STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365636	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pickerington Care and Rehabilitation	1300 Hill Road North Pickerington, OH 43147

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy and procedure, the facility failed to ensure residents were treated in a dignified manner by providing privacy during care and treatment. This affected three (Resident #52, #73 and #87) of 22 residents in the survey sample. The census was 71. Findings include: 1. Review of Resident #73's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure, tracheostomy, gastrostomy, esophageal obstruction. Review of the quarterly minimum data set assessment dated [DATE] revealed Resident #73's cognition was severely impaired. He required supervision and/or touching supervision for oral hygiene, dependent for toileting, shower/bathing and setup/clean up assistance for personal hygiene. On 09/24/25 at 8:25 A.M. an observation of Resident #73, revealed after preparing the medication's for the resident, Registered Nurse (RN) #194 checked the gastrostomy tube for residual and by auscultation (listening with a stethoscope). She then administered the medications one at a time and flushed with 30 cubic centimeters (cc) of water prior to administration and 15 cc of water in between the medications. Resident #73's bed was by the door. At no time did RN #194 close the door or pull the privacy curtain. On 09/24/25 at 8:48 A.M. RN #194 verified she had not provided privacy during Resident #73's procedure. 2. Review of Resident #87's medical record revealed he was admitted on [DATE]. Diagnoses included non-traumatic intracerebral hemorrhage, acute respiratory failure, seizures, encephalopathy, dysphagia, tracheostomy and gastrostomy. Review of the quarterly minimum data set assessment dated [DATE] revealed his cognition was not intact (Rarely/Never understood). He was dependent on staff for oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Had an indwelling urinary catheter and was always incontinent of bowel. On 09/24/25 at 10:23 A.M. observation of tracheostomy (trach) care by Respiratory Therapist (RT) #240 revealed she suctioned Resident #87's trach and mouth and changed trach ties. RT #240 left the door and the blinds open while providing care and did not pull the privacy curtain. On 09/24/25 at 10:31 A.M. an interview with RT #240 revealed he should have provided privacy while completing the care.3. Review of the medical record for Resident #52 revealed an admission date of 10/11/24. Diagnoses included cellulitis, contracture of right and left knee, muscle wasting, cerebral palsy and paraplegia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 11 indicating impaired cognition and dependence with toileting. Resident #52 was frequently incontinent of bowel and bladder. Observation on 09/22/25 at 11:18 A.M. revealed Resident #52 was receiving incontinence care with the curtain partially closed and the door wide opened. The curtain hung about a foot off the ground. A soiled brief was observed from the hallway being tossed onto the floor by Certified Nursing Aide (CNA) #183. Upon entrance to the room, the resident could be seen receiving care and was exposed with no brief on. Interview on 09/22/25 at 11:19 A.M. with Certified Nurse Aide (CNA) #183 stated she should have closed to door to provide privacy but stated she did not because the door was stuck. At that time, STNA #183 tapped the door which was held with the fire release holder and the door easily swung and closed. The CNA confirmed Resident #52 should have received privacy during care. Review of facility policy titled Resident Rights dated 06/01/24, revealed the resident had the right to privacy and confidentiality during medical treatment and personal care.This deficiency represents non-compliance investigated under Complaint Number 1260918.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and facility policy and procedure, the facility failed to maintain a clean and sanitary environment. This affected two residents (#25 and #26) of 25 residents rooms observed. The census was 71. Findings Include: 1. Review of Resident #26's medical record revealed an admission date of 05/22/23 with the diagnoses including, but not limited to, respiratory failure, epilepsy, anxiety, and schizoaffective disorder. Review of Resident #26's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #26 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 10 out of 15, he was dependent on staff for completion of bathing and personal hygiene tasks, was independent with eating and used a wheelchair for mobility. Review of the facility's weekly cleaning schedule revealed on Saturday wheelchairs for residents in odd