

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Pickerington Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, resident and staff interviews and policy review, facility failed to ensure the survey results binder was easily accessible to all residents. This had the potential to affect all facility residents. Facility census was 71. Findings include Observation on 09/25/25 at 11:34 A.M. revealed the survey book was located in the front hallway between the administration offices and the staff and visitor bathrooms. It was sitting in a folder shelf and the binder was bolted to the wall. The shelf sat about chest high on the wall and was pointed upward requiring a person to lift the binder up and out of the shelf which would be difficult for a resident sitting lower to the ground in a wheelchair. The chain was about 18-24 inches long and would not allow a resident to review the binder without standing in the hallway up against the wall. Interview on 09/25/25 at 2:00 P.M. with Director of Nursing revealed she did not know why the binder was chained to the wall and stated likely so residents would walk away with it or take it to their rooms. The Director of Nursing acknowledged it would be difficult for residents to get the binder and have to stand and read it in the hall. Interview on 09/25/25 at 2:15 P.M. with Regional Nurse #300 revealed she was unsure why the binder would be chained up in the front hallway. Review of facility policy titled Resident Rights dated 06/01/24, revealed the resident had the right to examine the results of the recent state survey and any plans of correction with respect of the facility.		

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 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.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 ensure splints ordered and care planned for residents with decreased range of motion were applied. This affected five (Resident #5, Resident #20, Resident #76, Resident #81 and Resident #87) of seven residents reviewed for mobility and position. The facility census was 71. 1. 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). Resident #87 was dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Resident #87 had an indwelling urinary catheter and is always incontinent of bowel. Review of the physicians orders revealed an order dated 08/11/25 for staff to don bilateral resting hand splints up to six hours daily as tolerated. Check skin integrity and circulation every shift. Review of the treatment records revealed staff documented the splints had been applied on 09/22, 09/23 and 09/24/25. Observations made on 09/23/2025 at 9:16 A.M. and 2:07 P.M. and 09/24/25 at 7:23 A.M., 10:23 A.M., 2:36 P.M., and 3:21 P.M. revealed no splints observed in place. Interview with Licensed Practical Nurse (LPN) #129 on 09/24/25 at 3:21 P.M. confirmed Resident # 87 did not have splints in place on this shift and splints had been signed off in the electronic record as being utilized. 2. Review of Resident #81's medical record revealed he was readmitted to the facility on [DATE]. Diagnoses included acute respiratory failure, protein calorie malnutrition, metabolic encephalopathy, adult failure to thrive, depression, old myocardial infarction, contractures and anoxic brain damage. Review of the quarterly Minimum data set assessment dated [DATE] revealed Resident #81's cognition was not intact, and he was rarely/never understood. Resident #81 was dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Resident #81 had an indwelling urinary catheter and was always incontinent of bowel. Further review of the plan of care dated 04/10/25 revealed the resident had loss of muscle function/range of motion (ROM) due to contractures of bilateral upper and bilateral lower extremities. Staff to don bilateral elbow orthotics, right rolling hand splint and left resting hand splint up to six hours daily each shift with frequent skin checks. Observations made on 09/23/2025 at 2:22 P.M., on 09/24/25 at 7:15 A.M., 9:21 A.M., 11:24 A.M., 3:00 P.M. and 5:50 P.M. and on 09/25/25 at 7:30 A.M., at 10:00 A.M. and 2:25 P.M. revealed no splints observed in place. On 09/25/25 at 2:25 P.M. observation and interview with Licensed Practical Nurse (LPN) #247 (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed his splints were not in place. 3. Review of Resident #76's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure, nontraumatic intracerebral hemorrhage, cerebral infarction, chronic obstructive pulmonary disease, peripheral vascular disease, contracture of right hand, and hemiplegia and hemiparesis. Review of the quarterly MDS assessment dated [DATE] revealed his cognition is not intact. Resident #76 was dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning, had a urinary catheter and was frequently incontinent of bowel. Resident #76 had a functional limitation in range of motion impairment on both sides of the upper and lower extremities. Review of the physician's orders dated 06/27/25 revealed staff to don bilateral elbow orthotics and bilateral resting hand splints up to six hours per shift as tolerated and check skin integrity and circulation. Observations of Resident #76 made on 09/22/25 at 9:10 A.M., 09/23/25 at 2:03 P.M. and 4:00 P.M. and 09/24/25 at 7:22 A.M., 9:58 A.M., 11:20 A.M., 2:34 P.M. and 3:18 P.M. revealed no splints were observed in place. On 09/24/25 at 3:18 P.M. LPN #129 was interviewed during the observation and it was verified the splints were not in place and the splints were located in the Resident's closet. 