 still had a sacrum stage IV pressure ulcer and measured 6.7 cm by 6.6 cm by 4.5 cm with the wound bed tissue composition as 80 percent granulation and 20 percent slough. A treatment plan of moistened gauze with Dakin's solution 0.25 percent, pack the wound with an entire kerlix roll and cover with dry dressing every shift and as needed. A new area assessed as a right lateral thigh stage III pressure ulcer measured 2.2 cm by 2.9 cm by 0.1 cm with the wound bed tissue composition as 50 percent epithelial, 30 percent granulation and 20 percent slough. A treatment plan of cleanse with normal saline or sterile water and apply wound gel to wound bed, cover with a dry dressing (no frequency). Review of the medical record for Resident #5 revealed no clarification/addendum with the Wound Physician #1127 of the right lateral thigh stage III pressure ulcer treatment frequency. Review of the physician orders for Resident #5, dated 08/22/25 at 8:47 A.M. revealed a treatment for the right lateral thigh stage III pressure ulcer of cleanse with normal saline, apply wound gel to wound bed, cover with a dry dressing every shift. Review of the physician orders for this resident, dated 08/22/25 at 08:49 A.M. revealed a treatment for the sacrum stage IV pressure ulcer of moistened gauze with Dakin's solution, no strength noted, and to pack the wound with an entire kerlix roll and cover with a dry dressing every shift and as needed. Review of the TAR for Resident #5 dated 08/22/25 through 08/28/25 revealed the incorrect treatment order was administered for the sacrum stage IV pressure ulcer. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 08/28/25. The sacrum stage IV pressure ulcer and right lateral thigh stage III pressure ulcer with no major changes, treatment orders to continue from the 08/21/25 visit note. Review of the medical record for Resident #5 revealed no clarification/addendum with Wound Physician #1127 of the right lateral thigh stage III pressure ulcer treatment frequency. Review of the TAR for Resident #5 dated 08/29/25 through 09/03/25 revealed the incorrect treatment order was administered for the sacrum stage IV pressure ulcer. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 09/04/25. The sacrum stage IV pressure ulcer measured 7.1 cm by 6.9 cm by 6.5 cm with the wound bed tissue composition as 80 percent granulation and 20 percent slough. A treatment plan for implementing negative wound therapy every Tuesday, Thursday and Saturday. Apply at 125 millimeters of Mercury (mmHg) continuously and pack wound completely with black foam. The right lateral thigh stage III pressure ulcer measured 3.1 cm by 1.6 cm by 0.2 cm with the wound bed tissue composition as 50 percent epithelial, 30 percent granulation and 20 percent slough. A treatment plan of cleanse with normal saline, apply nickel thick Santyl (a debriding agent) and cover with a dry dressing every day and as needed. Review of the physician's orders for Resident #5 dated 09/04/25 through 09/19/25 revealed Santyl was never ordered to come from the pharmacy. Review of the TAR for Resident #5 dated 09/04/25 through 09/06/25 revealed the incorrect treatment order was administered for the sacrum stage IV pressure ulcer and the right lateral thigh stage III pressure ulcer. Review of the physician's orders for Resident #5, dated 09/06/25 at 01:23 P.M. revealed a treatment order for the right lateral thigh of cleanse with normal saline, apply nickel thick Santyl and cover with dry dressing every day and as needed. Review of the physician orders for this resident, dated 09/06/25 at 1:25 P.M. revealed a treatment for the sacrum stage IV pressure ulcer of cleanse with Dakin's solution (no percent was mentioned in the order), apply black foam to wound, connect wound vac at 125mmHg continuous on Tuesday, Thursday and Saturday. Review of the TAR for Resident #5 dated 09/06/25 through 09/10/25 revealed the incorrect treatment order was administered for the sacrum stage IV pressure ulcer and the right lateral thigh stage III pressure ulcer. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 09/11/25. The sacrum stage IV pressure ulcer measured 5.3 cm by 5.9 cm by 5 cm with the wound bed tissue composition as 80 percent granulation and 20 percent slough. Treatment to continue from 09/04/25 visit note. The right lateral thigh was assessed as an unstageable pressure ulcer and measured 1.2 cm by 2 cm by no depth with the wound bed (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tissue composition as 20 percent epithelial and 80 percent slough. Treatment to continue from 09/04/25 visit note. Review of the TAR for Resident #5 dated 09/11/25 through 09/13/25 revealed the incorrect order was administered for the sacrum stage IV pressure ulcer. Review of the TAR for this resident dated 09/11/25 through 09/17/25 revealed the incorrect treatment order was administered for the right lateral thigh stage III pressure ulcer. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 09/18/25. The sacrum stage IV pressure ulcer had deteriorated and measured 6.1 cm by 7 cm by 5.5 cm with the wound bed tissue composition as 50 percent granulation and 50 percent slough. The wound had odor; bone can be palpated and tunneling at 7 o'clock to 9 o'clock and 5 cm in length. Treatment plan cleanse with normal saline, apply Calcium Alginate and Santyl, pack the wound with a complete roll of moistened gauze of Dakin's solution 0.25 percent with a dry dressing every shift. On the second dressing change, leave Calcium Alginate and Santyl in the wound bed and pack with the complete roll of moistened gauze of Dakin's solution 0.25 percent. The right lateral thigh was a stage III pressure ulcer and had deteriorated, measuring 2.9 cm by 1.8 cm by 0.2 cm with the wound bed tissue composition as 20 percent epithelial, 50 percent granulation and 30 percent slough. Overall, the wound deteriorated (enlarged, bruising) but less slough, so it was staged as a stage III pressure ulcer. Treatment plan to add Calcium Alginate to the nickel thick Santyl with dry dressing daily. Review of the physician order for Resident #5 dated 09/19/25 at 8:13 A.M. revealed a treatment for the sacrum stage IV ulcer cleanse with normal saline, apply Calcium Alginate and Santyl in the wound bed, pack with Dakin's solution (no percent mentioned) moistened gauze and apply Triad paste (a hydrophilic wound dressing) to the peri wound, cover with a dressing every shift. Review of the medical record for Resident #5 revealed no clarification/addendum with Wound Physician #1127 of the sacrum stage IV pressure ulcer Dakin's Solution strength. Review of the physician orders for this resident revealed no Dakin's solution was ordered to come from the pharmacy and the treatment plan from Wound Physician visit dated 09/18/25 for the right lateral thigh stage III pressure ulcer was not ordered. Review of the TAR for Resident #5 dated 09/19/25 through 09/22/25 revealed the incorrect treatment was administered for the sacrum stage IV pressure ulcer and the right lateral thigh stage III pressure ulcer. Review of the hospital records for Resident #5 revealed on 09/19/25 she was sent to the hospital emergency room for a urinary tract infection; blood cultures were drawn and sent back to the facility. On 09/22/25, this resident was sent back to the hospital due to positive blood cultures. During the hospital stay, the resident was diagnosed with osteomyelitis of the sacrum pressure ulcer with sepsis. The treatment plan was to not administer antibiotics at this time but treat with wound dressing changes. The sacrum stage IV pressure ulcer measured 7.5 cm by 8 cm by 3.7 cm and undermining at 7 o'clock. The wound bed composition was 90 percent non-granulated tissue and 10 percent bone with brown drainage. The right outer thigh wound was assessed as an unstageable pressure ulcer and measured 3 cm by 3 cm by 0.1 cm. The wound bed composition was 100 percent slough with brown/black drainage. Review of the discharge instructions from the hospital dated 09/26/25 revealed for the sacrum stage IV pressure ulcer treatment of cleanse with Vashe, a hypochlorous wound cleanser, apply wound vac at 150mmHg continuously and change three times a week. The right lateral thigh assessed as unstageable pressure ulcer treatment of cleanse with Vashe wound cleanser, apply Santyl with a Mepilex (a soft silicone foam dressing) dressing daily. Review of the physician orders dated 09/26/25 revealed the treatment for right lateral thigh unstageable wound was not ordered as well as no order for a low air loss mattress with air settings and to turn and reposition. Review of the physician order for Resident #5 dated 09/27/25 at 12:01 A.M. revealed a treatment for the sacrum stage IV pressure ulcer to apply Dakin's Solution 0.125 percent three times a week. Review of the TAR for Resident #5 dated 09/27/25 through 10/02/25 revealed the incorrect treatment was administered for the sacrum stage IV pressure ulcer and the right lateral thigh unstageable pressure ulcer. Review of Resident #5's Braden Scale for Predicting Pressure Sore Risk dated 09/29/25 revealed a score of 13 on a scale of 6 (high risk) to 23 (no risk). The resident was at (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	moderate risk for skin breakdown. Review of the skin and wound evaluation for Resident #5 dated 09/30/25 at 2:44 P.M. by Unit Manager LPN #1010 revealed a right lateral thigh unstageable pressure ulcer measuring 2 cm by 3.4 cm by undetermined depth with a wound bed composition of 90 percent eschar and 10 percent slough. Review of the skin and wound evaluation for this resident dated 09/30/25 at 2:52 P.M. by Unit Manager LPN #1010 revealed a sacrum stage IV pressure ulcer that measured 7 cm by 7.5 cm by 6 cm with a wound bed composition of 70 percent granulation and 30 percent slough. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 10/02/25. The sacrum stage IV pressure ulcer measured 7 cm by 9.1 cm by 6 cm with the wound bed tissue composition 70 percent granulation and 30 percent slough. The wound had an odor. The treatment plan was cleanse with normal saline, pack with an entire roll of Kerlix gauze moistened with Dakin's solution 0.25 percent every shift. The right lateral thigh stage III pressure ulcer measured 2.6 cm by 2.8 cm by 0.2 cm with the wound bed composition 80 percent granulation and 20 percent slough. The treatment plan was to cleanse with normal saline, apply collagen to wound bed and cover with a dressing. No frequency of the wound dressing change was listed. Review of the physician order for Resident #5 dated 10/02/25 at 12:38 P.M. revealed a treatment for the sacrum stage IV pressure ulcer cleanse with normal saline, pack wound with entire roll of kerlix moistened in Dakin's solution (no percent) apply Triad paste to peri wound and apply dressing every shift. Review of the physician orders for this resident dated 10/02/25 at 12:39 P.M. for the right lateral thigh stage III pressure ulcer cleanse with normal saline, apply collagen, cover with a dressing every day. Review of the medical record for Resident #5 revealed no clarification/addendum with the Wound Physician #1127 for the sacrum stage IV pressure ulcer Dakin's solution strength and to add Triad paste as well as the right lateral thigh stage III pressure ulcer treatment frequency. Review of the TAR for Resident #5 dated 10/03/25 through 10/09/25 revealed the incorrect treatment was administered for the sacrum stage IV pressure ulcer and the right lateral thigh stage III pressure ulcer. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 10/09/2. The sacrum stage IV pressure ulcer had no major changes. Continue treatment plan from 10/02/25 visit note. The right lateral thigh stage III pressure ulcer measured 2.3 cm by 2.64 cm by 0.1 cm with wound bed tissue composition 40 percent granulation and 60 percent slough. The wound continued to have odor with increased slough, so the treatment plan was to cleanse with Dakin's solution 0.25 percent, apply nickel thick Santyl with Silver Alginate and a dry dressing daily. Review of the physician order for Resident #5 dated 10/10/25 at 8:52 A.M. revealed a treatment for the right lateral thigh stage III pressure ulcer of cleanse with normal saline, apply Santyl and Silver Alginate and cover with a dressing daily. Review of the physician orders for this resident dated 10/10/25 through 10/16/25 revealed Santyl never was ordered to come from the pharmacy. Review of the physician order for Resident #5 dated 10/14/25 at 7:00 A.M. revealed a treatment for the sacrum stage IV pressure ulcer for Dakin's solution 0.125 percent, apply topically every shift. Review of the TAR for Resident #5 dated 10/10/25 through 10/16/25 revealed the incorrect treatment was administered for the sacrum stage IV pressure ulcer and the right lateral thigh stage III pressure ulcer. Review of the wound consult visit notes revealed Resident #5 was seen by Wound Physician #1127 on 10/16/25. The sacrum stage IV pressure ulcer measured 6.39 cm by 7.58 cm by 4.5 cm with wound bed tissue composition 80 percent granulation and 20 percent slough. The wound now has odor and is tunneling 4 cm at 9 o'clock. Treatment order to continue as 10/02/25 visit of cleanse with normal saline, pack with an entire roll of Kerlix gauze moistened with Dakin's solution 0.25 percent, change every shift. The right lateral thigh stage III ulcer had deteriorated and measured 3.12 cm by 3.25 cm by 1.5 cm with wound bed tissue composition of 100 percent. The wound continued to have odor and debridement was completed. The treatment plan was to cleanse with Dakin's solution 0.25 percent and apply Dakin's solution 0.25 percent moistened gauze to wound bed and apply dry dressing every shift. Review of the physician order for Resident #5 dated 10/16/25 at 2:55 P.M. revealed a treatment for the right lateral thigh stage III pressure ulcer to cleanse with normal saline, pack wound with (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dakin's solution (no percent) moistened gauze, cover with foam dressing and apply Triad paste to peri wound every shift. Review of the physician order for Resident #5 dated 10/20/25 at 7:52 A.M. revealed a treatment for the sacrum stage IV pressure ulcer cleanse with normal saline, pack with Dakin's solution (no percent) apply Triad paste to peri wound and cover with a dressing evert shift. Review of the progress note for Resident #5 dated 10/23/25 at 5:41 P.M. by LPN #1038 revealed an X-ray of the right hip was completed this shift for pain. Results show a possible right femoral fracture. Order to send to the emergency room. Review of the emergency room notes for Resident #5 on 10/23/25 revealed a Computed Tomography (CT) scan of the right hip with no fracture, but possible osteomyelitis of both pressure ulcer areas. The right lateral thigh pressure ulcer measured 6.2 by 3.8 by 7.2 with suspicion of fat necrosis. The sacrum pressure ulcer had no measurements completed. Resident #5 had an elevated white blood cell count of 14,000 (normal 4,500 to 11,000) and significant pain of the sacral area. Antibiotics started, discussed with family to transfer to a different hospital. Resident #5 was transferred to another hospital and review of those hospital notes from 10/24/25 through 10/28/25 revealed possible osteomyelitis of the sacrum stage IV pressure ulcer and soft tissue necrosis and myositis to the right lateral thigh pressure ulcer. Wound care consulted and dressing changes were the most appropriate course of action for treatment at this time. The sacrum stage IV pressure ulcer measured 9.5 cm by 7.5 cm by 6 cm with 4.5 cm of undermining and the right lateral thigh unstageable pressure ulcer measured 4cm by 4 cm by 3.2 cm. Review of the after-visit summary dated 10/28/25 revealed a treatment for the sacrum and right thigh pressure ulcers of cleanse and pat dry. Pack wounds with Vashe wound cleaner moistened Kerlix gauze and cover with a dry dressing and change twice a day and as needed. Review of the skin and wound evaluation for Resident #5 dated 10/30/25 at 11:17 A.M. by Unit Manager LPN #1010 revealed a right lateral thigh stage III pressure ulcer that measured 3.52 cm by 2.9 cm by 2.5cm with tunneling of 5 cm. The wound bed composition of 60 percent granulation and 40 percent slough. Review of the skin and wound evaluation for this resident dated 10/30/25 at 11:17 A.M. by Unit Manager LPN #1010 revealed a sacrum stage IV pressure ulcer measured 6.8 cm by 6.74 cm by 4.5 cm with tunneling at 4.5 cm. The wound bed composition was 90 percent granulation and 10 percent slough. Review of the physician orders for Resident #5 from 10/28/25 through 11/06/25 revealed treatment order for the sacrum stage IV pressure ulcer and the right lateral thigh unstageable pressure ulcer from the after-visit summary were never ordered as well as no order for a low air loss mattress and to turn and reposition. Review of the medical record for Resident #5 revealed no clarification to continue treatment orders for the sacrum stage IV pressure ulcer and the right lateral thigh unstageable pressure ulcer from prior to hospital admission on [DATE]. Review of the TAR for Resident #5 dated 10/28/25 through 11/6/25 revealed the incorrect treatment was administered for the sacrum stage IV pressure ulcer and the right lateral thigh stage III pressure ulcer. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had moderate cognitive impairment. Resident #5 required substantial or maximal assistance with shower and bathing, and bed mobility, and was totally dependent for toilet hygiene and transfers. Review of the medical record for Resident #5 revealed from 11/06/25 to present revealed no physician's orders for a low air loss mattress, to turn and reposition and incorrect treatment orders. Further review of the medical record also revealed staging and assessing pressure ulcers by an LPN #1010. During an observation on 01/05/26 at 11:09 A.M., Resident #5 was lying in bed on her back, resting with her eyes closed. The air mattress was set at four. During an observation on 01/06/26 at 10:23 A.M., Resident #5 was lying in bed on her back, resting with her eyes closed. The air mattress was set at four. During an observation on 01/07/26 at 11:00 A.M., 1:00 P.M., and 2:56 P.M., Resident #5 was lying in bed on her left side with a wedge under her right side. The air mattress was set on at four and alternating pressure. During an interview on 01/07/26 at 2:58 P.M. with CNA #1070 verified Resident #5 had been on her left side for hours and was not turned. The care plans are where the turn and reposition information for residents are found but some are to turn as needed. If she is working another unit, it is hard to de[TRUNCATED]		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, staff interview, and facility policy review, the facility failed to implement and maintain a comprehensive Quality Assurance Improvement Program (QAPI) program and plan to address care issues and/or concerns in the facility. This had the potential to affect all 84 residents who reside in the facility. The facility census was 84. Review of the Quality Assurance (QA) committee attendance records for the previous 12 months revealed QA meetings were held at the end of each month starting with January 2025. Specifically for the September 26, 2025, meeting, review of prevention/interventions for residents with pressure ulcers were discussed, but Resident #41 and Resident #5 were not discussed separately and identified as ongoing issues with their care. The findings for the annual survey, dated 01/05/26 revealed noncompliance in the area of pressure ulcer care, which included prevention and treatments, resulting in substandard quality of care with an Immediate Jeopardy beginning on 08/14/25 for Resident #5, and an Actual Harm, beginning on 08/26/25 to Resident #41. The facility was unable to provide evidence, including documentation, of its ongoing QAPI program's implementation with the pressure ulcer care of Resident #5 and Resident #41. Interview on 01/14/26 at 2:08 P.M. with the Regional Clinical Services #1128 verified for the past year of QAPI meetings, no residents were identified as ongoing issues and care for their pressure ulcers. The facility did review all residents with pressure ulcers and care to make sure interventions and treatments were in place on September 26, 2025, and Resident #41 and Resident #5 were included but was not individually identified as concerns for pressure ulcer care. Interview via telephone on 01/15/26 at 2:10 PM with the Director of Nursing revealed during the September 26, 2025, QAPI meeting, it was discussed for all residents with pressure ulcers, based on their Braden scales and skin conditions, they were reviewed to make sure interventions were in place for care. During QAPI meetings, care for residents are discussed such as skin issues, but no resident was ever brought to their attention for ongoing concerns by any staff member including Unit Managers who oversee the care of the residents on their halls. Review of the facility policy titled Quality Assurance Performance Improvement dated 10/24/2022 revealed the facility developed and maintains an effective, comprehensive, data-driven quality assurance and performance improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. The QAPI program shall utilize the best available evidence to design and measure indicators of quality and have facility goals that reflect process of care and facility operation that have been shown to be predictive of desired outcomes for residents. The QAPI plan will include written policies and procedures for feedback, data collection and monitoring including adverse event monitoring.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility provided food storage policies, the facility failed to ensure food was protected from potential spoilage and/or contamination in the areas of food storage and food preparation. This had the potential to affect all 83 residents who received food from the kitchen. The facility census was 84. Findings include: Observation on 01/05/26 at 8:40 A.M. revealed an opened bag of small frozen pizzas was stored with the bag open, exposing the food to air and potential contaminants in the reach-in freezer. Further observation at this time revealed a bag of frozen chicken fingers was also stored with the bag open, so that the food was exposed to air and there was no date marking on the opened bag of chicken fingers. Interview on 01/05/26 at 8:41 A.M. with Dining Services Manager #1011 revealed food items such as the frozen pizzas and frozen chicken fingers should be date-marked once they have been opened. Further interview at this time verified foods should be stored in closed containers or otherwise wrapped to protect from potential contamination. Observation on 01/05/26 at 8:45 A.M. revealed three bags of sandwich buns stored on the bread rack with a 12/30/25 best by date marked on the original packaging from the manufacturer of the bread. Further observation at this time revealed the buns were firm to the touch, indicating potentially stale texture or otherwise decreased quality of the food. Interview on 01/05/26 at 8:47 A.M. with Dining Services Manager #1011 revealed the facility does not necessarily follow a first in, first out procedure for rotating and using bread products, though the facility does receive bread products several times per week. Observation on 01/05/26 at 8:50 A.M. of the walk-in cooler revealed two heads of lettuce appeared to be wilted and brown, with no date marking to indicate either when the lettuce was first received or the discard/use-by date. Further observation at this time revealed a block of yellow cheese that had been removed from original packaging and then wrapped in plastic wrap with no date marking on the wrapping. Interview on 01/05/26 at 8:52 A.M. with Dining Services Manager #1011 verified the cheese and lettuce in the walk-in refrigerator should have date marking on the packaging while in storage. Observation on 01/05/26 at 8:54 A.M. of the walk-in freezer revealed one large box of frozen hamburger patties was stored with the box and bag open so that the food items were exposed to air and potential sources of contamination in the freezer. This finding was verified with the Dietary Manager at the time of the observation. Observation on 01/05/26 at 8:56 A.M. of the top of the prep cooler in the center of the kitchen revealed multiple food items had been stored without any date marking. These food items included one package of deli ham, one package of bologna, one package of boiled eggs, one block of yellow cheese covered in plastic wrap, one block of white cheese covered in plastic wrap, and one container of sliced onions. Observation on 01/05/26 at 8:58 A.M. revealed Dining Services Manager #1011 removed all food items that were not date marked in the prep cooler and asked nearby kitchen staff to ensure the items were discarded in the trash. Further observation at this time revealed the Dietary Manager reminding kitchen staff to make sure food items are date marked for storage in coolers. Observation on 01/05/26 at 9:00 A.M. revealed two squeeze bottles of sauces/dressings in the bottom of the prep cooler at the center of the kitchen, with date marking on the containers that indicated preparation in November of 2025. Interview on 01/05/26 at 9:02 A.M. with Dietary Services Manager #1011 revealed the two bottles of dressing in the prep cooler from November 2025 were employee food items and verified these employee food items were being stored in the same refrigerated unit with foods that are prepared for and served to residents. Observation on 01/07/26 at 11:18 A.M. revealed [NAME] #1102 was wearing a hairnet while plating foods for lunch service, but the hairnet was only seen covering the back portion of her hair where the employee's hair was pulled up into a bun. Observation at this time revealed the majority of [NAME] #1102's head was not covered by a hairnet as the