STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365611	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westerville Post Acute.	1060 Eastwind Drive Westerville, OH 43081

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, pharmacist interview, and review of facility policy, the facility failed to have an adequate post discharge plan for medication administration when the facility did not ensure an adequate supply of medications were available for a resident at discharge. This affected one former resident (#95) out of three residents reviewed for discharge planning. The facility census was 91 residents. Findings Include:Review of a closed medical record revealed that former Resident #95 was admitted to the facility on [DATE] and had diagnoses that included cerebral infarction, hypertension, malignant neoplasm of kidney, and atrial fibrillation.Review of Resident #95's Minimum Data Set (MDS) 3.0 assessment on 12/12/25 revealed that Brief Interview with Mental Status (BIMS) score of 15, indicative of intact cognitive status. Resident #95 was assessed as being on antidepressant, anticoagulant, antiplatelet and diuretic medications.Review of Resident #95's discharge summary initiated on 12/10/25, revealed Resident #95 was discharging to home in the community. Resident #95's primary care physician appointment was made for 12/18/25. The pharmacy, home health company, and durable medical equipment company were listed in the discharge summary. The summary indicated that Resident #95 was given a copy of his current medications and when they were last received. The discharge summary was signed by Resident #95 on 12/12/25.Review of Resident #95's progress notes dated 12/12/25 revealed that Resident #95 was discharging home from his dialysis appointment. Medications were sent with the resident. Resident #95 was educated on his upcoming appointments and medication schedule.Review of Resident #95's physician orders revealed that on his discharge date of 12/12/25, Resident #95's prescribed medications included: amlodipine besylate (a calcium channel blocker to treat high blood pressure), atorvastatin (a medication to treat high cholesterol), darbepoetin alfa injection solution (a man-made form of protein to help the body produce red blood cells), melatonin (a natural hormone and supplement that regulates the sleep-wake cycle), midodrine (a medication used to treat severe low blood pressure), mirtazapine (an antidepressant to treat major depressive disorder), pantoprazole (a proton pump inhibitor that decreases the amount of acid produced in the stomach), torsemide (a loop diuretic used to treat fluid retention and high blood pressure), warfarin sodium (an anticoagulant used to prevent and treat blood clots), metoprolol tartrate (a beta blocker medication used to treat high blood pressure), and Renvela (a phosphate binder used to control high phosphorus levels in people with chronic kidney disease). An interview with Family Member #530 on 05/04/26 at 9:22 A.M. revealed that Resident #95 did not have medications that were important for his health conditions for several days after discharge because the facility failed to call the medications into Resident #95's pharmacy upon discharge.An interview with Pharmacist #500 on 05/06/26 at 11:36 A.M. revealed that Nurse Practitioner #455 called in Resident #95's medications to the pharmacy on 12/16/25, four days after Resident #95 discharged from the facility.An interview with the Director of Nursing (DON) on 05/06/26 at 2:16 P.M. confirmed that the supply of medications given to Resident #95 was only sufficient to cover one additional day of medications, as the facility pharmacy only delivered one day of medication in advance. The nurse practitioner was responsible for ordering the medications into the (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy upon discharge. She stated if the resident had already been discharged out of the electronic medical record, the nurse practitioner would have to physically call the pharmacy to get the medications ordered for the resident.Review of the facility policy titled, Discharge Summary and Plan, dated March 2025, revealed that as part of the discharge summary, the nurse reconciles the pre-discharge medications with the resident's post-discharge medications. The final discharge plan of care shows what arrangements have been made for the resident regarding needed medical services. The discharge plan will meet the resident's health and safety needs.This represents noncompliance investigated under Complaint Number 2734219.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident medical records, resident interviews, staff interviews and review of facility policy, the facility failed to offer activities of interest to residents. This affected one resident (#95) out of four residents reviewed for activities. The facility census was 91 residents. Findings include:Review of a closed resident medical record revealed that Former Resident #95 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction and depression. Review of Former Resident #95's Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed that he had a Brief Interview for Mental Status (BIMS) score of 15, indicative of cognitively intact status. Resident #95 was assessed as having books, newspapers and magazines to read while in the facility as somewhat important to him. He was assessed as feeling that it was somewhat important for him to have music that he liked to listen to while he was in the facility. It was also somewhat important to him to do things in groups of people, to keep up with the news, to participate in religious services or practices, and to do his favorite activities. Review of Former Resident #95's activity assessment dated [DATE] revealed that it was somewhat important for him to have books, newspapers and magazines to read, to listen to music that he liked, to do things in groups of people, to keep up with the news, to participate in religious services and to do his favorite activities while he was in the facility. His other interests included fishing and skiing. It was noted that Former Resident #95 preferred in-room activities. Review of Former Resident #95's care plan dated 11/26/25 revealed that Resident #95 had a need for activities that were consistent with his abilities and interests. Enjoyable meaningful activities listed included, but were not limited to, music and one on one visits. A goal listed included for Former Resident #95 