4. Review of Resident #5's medical record revealed an admission date of 03/03/23 with diagnoses including but not limited to congestive heart failure (CHF), anoxic brain damage, respiratory failure, ventilator dependent, high blood pressure, contractures, and anxiety. Review of Resident #5's physician orders revealed an order dated 06/17/25 for staff to don bilateral resting hand splints up to six hours daily as tolerated. Check skin integrity and circulation every shift. Review of Resident #5's Treatment Administration Record (TAR) dated 09/01/25 to 09/24/25 revealed the order for staff to don bilateral resting hand splints up to six hours daily as tolerated. Check skin integrity and circulation every shift, had been marked as being completed as ordered. An observation on 09/22/25 at 10:15 A.M. revealed Resident #5 lying in bed with the television on. There were no bilateral hand splints in place for Resident #5 and there were no hand splints visible in the room. An observation on 09/24/25 at 8:37 A.M. revealed Resident #5 lying in bed with staff performing personal hygiene tasks. Resident #5 did not have any hand splints in place and there were no hand splints visible in the room. An interview on 09/24/25 at 9:05 A.M. with Unit Manager (UM) #197 confirmed Resident #5 did not have bilateral hand splints in place. UM #197 stated Resident #5's hand splints should be somewhere in his room. An observation on 09/24/25 at 9:12 A.M. revealed UM #197 located Resident #5's bilateral hand splints in the bottom drawer of the three-drawer dresser in Resident #5's room. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record for Resident #20 revealed an admission date 11/14/22 with diagnoses including but not limited to high blood pressure, depression, dementia and contracture of left hand. Review of Resident #20's quarterly minimum data set (MDS) dated [DATE] revealed Resident #20 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of a 9 out of a possible score of 15 and Resident a#20 was dependent on staff for completion of cares. Review of Resident #20's physician orders revealed an order dated 09/09/25 for resident to wear right palm protector to right hand up to four hours daily as tolerated, check skin integrity and circulation every shift. Review of Resident #20's Activities of Daily Living (ADL) care plan dated 12/20/19 revealed encourage resident to wear left hand roll splint to right hand and fingers to wear four hours a day as tolerated, and contracture care plan dated 06/07/24 revealed Resident has contractures of bilateral knees, elbows, hips, and right hand and wrist. Review of Resident #20's TAR dated 09/01/25 to 09/24/25 revealed right hand palm protector order being documented as completed per order. An observation on 09/24/25 at 8:38 A.M. revealed a hand splint located in the broken second drawer of Resident #20's three-drawer dresser in her room. An observation on 09/24/25 at 3:10 P.M. revealed Resident #20's hand splint continued to be located in the broken drawer in her room. An interview on 09/24/25 at 3:15 P.M. with Licensed Practical Nurse (LPN) #152 confirmed Resident #20's right palm protector was located in the broken drawer of the three-drawer dresser. LPN #152 stated Resident #20 should have the right palm protector in place every day. Reviewed the facility's policy titled Promoting Range of Motion dated 10/01/22 revealed residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable.		

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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 facility policy review the facility failed to store and label frozen food in a sanitary manner. This deficient practice had potential to affect 49 residents receiving prepared food from the facility's kitchen. The facility's census was 71. Findings Include: An observation on 09/22/25 at 8:45 A.M. during the initial kitchen tour revealed in the walk-in freezer a crate with an opened cardboard box of approximately 30 beef patties in a clear unsealed bag exposed to the open air, a cardboard box of frozen diced carrots in an unsealed opened blue plastic bag exposed to the open air, an opened cardboard box of frozen peas in an unsealed blue plastic bag located under the box of frozen diced carrots the bag of frozen peas were exposed to the bottom of the cardboard box of frozen carrots, and there was an opened cardboard box of frozen green beans in an opened unsealed blue plastic bag which was opened to the air. There were no open dates on any of the four cardboard boxes of frozen food. An interview on 09/22/25 at 9:00 A.M. with the Dietary Manager (DM) #206 confirmed the opened and undated boxes of frozen beef patties and frozen vegetables. DM #206 stated the bags inside the cardboard boxes should be sealed with a clip once opened, the boxes should be closed and there should be dates placed on the boxes once opened. Review of the facility's policy titled Food Handling and Storage policy dated 12/10/24 revealed all opened frozen food will be dated, labeled and wrapped or sealed. This deficiency represents non-compliance investigated under Complaint Number 1260918.		