cook went to the hot food service line to measure food temperatures for lunch service and began preparing plates for residents. Observation on 01/07/26 at 11:20 A.M. revealed [NAME] #1102 was wearing a glove on only her right (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand while taking temperatures of food items on the hot service line for lunch service. Further observation at this time revealed [NAME] #1102 used her bare hand to open an alcohol prep pad to clean the tip of her thermometer used to measure food temperatures. Observation then revealed the torn alcohol pad wrapper fell directly into a tray of pureed green beans when [NAME] #1102 went to take a temperature of the food item after having been held with the cook's bare hand. [NAME] #1102 then used their gloved hand to remove the wrapper from the food item but kept the food item for service. Interview on 01/07/26 at 11:25 A.M. with Dining Services Manager #1011 revealed she had noticed that [NAME] #1102 was wearing a hairnet, but the hairnet was not covering the employee's hair during lunch service. Further interview at this time revealed cooks and other food service staff should be wearing hairnets that cover their hair and/or beards if applicable when preparing food for residents, to prevent possible contamination of foods. Observation on 01/08/26 at 9:50 A.M. revealed multiple food items were opened with no date marking in the activity room refrigerator. These food items included two containers of French onion dip, two bags of salami, one bag of cheese cubes, and one container of salsa. Interview on 01/08/26 at 9:52 A.M. with the Activities Director #1059 verified there were multiple food items for residents kept in the activity room refrigerator that were not labeled or date marked properly, and the foods in the activity room refrigerator should be labeled and date marked to prevent potential spoilage or contamination. Review of the facility policy titled Food Storage with an approval date of 04/01/22 and policy replacement date of 12/26/22 revealed foods must be rotated using the first in first out storage method (FIFO), where oldest foods are used first and newer items are stored behind older food items. Further review of this policy revealed guidelines for food labeling and dating must be adhered to by all food service personnel and closely monitored by the food service manager. Additional review of this policy revealed arrival dates should be placed on all foods removed from the case at the time of delivery, and all foods removed from original packing must have an arrival date. If food has a manufacturers expiration date, an open date will be added to the label.		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, interviews, and facility policies, the facility failed to ensure Licensed Practical Nurses (LPN's) acted within their professional standards and their scope of training related to pressure ulcer wound assessments and staging's. This affected four Residents (#5, #41, #99, and #82) out of six reviewed for pressure ulcer assessments and staging's by facility staff. The facility census was 84. 1. Review of the medical record for Resident #5, revealed an admission date of 12/3/24. Diagnoses included but were not limited to type 2 diabetes, central cord syndrome at cervical 5 level of cervical spinal cord, specified disorder of muscle, generalized anxiety disorder and major depressive disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 out of 15 which suggested moderate cognitive intactness. The resident was assessed to require substantial/maximal assistance with shower/bathe self, bed mobility, and total dependence for toilet hygiene and transfers. Review of the skin and wound evaluation for Resident #5 dated 02/03/25 by Unit Manager LPN #1010 revealed a sacrum stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcer measured 6.7 centimeters (cm) by 1.4 cm by 1.4 cm. Review of the skin and wound evaluation for Resident #5 dated 08/14/25 by Unit Manager LPN #1010 revealed a sacrum stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough, a yellowish, stringy dead tissue or eschar, a layer of dead, dry tissue that forms a dark leathery scab over the ulcer may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer measured 6.7 cm by 6.6 cm by 4.5 cm. Further review of the skin and wound evaluation for this resident dated 08/14/25 by Unit Manager LPN #1010 revealed a deep tissue injury of the right lateral thigh, in house acquired that day measured 4 cm by 3.3 cm by no depth. Review of the skin and wound evaluation for Resident #5 dated 09/30/25 by Unit Manager LPN #1010 revealed a sacrum stage 4 pressure ulcer measured 7.0 cm by 7.5 cm by 6 cm. Further review of the skin and wound evaluation for this resident dated 09/30/25 by Unit Manager LPN #1010 revealed a right lateral thigh unstageable pressure ulcer measured 2.0 cm by 3.4 cm by undetermined depth. Review of the skin issue assessment for Resident #5 dated 10/30/25 by Unit Manager LPN #1010 revealed a sacrum stage 4 pressure ulcer measured 6.8 cm by 6.74 cm by 4.5 cm with tunneling at 4.5 cm. Further review of the skin issue assessment for this resident dated 10/30/25 by Unit Manager LPN #1010 revealed a right lateral thigh stage 3 pressure ulcer measured 3.52 cm by 2.9 cm by 2.5cm with tunneling 5 cm. (continued on next page)		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the skin issue assessment for Resident #5 dated 11/19/25 by Unit Manager LPN #1010 revealed a sacrum stage 4 pressure ulcer measured 7.25 cm by 7.04 cm by 5 cm. Further review of the skin issue assessment for this resident dated 11/19/25 by Unit Manager LPN #1010 revealed a right lateral thigh stage 3 pressure ulcer measured 4.42 cm by 3.1cm by 5 cm. Interview on 01/13/26 from 1:02 P.M. through 2:01 P.M. with the Director of Nursing (DON), Regional Nurse #1054 and the Regional Clinical Services Registered Nurse #1127 verified an LPN completed staging and measurements for Resident #5's pressure ulcers on: 02/01/25, 08/14/25, 09/30/25, 10/30/25 and 11/19/25. 2. Review of the medical record for Resident #41, revealed an admission date of 08/22/25. Diagnoses included but were not limited to type 2 diabetes mellitus with diabetic neuropathy, displaced unspecified condyle fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing, major depressive disorder, senile degeneration of brain, anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 05 out of 15 which indicated severe cognitive impairment. The resident was assessed to require partial/moderate assistance with shower/bathe self, bed mobility, substantial/maximal assistance with transfers and total dependence with toilet hygiene. Review of the skin and wound evaluation for Resident #41 dated 08/26/25 by Unit Manager LPN # 1010 revealed a coccyx pressure with no staging measured 4.6 cm by 4.3 cm by 0.1 cm. Review of the skin and wound evaluation for Resident #41 dated 09/24/25 by Unit Manager LPN # 1010 revealed the left heel deep tissue pressure injury facility acquired on 09/22/25 measured 6.7 cm by 6.3 cm by no depth. Review of the skin issue assessment for Resident #41 dated 12/23/25 by Unit Manager LPN #1010 revealed the left heel deep tissue pressure injury measured 9.07 cm by 10.04 cm by no depth. Review of the skin issue assessment for Resident #41 dated 12/31/25 by Unit Manager LPN #1010 revealed the left heel deep tissue pressure injury measured 5.05 cm by 6.21 cm by no depth. Interview on 01/08/26 at 3:10 P.M. with the DON and Regional Nurse #1054 verified on 08/26/25, 09/24/25, 12/23/25 and 12/31/25 an LPN staged and measured the left heel pressure ulcer for Resident #41. 3. Review of the medical record for Resident #99, revealed an admission date of 12/30/25. Diagnoses included but were not limited to pressure ulcer of sacral region, chronic kidney disease, need for assistance with personal care, and chronic systolic heart failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 which indicated cognitive intactness. The resident was assessed to require partial/moderate assistance with bed mobility, substantial/maximal assistance with toilet hygiene, shower/bathe self and total dependence on transfers. This resident was also assessed to have a stage 3 pressure ulcer on admission. Review of the skin issues assessment for Resident #41 dated 12/31/25 by Unit Manager LPN #1010 (continued on next page)		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed a stage 3 pressure ulcer on admission measured .79 cm by .72 cm by .1 cm. Interview on 01/08/26 at 8:21 A.M. with the DON verified an LPN completed the pressure ulcer measurement and assessment for Resident #99 on 12/31/25. 