numbered rooms would be cleaned, and on Sunday wheelchairs for residents in even numbered rooms would be cleaned. An observation on 09/22/25 at 2:15 P.M. revealed Resident #26 sitting in his wheelchair watching television in his room. Resident #26's wheelchair cushion was stained, and food particles were present in the seams of the cushion. The rails and footrest pegs were noted to be covered in a white colored substance and dried food was noted to the top of the rails. An interview on 09/25/25 1:25 P.M. with Certified Nursing Assistant (CNA) #224 confirmed Resident #26's wheelchair cushion, footrest pegs, and the rails were dirty with dried food and a white substance. CNA #224 stated night shift usually cleaned the wheelchairs, but if he saw a dirty wheelchair then he would clean the wheelchair. 2. Review of the medical record for Resident #25 revealed an admission date of 06/10/20. Diagnoses included parkinsonism, kidney disease, schizophrenia, type two diabetes, lumbago with sciatica, and heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating impaired cognition, stating the resident was rarely, if ever, understood and required substantial/maximum assistance to roll in bed and was dependent on personal hygiene. Observations on 09/22/25 at 10:40 A.M. revealed Resident #25 had a navy-blue padding bolted to the wall next to the resident's bed with a dried brownish material caked and smeared on it. Additional observations at 1:19 P.M. and 1:51 P.M. confirmed the brown smeared material remained without being cleaned up. Several staff had been observed going in and out of the Resident #25's room to provide care to Resident #25 and her roommate from 10:40 A.M. to 1:51 P.M. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/22/25 at 1:53 P.M. with Certified Nurse Aide (CNA) #111 confirmed a dried brown substance was smeared on the wall padding against Resident #25's bed. CNA #111 could not confirm what the substance was but confirmed it was dirty. CNA stated Resident #25 was not on their assignment. Observations on 09/22/25 from 1:55 to 2:10 P.M. revealed after the interview with CNA #111, CNA #111 did not obtain supplies to clean the dirty mat on the wall and was not seen alerting other staff to clean the area. Observation on 09/22/25 at 2:30 P.M. revealed Resident #25's wall mat remained soiled with the dried brown substance. Observations on 09/23/25 at 8:35 A.M. and 9:10 A.M. revealed Resident #25's wall mat remained soiled with the dried brown substance. Observation on 09/23/25 at 9:55 A.M. revealed Resident #25's wall mat was being cleaned by housekeeping staff. Review of facility policy titled Resident Environmental Quality dated 11/29/22, revealed the facility shall maintain and provide a safe, functional, sanitary and comfortable environment for residents, maintain all essential patient care equipment in safe operating condition, and all facility personnel were responsible for reporting broken, defective equipment and furnishings upon identification. This deficiency represents non-compliance investigated under Complaint Number 1260942.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and facility policy review, the facility failed to ensure nail care was provided for dependent care residents. This deficient practice affected three residents (Residents #26, #77, and #80) out of seven residents reviewed for activities of daily living (ADL) care for dependent residents. The facility's census was 71.Findings Include: 1. Review of Resident #26's medical record revealed an admission date of 05/22/23 with the diagnoses including, but not limited to, respiratory failure, epilepsy, anxiety, and schizoaffective disorder. Review of Resident #26's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #26 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 10 out of possible 15 and was dependent on staff for completion of bathing and personal hygiene tasks. Review of Resident #26's ADL care plan dated 06/07/23 revealed Resident #26 required staff assistance with personal hygiene tasks. Review of Resident #26's shower sheets dated 08/02/25 to 09/20/25 revealed nail care was not completed for 13 showers; there were no refusals documented. An observation on 09/22/25 at 10:04 A.M. revealed Resident #26 sitting in his wheelchair in his room. Resident #26's fingernails were noted to be long, with a dark colored substance under the nails. An interview on 09/23/25 at 2:32 P.M. with Certified Nursing Assistant (CNA) #161 confirmed Resident #26's fingernails were long and appeared to be dirty under the nails. CNA #161 stated nail care was completed following bathing or showering for the residents and refusals were reported to the nurse. 