to continue to pursue independent activities of choice as well as group programs, while accepting one to one visits to promote socialization and mental stimulation, encouragement and prevent episodes of depression to the extent possible. Interventions included to assist Former Resident #95 to and from activity locations as needed, to assist with in-room activities as needed, to couple him with peers of similar interest, to encourage to attend activities of interest, providing assistance as needed, to provide activity materials like books, magazines, television, arts and crafts in accordance with interests, and to have room visits for socialization as needed. Review of activity logs for Former Resident #95 revealed that there were no documented one on one visits, and no group activities listed. Review of Former Resident #95's medical record revealed that there was no documentation of any activities offered or provided to Former Resident #95. An interview with Activity Director #379 on 05/05/26 at 11:53 A.M. confirmed that she did not have any evidence that activities were offered to Former Resident #95 and that she did not have activity logs available for Former Resident #95 for either one on one visits or group activities. Review of the facility policy titled, Activity Programs, revised June 2018, revealed that activities are offered based on the resident-centered assessment and the preferences of each resident. All activities are documented in the resident's medical record. This represents noncompliance investigated under Complaint Number 2734219.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and review of facility policy, the facility failed to ensure Resident #25 was free from a significant medication error when the physician was not notified of a high blood glucose per sliding scale order. This affected one resident (#25) of two residents reviewed for insulin management. The facility census was 91.Findings Include: Review of Resident #25's medical record revealed an admission date of 04/25/26 with diagnoses that included but were not limited to diabetes type one (DM), hypertension and chronic obstructive pulmonary disease. Review of Resident #25's functional abilities assessment dated [DATE] revealed he required assistance from staff with toileting, dressing and mobility.Review of Resident #25's physicians orders dated 04/25/26 revealed the following orders for insulin: Insulin Glargine Subcutaneous Solution 100 units per milliliter (ml) with instructions to inject 15 units subcutaneously one time a day; Insulin Lispro Injection Solution 100 units per ml with instructions to inject eight units three times a day for DM and to give with sliding scale; and Insulin Lispro Injection Solution 100 units per ml with instructions to inject as per sliding scale: if blood sugar 151-200 milligrams per deciliter (mg/dL) give one unit; 201-250 mg/dL give two units; 251-300 mg/dL give three units; 301-350 mg/dL give four units; 351-400 mg/dL give five units, and to NOTIFY MD [medical doctor] WHEN BS [blood sugar] IS ABOVE 400. There were no orders for a continuous glucose monitor.Review of Resident #25's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Mental Status Interview (BIMS) score of 14 indicating intact cognition.Observation of medication administration on 05/06/26 at 8:30 A.M. for Resident #25 revealed Licensed Practical Nurse (LPN) #143 stated the resident was due for his insulin and he used a glucose monitoring sensor and she would check the reading prior to giving insulin. Upon entering the room, LPN #143 asked the resident if he could check his monitor for a blood glucose reading, at that time the monitor read the word HI with no associated number reading. LPN #143 returned to her cart and drew up 13 units of Lispro. She returned to the resident who requested a manual blood sugar check. LPN #143 did not respond and gave the insulin. Interview on 05/06/26 at 8:40 A.M. with LPN #143 confirmed she did not take a manual glucose reading after Resident #25 requested to confirm accuracy. She also verified she had not contacted the physician of the HI blood glucose reading stating she would re-check his glucose reading in about 30 minutes.Review of Resident #25's medication administration record (MAR) dated 05/06/26 at 8:43 A.M. revealed LPN #143 documented a blood glucose reading of 388 mg/dL.Observation on 05/06/26 at 9:25 A.M. revealed Resident #25 had a blood glucose reading on his continuous monitor as HI. Resident #25 expressed at that time the nurses should take his blood glucose manually to check if his continuous glucose monitoring readings are accurate because sometimes they vary.Interview on 05/06/26 at 9:30 A.M. with the Director of Nursing (DON) confirmed Resident #25 received insulin for a high blood glucose reading and the physician was not notified. After surveyor intervention, the DON notified the nurse practitioner (NP) of the high blood sugar and LPN #143 was instructed to obtain a manual reading. Resident #25's blood sugar was 491 mg/dL and orders were received for five additional units and to monitor.Review of facility policy titled Insulin Administration dated March 2025 revealed the nurse will notify the provider of any discrepancies prior to administering insulin and the nurse must document the resident's blood glucose result, as ordered.This deficiency represents non-compliance investigated under Complaint Number 2747255.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure that opened bulk medications were properly labeled with an open date or discard date to prevent the risk of use of contaminated or expired medications. This had the potential to affect all 32 residents in the 400 hall receiving medications. The facility census was 91.Findings Include: Observation on 05/05/26 at 7:45 A.M. of medication storage for the 400 hall nurses cart revealed the following opened and undated bulk medications: Milk of Magnesia 473 milliliter (ml) bottle that was half empty; Tylenol 325 milligram (mg) 100 count bottle that was half empty; Tylenol 500 mg 100 count bottle that was half empty; Active Liquid Protein 887 ml bottle that was half empty; Geri-Tussin 473 ml bottle that was half empty; and Alkums antacid tablets 150 count bottle that was half empty.Interview on 05/05/26 at 7:45 A.M. with Licensed Practical Nurse (LPN) #525 revealed opened bulk medication bottles once opened should be dated with the open date. LPN #525 also verified the above medications were not dated.