4. Review of Resident #82's medical record revealed an admission date of 08/06/25 and diagnoses including atherosclerotic heart disease, Atrial fibrillation, peripheral vascular disease, diabetes, pulmonary hypertension, hypertension, hyperlipidemia, major depressive disorder, and acquired absence of other left toes. Review of Resident #82's quarterly minimum data set (MDS) dated [DATE] revealed a brief interview for mental status score (BIMS) of eight out of 15 indicating the resident was moderately cognitively impaired. Further review of the MDS revealed Resident #82 required partial/moderate assistance with bed mobility and was dependent on facility staff for toileting hygiene and transfers, was always incontinent of bladder and bowel, and was at risk for pressure ulcers but had none at the time of the assessment. Review of Resident #82's progress notes revealed a note written on 11/05/25 at 5:30 P.M. by LPN #1066 that stated LPN #1066 found the left heel open when the nurse was completing the preventative treatment to the heels. The area measured four centimeters (cm) in length, three cm in width and had a depth of 0.1 cm. LPN #1066 cleansed the area with normal saline and patted it dry. Medical grade honey was applied to the wound, and the wound was covered with an abdominal dressing pad and wrapped with kerlix. The resident's medical provider and responsible party were notified of the wound. Review of Resident #82's progress notes revealed a note written on 11/05/25 at 5:35 P.M. by LPN #1032 for completion of the Braden scale, used to assess the resident's risk of developing pressure ulcers, with a score of 14 indicating the resident had a moderate risk of developing pressure ulcers. Review of Resident #82's progress notes a note written on 11/06/25 at 12:30 P.M. by LPN #1032 revealed the resident had a new skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as an unstageable pressure injury presenting as a deep tissue injury acquired in house. The wound measured 2.05 cm in length 1.69 cm in width and had no depth. Review of Resident #82's progress notes a note written on 11/12/25 at 9:55 A.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as an unstageable pressure injury presenting as a deep tissue injury acquired in house. The wound measured 2.88 cm in length 2.88 cm in width and had no depth. Review of Resident #82's progress notes a note written on 11/19/25 at 12:25 P.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as an unstageable pressure injury presenting as a deep tissue injury acquired in house. The wound measured 1.56 cm in length 1.72 cm in width and had no depth. Review of Resident #82's progress notes a note written on 11/26/25 at 1:59 P.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as an unstageable pressure injury presenting as a deep tissue injury acquired in house. The wound measured 1.81 cm in length 2.19 cm in width and had no depth. Additional care section in the note stated, mattress with pump. (continued on next page)		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's progress notes revealed a note written on 12/02/25 at 10:24 A.M. by LPN #1032 for completion of the Braden scale, used to assess the resident's risk of developing pressure ulcers, with a score of 15 indicating the resident had a mild risk of developing pressure ulcers. Review of Resident #82's progress notes a note written on 12/02/25 at 1:37 P.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as a stage three pressure ulcer/injury with full thickness loss acquired in house. The wound measured 3.77 cm in length 3.56 cm in width and 0.2 cm in depth. The wound had a moderate amount of clear watery drainage, and the wound bed was pink or red. An additional care section in the note stated, mattress with pump. Review of Resident #82's progress notes a note written on 12/10/25 at 12:27 P.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as a stage three pressure ulcer/injury with full thickness loss acquired in house. The wound measured 3.45 cm in length 3.55 cm in width and 0.2 cm in depth. The wound had a moderate amount of clear watery drainage, and the wound bed was pink or red. An additional care section in the note stated, mattress with pump. Review of Resident #82's progress notes a note written on 12/17/25 at 12:43 P.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as a stage three pressure ulcer/injury with full thickness loss acquired in house. The wound measured 3.18 cm in length 2.45 cm in width and 0 cm in depth. The wound had a moderate amount of clear watery drainage, and the wound bed was pink or red. An additional care section in the note stated, mattress with pump. Review of Resident #82's progress notes revealed a note written on 12/20/25 at 2:37 P.M. by LPN #1032 for completion of the Braden scale, used to assess the risk of developing pressure ulcers, with a score of 16 indicating the resident had a mild risk of developing pressure ulcers. Review of Resident #82's progress notes a note written on 12/24/25 at 10:35 A.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as a stage three pressure ulcer/injury with full thickness loss acquired in house. The wound measured 4.46 cm in length 3.23 cm in width and 0 cm in depth. The wound had a moderate amount of clear watery drainage, and the wound bed was pink or red. Further review of the progress note revealed Resident #38 had a new skin issue to her right heel. The type of skin issue was a pressure ulcer injury acquired in house. The wound was 1.2 cm in length, 4.8 cm in width and 0 cm in depth. The wound had a light amount of clear watery drainage. Review of Resident #82's progress notes a note written on 12/31/25 at 12:44 P.M. by LPN #1032 revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as a stage three pressure ulcer/injury with full thickness loss acquired in house. The wound measured 4.61 cm in length 3.21 cm in width and 0 cm in depth. The wound had a light amount of clear watery drainage, and the wound bed was pink or red. Further review of the progress note revealed Resident #38 had a new skin issue to her right heel. The type of skin issue was a pressure ulcer injury acquired in house and staged as an unstageable pressure ulcer/injury slough and or eschar. The wound was 1.2 cm in length, 4.8 cm in width and 0 cm in depth. The wound had no drainage, and the wound bed was pink or red. Review of Resident #82's progress notes a note written on 01/07/26 at 3:07 P.M. by LPN #1032 (continued on next page)		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the resident had a skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as a stage three pressure ulcer/injury with full thickness loss acquired in house. The wound measured 2.16 cm in length 2.69 cm in width and 0.2 cm in depth. The wound had a light amount of clear watery drainage, and the wound bed was pink or red. Further review of the progress note revealed Resident #38 had a new skin issue to her right heel. The type of skin issue was a pressure ulcer injury acquired in house and staged as an unstageable pressure ulcer/injury slough and or eschar. The wound was 1.74 cm in length, 2.17 cm in width and 0 cm in depth. The wound had a light amount of clear watery drainage, and the wound bed was pink or red. Interview on 01/08/26 at 9:00 A.M. with the Director of Nursing revealed the Unit Managers, who are Licensed Practical Nurses (LPN), are assessing and staging pressure ulcers weekly and on admission during the week, for the residents when the Wound Doctor does not see them and/or if the Wound Doctor does not see them at all for care. Review of the facility policy titled Skin and Wound Guidelines revised 03/20/24 revealed pressure injuries are evaluated and documented by a licensed nurse and are evaluated weekly by the wound team or a licensed nurse per state and federal regulations. Review of the facility job description for the job title Licensed Practical Charge Nurse in the Nursing Department last revised 01/01/2012 revealed no pressure ulcer wound assessments which include measuring, staging and assessments to be part of their role statement, essential activities and tasks, knowledge, skills, abilities and qualifications. Review of the facility job description for the job title Unit Manager in the Nursing Department last revised 01/01/2012 revealed no pressure ulcer wound assessments which include measuring, staging and assessments to be part of their role statement, essential activities and tasks, knowledge, skills, abilities and qualifications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, observations, interviews, and facility policies, the facility failed to perform hand hygiene before and after