2. Review of the medical record for Resident #80 revealed an admission date 10/12/24 with diagnoses including, but not limited to, respiratory failure, hemiplegia to left side, dysphagia, dementia, and anxiety. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #80 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 08 out of possible 15 and it noted the resident was dependent on staff for showering and personal hygiene task completion. Review of Resident #80's ADL care plan dated 10/25/24 revealed staff assistance was required for personal hygiene tasks. Review of Resident #80's shower sheets dated 08/02/25 to 09/20/25 revealed nail care was not completed during eight showers; there were three refusals of care documented during those dates. An observation on 09/22/25 at 10:45 A.M. revealed Resident #80 was lying in bed watching television. Resident #80's fingernails were observed to be long and Resident #80's fingernails on his left hand appeared to have a dark substance underneath the fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/23/25 at 2:29 P.M. with Certified Nursing Assistant (CNA) #161 confirmed Resident #80's long fingernails and the left-hand fingernails with a dark substance under the fingernails. CNA #161 stated if long, dirty fingernails were observed, she would clean and cut the fingernails. 3. Review of Resident #77's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure, tracheostomy, diabetes, psoriasis, obstructive hydrocephalus, high blood pressure and gastrostomy. Review of the quarterly minimum data set assessment dated [DATE] revealed the resident was rarely/never understood. He was dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene, and turning and repositioning. It further noted he was always incontinent of bowel and bladder. Observations on 09/22/25 at 2:41 P.M. revealed Resident #77 fingernails and toenails were long and jagged. On 09/23/25 at 1:58 P.M. Resident #77 remained in bed with fingernails and toenails observed as long, thick and jagged. On 09/23/25 at 3:30 P.M. observation of Resident #77's fingernails and toenails revealed they were thick, long and jagged. This was verified during an interview with Registered Nurse (RN) #194 at the time of the observation. Reviewed the facility policy titled Activities of Daily Living (ADLs) dated 01/01/25 revealed care and services will be provided for the following activities of daily living including bathing, dressing, grooming and oral care.

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of facility policy, the facility failed to ensure appropriate care and services for Resident #32 who utilized a Foley catheter. This affected one resident (#32) of one reviewed for catheters. Facility census was 71. Findings include Review of the medical record for Resident #32 revealed an admission date of 02/03/25. Diagnoses included cardiac arrest, open wound to the buttock, malnutrition, spinal stenosis, vascular disease, dysphagia, muscle weakness, intellectual disabilities, retention urine. Review of the plan of care dated 02/06/25 revealed the resident had potential for complications related to use of the Foley (indwelling) catheter. The catheter was indicated due to obstructive uropathy. Interventions included change Foley catheter as needed for plugging or displacement, notify the physician if there was a change in urine color consistency or output, obtain output each shift and total for 24-hour period, and provide Foley care per facility policy. Review of the physician order dated 07/16/25 to 07/17/25 revealed an order to place a Foley catheter. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 11 indicating impaired cognition. The MDS assessment stated the resident had a catheter. Review of the progress note from Nurse practitioner dated 08/04/25 revealed the Foley was in place and draining without issues. Review of the progress note from Nurse practitioner dated 08/25/25 revealed the Foley was in place and draining without issues. Review of the medical record from 07/16/25 to 09/22/25 revealed no evidence of catheter care being provided and no evidence of urine output being measured documented and monitored.Review of the physician orders dated 09/22/25 from 10:42 A.M. to 6:00 P.M. revealed orders for a urinary catheter drainage bag as needed, 16 French (F) catheter with 30 milliliters (ml) of water every day shift every 30 days, change catheter anchor every 30 days and as needed, urinary catheter care every shift, Foley catheter 16 F with 30 ml balloon to straight drain due to retention, irrigate foley catheter as needed for leakage or blockage, and to change indwelling Foley as needed. There was no documented evidence of catheter orders prior to this date. Review of the progress note dated 09/22/25 revealed the nurse inserted