wearing contact precautions when passing a lunch tray to Resident #21. This had the potential to affect 5 other residents at the facility in contact precautions who received lunch trays for meals. The facility also failed to ensure enhanced barrier precautions were ordered timely for eight Residents (#5, #41, #99, #46, #64, #52, and #82) out of eight who required enhanced barrier precautions. This had the potential to affect 5 other residents in enhanced barrier precautions. The facility census was 84.1. Review of the medical record for Resident #21 revealed the resident was admitted on [DATE] with diagnoses that included severe chronic kidney disease, acidosis, and anemia amongst other diagnoses. Further review of the resident record revealed the resident had an active order for contact precautions during the time of the survey due to an active diagnosis of a methicillin-susceptible staphylococcus aureus (MSSA) infection in the bloodstream, referred to as MSSA bacteremia. Observation on 01/07/26 at 12:40 P.M. of the contact precautions signage posted on the door of Resident #21's room revealed everyone must clean their hands, including before entering and when leaving the room, and that providers and staff must also put on a gown and gloves before room entry and then discard the gown and gloves before room exit. Observation on 01/07/26 at 12:41 P.M. revealed Certified Nursing Assistant (CNA) #1003 entered Resident #21's room to deliver a lunch tray. Observation at this time revealed the CNA did not perform any type of hand hygiene before donning a gown and gloves prior to entering the room to deliver the tray, or after doffing the gown and gloves when leaving the room. Further observation at this time revealed CNA #1003 returned to the meal delivery cart in the hallway and continued to pass out trays for lunch service immediately after doffing the gown and gloves worn in Resident #21's room. Interview on 01/07/26 at 12:49 P.M. with Dining Services Manager #1011 verified they had seen CNA #1003 enter and exit Resident #21's room without performing hand hygiene as indicated by the signage on the door. Review of the facility policy titled hand hygiene (issued 08/01/22) and last revised on 04/14/23 revealed the purpose of the policy was to provide guidelines to staff for proper hand hygiene techniques that will aid in the prevention and transmission of infections. Further review of this policy revealed hand hygiene is indicated before and after removing personal protective equipment (PPE), including gloves. 2. Review of the medical record for Resident #5, revealed an admission date of 12/03/24. Diagnoses included but were not limited to type 2 diabetes, central cord syndrome at cervical 5 level of cervical spinal cord, specified disorder of muscle, generalized anxiety disorder and major depressive disorder. Review of the progress note for Resident #5 dated 04/25/25 revealed this resident returned to the facility from a hospital stay. Review of the skin and wound evaluation for Resident #5 dated 04/25/25 revealed a sacrum stage 4 pressure ulcer. Review of the physician order for Resident #5 dated 04/30/25 revealed enhanced barrier precautions (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ever shift due to wound. Interview on 01/07/26 at 2:59 P.M. with the DON confirmed Resident #5 was readmitted to the facility on [DATE] and had a pressure ulcer with no order for enhanced barrier precautions ordered until 04/30/25. 3. Review of the medical record for Resident #41, revealed an admission date of 08/22/25. Diagnoses included but were not limited to type 2 diabetes mellitus with diabetic neuropathy, displaced unspecified condyle fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing, major depressive disorder, senile degeneration of brain, anxiety disorder. Review of the skin and wound evaluation for Resident #41 dated 08/25/25 revealed a coccyx (no staging) pressure ulcer wound. Review of the physician order for Resident #41 dated 09/03/25 revealed enhanced barrier precautions every shift due to wound. Interview on 01/08/26 at 8:01 A.M. with the DON confirmed Resident #41 was assessed to have a pressure ulcer wound on 08/25/25 and no order for enhanced barrier precautions were ordered until 09/03/25. 4. Review of the medical record for Resident #99, revealed an admission date of 12/30/25. Diagnoses included but were not limited to pressure ulcer of sacral region, chronic kidney disease, need for assistance with personal care, and chronic systolic heart failure. Review of the admission assessment for Resident #99 dated 12/30/25 revealed a coccyx pressure ulcer (no staging and measurements). Review of the physicians order for Resident #99 dated 01/01/26, to start on 01/02/26, revealed enhanced barrier precautions every shift due to a wound. Interview on 01/08/26 at 8:02 A.M. with the DON confirmed Resident #99 was assessed to have a pressure ulcer wound on admission [DATE] and no order for enhanced barrier precautions were ordered until 01/01/26 with a start date of 01/02/26. 5. Review of the medical record for Resident #46 revealed an admission date of 12/11/2025. Diagnoses included multiple sclerosis, heart disease, and chronic obstructive pulmonary disease. Review of the skin issue progress note dated 12/30/2025 at 3:16 P.M. revealed Resident #46 has a new in-house acquired pressure ulcer located on their coccyx. This pressure wound was noted as a stage 3 (full thickness loss) measuring 0.52 centimeters (cm) in length by 1.01 cm in width by 0.1 cm in depth with the area totaling 0.49 cm. Review of the nursing progress note dated 01/01/2026 at 8:35 A.M. that Resident #46 had been transferred to the hospital for evaluation due to a change in condition where she was noted to be admitted . Continued review of nursing progress notes and physician orders revealed no evidence to indicate enhanced barrier precautions had been implemented due to this residents pressure wound. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/08/26 at 8:01 A.M. with the DON confirmed Resident #46 was assessed to have a pressure ulcer wound on 12/30/2025 and no order for enhanced barrier precautions were implemented. 6. Review of the medical record for Resident #52 revealed an initial admission date of 12/04/2025 with a re-entry date of 12/20/2025. Diagnosis included an intraspinal abscess, methicillin susceptible staphylococcus aureus infection and an open surgical wound of the lower back and pelvis. Review of Resident #52's nursing progress notes and physician orders revealed no evidence of enhanced barrier precautions being implemented for this resident who was noted to have multiple open surgical wounds. Interview on 01/08/26 at 8:01 A.M. with the DON confirmed Resident #52 was admitted to the facility with multiple surgical wounds which would require enhanced barrier precautions upon admission which were never implemented or ordered. 7. Review of the medical record for Resident #64 revealed an admission date of 05/23/2025 and a discharge date of 01/09/2026. Diagnosis included peripheral vascular disease, stage 3 pressure ulcer of the sacral region, and a stage 3 pressure ulcer of the left heel. Review of nursing progress notes and physician orders revealed no evidence to indicate that enhanced barrier precautions had been ordered or implemented for Resident #64 who was noted with multiple pressure wounds. Interview on 01/08/26 at 8:01 A.M. with the DON confirmed Resident #64 was admitted to the facility with multiple pressure wound which would require enhanced barrier precautions upon admission but were never ordered or implemented. 8. Review of Resident #82's medical record revealed an admission date of 08/06/25 and diagnoses including atherosclerotic heart disease, Atrial fibrillation, peripheral vascular disease, diabetes, pulmonary hypertension, hypertension, hyperlipidemia, major depressive disorder, and acquired absence of other left toes. Review of Resident #82's quarterly minimum data set (MDS) dated [DATE] revealed a brief interview for mental status score (BIMS) of eight indicating the resident was moderately cognitively impaired. Further review of the MDS revealed Resident #82 required partial/moderate assistance with bed mobility and was dependent on facility staff for toileting hygiene and transfers, was always incontinent of bladder and bowel, and was at risk for pressure ulcers but had none at the time of the assessment. Review of Resident #82's physician's orders revealed an order dated 12/03/25 for enhanced barrier precautions. Review of Resident #82's progress notes revealed a note written on 11/05/25 at 5:30 P.M. by Licensed Practical Nurse #1066 that stated LPN #1066 found the left heel open when the nurse was completing the preventative treatment to the heels. The area measured four centimeters (cm) in length, three cm in width and had a depth of 0.1 cm. LPN #1066 cleansed the area with normal saline and patted it dry. Medical grade honey was applied to the wound, and the wound was covered with an abdominal dressing pad and wrapped with kerlix. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's progress notes a note written on 11/06/25 at 12:30 P.M. by LPN #1032 revealed the resident had a new skin issue to her left heel. The type of skin issue was a pressure ulcer/injury staged as an unstageable pressure injury presenting as a deep tissue injury acquired in house. The wound measured 2.05 cm in length 1.69 cm in width and had no depth. In an interview on 01/08/2026 at 8:00 A.M. the Director of Nursing (DON) verified Resident #82 developed a wound on 11/05/25 and enhanced barrier precautions were not put place until 12/03/25. Review of the facility policy titled Enhanced Barrier Precautions dated 09/30/2025 revealed residents admitted to the facility with or during their stay with a wound will be placed in enhanced barrier precautions with a physician order.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a resident's call light within reach. This affected one resident (#25) of one sampled for call light placement. The facility census was 84. Findings include: Review of Resident #25's medical record revealed an admission date of 09/14/18, a re-entry date of 11/03/22 and diagnoses including hypertensive heart disease with heart failure, vascular dementia, major depressive disorder, history of falling, hypothyroidism, orthostatic hypotension, and other abnormalities of gait and mobility. Review of Resident #25's quarterly minimum data set (MDS) dated [DATE] revealed a brief interview for mental status score (BIMS) of three out of 15 indicating the resident had severe cognitive impairment. Further review of the MDS revealed the resident required set up help for eating, partial/moderate assistance with moving about in the bed and was dependent on staff for toileting hygiene tasks and transferring between her chair and bed. Resident #25 was always incontinent of bladder and bowel, had not had pain in the past five days prior to the assessment, had not fallen since the last assessment, has no pressure areas or other skin issues and was receiving diuretic medication. An observation on 01/05/2026 at 11:59 A.M. revealed Resident #25 to be in bed and the call light to be on the floor. An observation on 01/05/2026 at 2:30 P.M. revealed Resident #25 to be in bed and the call light to be on the floor. An observation on 01/06/2026 at 9:00 AM revealed the call light wrapped around the bed rail with the call button between the bed rail and the mattress and Resident #25 seated in the recliner by the bed and unable to reach the call light. An observation on 01/06/2026 at 2:40 P.M. revealed the call light wrapped around the bed rail with the call button between the bed rail and the mattress and Resident #25 seated in the recliner by the bed and unable to reach the call light. An observation on 01/07/2026 at 9:20 A.M. revealed Resident #25 in bed (low bed) with the head of the bed elevated and the call light wrapped around the bedrail, bedrail in low position and call button between the mattress and the rail. With the head of the bed elevated the call light was behind and out of sight of the resident as well as out of reach. An observation on 01/07/2026 at 11:34 A.M. revealed Resident #25 in bed (low bed) with the head of the bed elevated and the call light wrapped around the bedrail, bedrail in low position and call button between the mattress and the rail. With the head of the bed elevated the call light was behind and out of sight of the resident as well as out of reach. An observation on 01/13/2026 at 8:00 A.M. revealed Resident #25 resting in bed and the call light to be draped over the resident's recliner chair. In an interview at the time of the observation the Director of Nursing (DON) confirmed the call light was draped over the recliner while the resident was resting in bed and unable to reach the call light.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement fall interventions as ordered. This affected two residents (#38 and #84) of two sampled for falls. The facility census was 84. Findings Include: 1. Review of Resident #38's medical record revealed an admission date of 07/30/20, a re-entry date of 11/25/23, and diagnoses including chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, major depressive disorder, vascular dementia, anxiety disorder, and congestive heart failure. Review of Resident #38's quarterly minimum data set (MDS) dated [DATE] revealed a brief interview for mental status score (BIMS) of 13 indicating the resident was cognitively intact. Further review of the MDS revealed the resident required supervision or touching assistance with toileting hygiene, bed mobility, and transfers, had no pain in the five days prior to the assessment, had not fallen since the previous MDS assessment and had no skin issues at the time of the assessment. Review of Resident #38's physician's orders revealed an order dated 02/09/24 for the resident to have a perimeter mattress to her bed for safety every shift. Review of Resident #38's fall care plan revealed an intervention dated 06/27/24 for the resident to have a perimeter mattress to her bed. Review of Resident #38's progress notes written on 11/19/25 at 2:02 P.M. by Licensed Practical Nurse (LPN) #1066 revealed LPN#1066 was standing at the nurse's station and heard Resident #38 yell calling out for help. LPN#1066 went down hall to investigate and found the resident in her room on the floor beside the bed. LPN#1066 assisted Resident #38 up from the floor to her wheelchair. A head-to-toe assessment was completed and the resident was found to have an abrasion to her left knee and to the forth and fifth toes of her right foot. Review of Resident #38's progress notes written on 01/07/26 at 11:10 P.M. revealed Resident #38's roommate came out into hallway calling for staff. Staff entered the room and found the resident on the floor on her bottom beside the bed. Resident #38 stated she was sitting on the side of her bed trying to look under her bed for her tv remote and slipped onto the floor. Resident #38 was found to have a penny sized abrasion to the left elbow. An observation on 01/05/2026 at 10:43 A.M. revealed Resident #38's bed was against the wall to the left of the door with the foot of the bed by the door. Resident #38 was lying on her right side, sideways in the bed at the middle of the bed with her buttocks at the edge of the bed not against the wall. A perimeter mattress was not present on her bed. An observation on 01/06/26 at 09:20 A.M. revealed Resident #38 was not present in her room. A perimeter mattress was not present on her bed. An observation on 01/06/26 at 2:00 P.M. revealed Resident #38 was not present in her room. A perimeter mattress was not present on her bed. An observation on 01/07/2026 at 9:31 A.M. revealed Resident #38 was not present in her room. A perimeter mattress was not present on her bed. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/07/2026 at 11:33 A.M. revealed Resident #38 was resting in bed on her right side facing the wall. A perimeter mattress was not present on her bed. An observation on 01/08/2026 at 10:52 A.M. revealed Resident #38 resting in bed on her right side, curled into the middle of the bed with her buttocks at the edge of the bed. A perimeter mattress was not present on her bed. In an interview on 01/08/2026 at 10:52 A.M. the Director of Nursing (DON) verified the mattress on Resident #38's bed was not a perimeter mattress. 2. Review of the medical record for Resident #84 revealed an admission date of 05/09/2023. Diagnosis included osteoporosis, hypotension, and a pain to bilateral lower extremities. Review of Resident #84's Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #84 was noted with impairment to one of the upper extremities and required the use of a wheelchair. Resident #84 required substantial to maximal assistance for toileting hygiene and bathing, and partial to moderate assistance for personal hygiene and bed mobility. Review of the plan of care dated 05/10/23 revealed Resident #84 was at risk for falls and potential for injury related to decreased mobility, the use of assistive device, needing assist of staff status post hospital admit on 11/2023, with confusion and encephalopathy secondary to a urinary tract infection and being treated with intravenous antibiotics. Interventions included to completed 15-minute checks as directed and needed, placing a 9-inch fall matt at bedside, keeping residents' bed in a low position with fall mat when occupied. Observation completed on 01/07/2026 at 2:00 P.M. revealed Resident #84 lying in bed where the bed was noted to be elevated off the floor and not in the lowest position. Observation completed on 01/12/2026 at 10:25 A.M. of Resident #84 revealed this resident laying supine in bed, resting with eyes open. Resident #84's bed was noted to be elevated in the air during this observation. Interview on 01/12/2026 10:42 A.M. with Licensed Practical Nurse (LPN) #1033 confirmed Resident #84 was resting quietly in bed and her bed was not in the lowest position as per care plan for fall interventions indicated it needed to be.		

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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 interview and record review the facility failed to properly maintain an indwelling catheter for one resident (#21) of one sampled for catheter use. The facility census was 84. Findings include: Review of Resident #21's medical record revealed an admission date of 11/04/25, re-entry date of 01/01/26 and diagnoses including chronic kidney disease stage five hydronephrosis, carrier or suspected carrier of methicillin susceptible staphylococcus aureus, urinary tract infection, bacteremia, benign prostatic hyperplasia, obstruction and reflux uropathy, retention of urine and hypotension. Review of Resident #21's admission minimum data set (MDS) dated [DATE] revealed a brief interview for mental status score (BIMS) of 15 indicating the resident had intact cognition. Further review of the MDS revealed Resident #21 had no behaviors during the assessment look back period, required supervision or touching assistance with showering/bathing and was independent with all other activities for daily living, had an indwelling catheter, was continent of bowel, had no pain in the five days prior to the assessment and had no skin issues. Review of Resident #21's physician's orders revealed an order dated 11/04/25 to change the resident's foley catheter on day shift every 30 days. Review of Resident #21's treatment administration record (TAR) for December of 2025 revealed the order for the residents catheter change was to have been completed on 12/10/25, however no initials were on the TAR for that day to indicate the catheter change was completed. Review of Resident #21's nursing progress notes for the month of December revealed no evidence the catheter change was completed. In an interview on 01/14/25 at 11:42 A.M. Licensed Practical Nurse (LPN) #1038 revealed that if a monthly task could not be completed the resident's medical provider would be notified and an order obtained to complete the task at a different time and/or date, so the task was not missed for that month. In an interview on 01/14/25 at 1:15 P.M. the Director of Nursing confirmed the catheter was not changed in December as ordered.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Pickaway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 391 Clark Drive Circleville, OH 43113	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, this facility failed to ensure meal intakes were being monitored to ensure residents highest nutritional status. This affected one (Resident #84) of the one resident reviewed for nutrition. The facility census was 84. Findings include: Review of the medical record for Resident #84 revealed an admission date of 05/09/2023. Diagnoses included dementia, end stage renal failure, and osteoporosis. Review of the plan of care dated 11/02/2023 revealed Resident #84 was at risk for malnutrition related to end stage renal disease. Resident continues to refuse nutritional supplements. Interventions include to provide and serve diet as ordered, monitor and record intakes for every meal, and alert dietician if consumption is poor for more than 48 hours. Review of the plan of care dated 12/22/2025 revealed Resident #84 has renal insufficiency related to end stage renal disease. Interventions include to consult with dietary to regulate protein, sodium, and potassium intake. Review of Resident #84's Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #84 required set up or clean up assistance for eating meals. Resident #84 was noted to be 59 inches tall and weighted 117 pounds with no noted weigh loss or gain. Review of Resident #84's breakfast intake from 12/14/2025 through 01/10/2026 revealed no meal intake percentage was documented for 14 of the 30 days reviewed. Review of Resident #84's lunch intake form 12/14/2025 through 01/10/2026 revealed no meal intake percentage was documented for 16 of the 30 days reviewed. Review of Resident #84's dinner intake from 12/14/2025 through 01/10/2026 revealed no meal intake percentage was documented for 14 of the 30 days reviewed. Continued review of Resident #84's meal and snack intake from 12/14/2025 through 01/10/2026 revealed no snacks were offered or documented as consumed. Interview on 01/12/2026 10:28 A.M. interview with Certified Nursing Assistant (CNA) #1017 revealed when a resident is done eating, staff will pick up the meal tray and then write the intake percentage on that meal slip. When that staff member gets a chance, they will then enter the meal intake percentage, most likely, at the end of their shift. Interview on 01/12/2026 10:49 A.M. with Regional Nurse (RN) #1054 confirmed there was multiple days of missing meal intakes for Resident #84. RN #1054 also confirmed that this resident was at a risk for nutritional decline due to medical history and their meal percentage intake needed to be closely monitored.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Pickaway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 391 Clark Drive Circleville, OH 43113	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and dialysis communication documents, this facility failed to ensure orders and recommendations for residents receiving dialysis services were followed. This affected one (Resident #84) of the one resident reviewed for dialysis. The facility census was 84. Findings include: Review of the medical record for Resident #84 revealed an admission date of 05/09/2023. Diagnoses included end stage renal disease, dependence on renal dialysis, and hypertension. Review of the plan of care dated 05/10/23 revealed Resident #84 was at risk for bleeding internally or externally related to medication. Interventions included to administer medication as ordered, contact primary care physician immediately if coffee ground emesis is observed, monitor for signs and/or symptoms of bleeding, monitor vital signs, and labs. Review of the plan of care dated 05/10/25 revealed Resident #84 required dialysis treatments related to end stage renal disease. Interventions include to administer medication as order, check access site for lack of thrill or bruit, monitor for evidence of infection, swelling or excessive bleeding, check and change dressing daily at access site, coordinate dialysis care with center, diet per physician orders, do not draw labs or check blood pressure (BP) in dialysis port site arm, and encourage to rest after dialysis. Review of the nursing progress note dated 12/26/2025 at 10:40 P.M. created by Licensed Practical Nurse (LPN) #1094 revealed a Change in Condition documentation indicating a change in this resident's skin status evaluation which was noted as other as well as noting that this resident claimed it occurred after dialysis. Review of Resident #84's Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #84 was noted to receive dialysis services. Review of Resident #84's recorded blood pressure checks from 10/14/2025 through 01/12/2026 revealed her blood pressure had been checked or measured 123 times using her left arm, which was the arm where the dialysis access port was located. Interview on 01/12/2026 12:18 P.M. with Resident #84 revealed staff do check her blood pressure in both her right and left arm. Resident #84 claimed she had a bracelet on her left arm that says No blood pressure or lab draws Observation on 01/12/2026 at 12:18 P.M. of Resident #84 confirmed a bracelet was in place around her left wrist indicating no blood pressure checks and no lab draws on that arm. Interview on 01/12/2026 11:47 A.M. with Regional Nurse (RN) #1054 and Licensed Practical Nurse (LPN) #1010 confirmed there were multiple documented blood pressure checks which were being completed on Resident #94's left arm which was the arm her dialysis port was in. Resident #84 was also noted to have a wrist band on that wrist indicating no blood pressure or blood draws for that arm.		