the Foley catheter without issues. The catheter was flowing with light yellow urine draining into the catheter bag. The resident tolerated well with no complaints of pain or discomfort. Review of the medical record from 09/20/25 to 09/22/25 revealed no documentation that Resident #32's catheter came out, no documentation of what nursing staff did and no evidence of physician notification that the catheter had come out. Interview on 09/22/25 at 10:47 A.M. with Resident #32 revealed he had a catheter and it accidentally came out overnight shift (09/21/25). He revealed he was waiting for the nurse to come and replace it. Interview on 09/22/25 at 11:40 A.M. with Licensed Practical Nurse (LPN) #104 revealed she was working 6:00 A.M. to 6:00 P.M. this date (09/22/25) and during handoff, the night nurse informed her that Resident #32's catheter had come out. LPN #104 revealed she contacted the physician to clarify orders as Resident #32 did not have any orders related to his catheter. She revealed the night nurse, to her knowledge, did not attempt to replace the catheter and did not contact the physician to notify them or get orders. Interview on 09/24/25 at 2:12 P.M. with the Director of Nursing (DON) revealed the facility caught that the resident did not have orders for his catheter and reported no negative findings. The DON confirmed it was an oversite and confirmed facility had no evidence of catheter care being provided in 07/2025, 08/2025, or 09/2025. Interview on 09/24/25 at 6:45 P.M. with Registered Nurse (RN) #222 revealed she was informed by the aide that Resident #32's catheter had come out. She revealed she reviewed the chart and found the resident had no orders in place for a catheter. She revealed this happened 09/21/25 around 8:00 P.M. and she did not attempt to replace the catheter due to having no orders and also she did not contact the physician about getting orders for replacement. The RN revealed since Resident #32 did not have orders, he did not need the catheter but was unable to state why it was put in place. Review of the record further revealed no mention or evidence related to how much urine was obtained after Resident #32 was without a Foley catheter from 09/21/25 around 8:00 P.M. to 09/22/25 around 12:00 P.M., for a total of 16 hours.Interview on 09/25/25 at 1:45 P.M. with the Administrator confirmed the facility did not have any evidence the residents Foley catheter output was measured from 07/2025, 08/2025, or 09/2025. Review of facility policy titled Notification of Changes dated 01/01/25 revealed facility shall promptly inform resident's physician when there was a change requiring notification. These circumstances included accidents, significant changes, and circumstances that require a need to alter treatment.Review of facility policy titled Catheter Care dated 06/01/24 revealed facility shall ensure residents with catheters receive appropriate care

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. Based on observation, interview, manufacturers guidelines, and policy and procedure review the facility failed to maintain infection control practices during finger stick blood glucose monitoring. This affected one (Resident #15) of one reviewed for Fingerstick blood glucose monitoring. It had the potential to affected three additional residents (Resident #51, #57 and #80) on 100 hall who receive a finger stick blood sugar. The facility also failed to perform hand hygiene during meal service. This affect three residents (Residents #20, #26, and #69) out of nine residents observed eating the lunch meal in the main dining room. The census was 71.Findings include:1. Observation completed on 09/24/2025 at 7:35 A.M. of a fingerstick blood sugar for Resident #15 revealed Licensed Practical Nurse (LPN) #196 placed the glucometer on the resident's overbed table without a barrier under the glucometer. LPN #196 put on gloves, and obtained the blood sample then placed the glucometer on a tissue. LPN #196 removed her gloves and put on new gloves without performing hand hygiene. LPN #196 then placed the glucometer on the medication cart without a barrier, picked it up and then placed it on a tissue. LPN #196 then removed her gloves and used hand sanitizer. LPN #196 put on new gloves and cleaned the glucometer with a germicidal wipe for five seconds and placed the glucometer back on the same tissue, removed her gloves and put on new gloves without performing hand hygiene. LPN # 196 was then observed to prepared MiraLAX (laxative) then remove her gloves and use hand sanitizer. The actions listed were above verified during interview with LPN #196 on 09/24/25 at 7:53 A.M. Review of the policy and procedure Hand Hygiene dated 02/2019 revealed hands should be washed with soap and water or an antiseptic agent used after removing gloves. Review of the manufacturers guidelines for disinfectant wipes revealed it is registered to kill many dangerous viruses, bacteria and fungi in two minutes. 2. Review of Resident #20's medical record revealed an admission date of 11/14/22 with diagnoses including high blood pressure, dysphagia, and dementia. Further review revealed physician order dated 12/17/24 for regular diet pureed texture, regular/thin consistency. Review of Resident #26's medical record revealed admission date of 05/22/23 with diagnoses including respiratory failure, epilepsy, anxiety, and schizoaffective disorder. Review of Resident #69's medical record revealed an admission date of 09/09/25 with diagnoses high blood pressure, depression dysphagia, anxiety and heart failure. Further review revealed a physician order dated 09/10/25 for a regular diet, regular texture, regular/thin consistency. An observation on 09/22/25 from 12:14 P.M. to 12:30 P.M. during lunch meal service in the main dining room revealed Certified Nursing Assistant (CNA) #138 began serving lunch trays, prior to serving Resident #69's meal tray CNA #138 did not perform hand hygiene. CNA #138 set up Resident #69's lunch meal and went to get another meal tray without performing hand hygiene. CNA #138 served Resident #26's lunch tray and assisted in setting up Resident #26's meal and went to get another meal tray without performing hand hygiene. CNA #138 served Resident #20's lunch tray and assisted setting up Resident #20's meal without performing hand hygiene. Interview on 09/22/25 at 12:35 P.M. with CNA #138 confirmed there was no hand hygiene completed prior to and during lunch meal service for Residents #20, #26, and #69. CNA #138 verified hands are to be washed prior to and during meal service for residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility's policy titled Handwashing/Hand Hygiene undated revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. This deficiency represents non-compliance investigated under Complaint Number 2575168.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interviews, and record review, the facility failed to maintain flooring for two residents (#53 and #67) out of 25 residents observed for environment. Additionally, the facility failed to ensure carpeting throughout facility was maintained in clean and sanitary manner. This had the potential to affect all 71 facility residents.Findings include 1. Observation on 09/22/25 at 2:08 P.M. of Resident #53 and #67's room revealed flooring under and around the room air conditioner was peeling up about an inch off the floor and about eight tiles were affected. Observation and interview on 09/23/25 at 12:10 P.M. with Maintenance Director (MD) #190 confirmed Resident #53 and #67's flooring was peeling up and stated he was aware of issues with flooring and was trying to get the broken flooring replaced in order of severity. He stated the facility had been working on replacing flooring and he had a list they were working through. He reported the facility had been working on the flooring for several months and had only completed five rooms. 2. Observations from 09/22/25 from 8:00 A.M. to 4:45 P.M. and 09/23/25 from 8:20 A.M. to 12:00 P.M. found facility carpeting in hallways to be dirty with grime and dark staining showing tracks and old moisture stains outside each resident room and down the middle of the hallway and around the offices and nursing stations. Observation and interview on 09/23/25 at 12:10 P.M. with Maintenance Director (MD) #190 confirmed the carpet was dirty and stated they tried to clean it, but it did not work. He revealed the facility was trying to get it replaced and revealed the corporate office was reviewing options for replacement. MD #190 was unable to provide any evidence that facility had taken any steps for replacement including quotes or order confirmations. He revealed they had a carpet cleaner that was used once monthly to maintain the carpets but confirmed they did not maintain it in a sanitized and clean manner. Review of facility policy titled Resident Environmental Quality dated 11/29/22, revealed the facility shall maintain and provide a safe, functional, sanitary and comfortable environment for residents, maintain all essential patient care equipment in safe operating condition, and all facility personnel were responsible for reporting broken, defective equipment and furnishings upon identification. It stated preventative maintenance schedules should be in place to maintain the building and equipment to maintain a safe environment.This deficiency represents non-compliance investigated under Complaint Number 2575168 and Complaint Number 1260918.