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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. 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	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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **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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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. 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 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pickerington Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Hill Road North Pickerington, OH 43147	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to develop and implement a comprehensive care plan addressing the use of hand splints for a resident with contractures. This deficient practice affected one resident (Resident #5) out of three residents reviewed for care planning. The facility census was 71. Findings Include: Review of Resident #5's medical record revealed admission date 03/03/23 with diagnoses including but not limited to congestive heart failure (CHF), anoxic brain damage, respiratory failure, ventilator dependent, high blood pressure and anxiety. Review of Resident #5's quarterly [NAME] Data Set (MDS) dated [DATE] revealed Resident #5 had severe impaired cognition and was dependent on staff for all care. Review of Resident #5's physician orders revealed an order dated 06/17/25 for staff to don bilateral resting hand splints up to 6 hours daily as tolerated and to check skin integrity and circulation every shift. Review of Resident #5's Treatment Administration Record (TAR) dated 09/01/25 to 09/24/25 revealed the order for staff to don bilateral resting hand splints up to 6 hours daily as tolerated and to check skin integrity and circulation every shift were marked as being completed every shift. Review of Resident #5's comprehensive care plan revealed as of 09/23/25 there was not a care plan implemented for the use of Resident #5's bilateral resting hand splints. An interview on 09/24/25 at 3:45 P.M. with the Director of Nursing (DON) confirmed Resident #5 did not have a care plan for the use of bilateral resting hand splints implemented at the time of Resident #5's record review. The DON confirmed the care plan for Resident #5's use of bilateral resting hand splints had been written and implemented on 09/24/25. Review of facility policy titled Comprehensive Care Plans dated 08/22/22 revealed facility shall develop and implement a comprehensive care plan for each resident. Factors identified by the interdisciplinary team in accordance with residents needs and preferences. The care plan shall describe services to be furnished, services that should be provided but were not due to resident expressing their right to refuse, specialized services resulting from the PASARR assessment, discharge goals and information, resident specific preferences and interventions related to trauma. The care plan shall be reviewed and revised after each comprehensive and quarterly assessment.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and record review, facility failed to revise a dental care plan for two Residents (#32 and #60) and a vision care plan for one Resident (#82). This affected three residents (#32, #60 and #82) out of 25 residents in the survey sample. Facility census was 71. Findings include 1. 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 an impaired dental status as evidenced by dentures. It noted the resident lost some/all natural teeth with interventions to arrange for dental consults and follow up visits by dentistry as needed. Review of dental visit note dated 03/28/25 revealed the resident wore dentures. Review of progress note dated 07/15/25 revealed the resident returned from a hospital stay back to the facility and the resident's dentures had gone missing while he was at the hospital. Review of speech therapy notes dated 07/16/25 revealed Resident #32's dentures were lost during a hospital stay and stated the resident was requesting a diet downgrade to mechanical soft. Speech therapy was consulted to evaluate. There was no documented evidence of an update to the care plan regarding Resident #32's missing dentures. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 11 indicating impaired cognition. Interview and observation on 09/22/25 at 10:39 A.M. with Resident #32 revealed he was missing his dentures. He revealed they were lost when he was at the hospital and was wondering if the facility was getting his dentures back. Resident #32 stated he had been asking to see the social services staff, but she had not spoken with him. Interview on 09/24/25 at 8:35 A.M. with Regional Administrator #350 confirmed the facility had no documentation that staff followed up with Resident #32 related to dental services after his dentures were lost. He revealed the facility requested an emergency request for a dental visit to address the concerns or resident getting new dentures. Interview on 09/24/25 at 11:06 A.M. with Social Services #139 revealed the facility was informed of the missing dentures when he returned from the hospital on [DATE], but she thought the resident would not want his dentures replaced and confirmed she did not speak with him about the replacement of his dentures. Interview on 09/24/25 at 4:35 P.M. with Minimum Data Set (MDS) Nurse #208 confirmed Resident #32's care plan and was not updated after the resident's dentures went missing at the hospital. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #60 revealed an admission date of 11/11/22. Diagnoses included schizophrenia, Parkinson's dementia, diabetes, dysphagia and encephalopathy. Review of the plan of care dated 10/29/24 revealed the resident was at risk for dental or chewing problems related to impaired cognition and poor dentition with notes dated 07/16/24 that the resident refused to brush her teeth and a tooth was extracted. Interventions included arrange for periodic dental consults, assist with oral hygiene, review nutritional status at least quarterly, and follow-up with dentistry. The care plan did not include mention of broken teeth, mouth infections, and needing or declining full mouth extractions. Review of the dental notes dated 11/01/24 revealed the resident had broken teeth causing some discomfort and was requesting to have all teeth pulled and to get dentures. They informed her she would need to see an oral surgeon for the procedure and recommended her to follow up for extractions. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of dental notes dated 08/04/25 revealed the resident informed the dentist she had spoken with a doctor at the hospital and was informed she would need to be under (anesthesia) for extractions and so she decided against the procedure. Interview on 09/23/25 at 8:50 A.M. with Resident #60 revealed she was supposed to get her teeth pulled and had mouth pain. Interview on 09/24/25 at 4:35 P.M. with Minimum Data Set (MDS) Nurse #208 confirmed Resident #60's care plan was not updated with changes in dental needs including needing full mouth extractions and having pain and mouth infections. 3. Review of the medical record for Resident #82 revealed an admission date of 08/24/20. Diagnoses included acute cystitis, sepsis, diabetes type two, cognitive communication deficit, dysphagia, and muscle weakness. Review of the plan of care dated 04/21/22 revealed the resident was at risk for visual decline and wore glasses. Interventions included encourage the resident to wear glasses, keep call light in reach, and keep glasses in a safe space. The care plan did not include any mention of changes in vision, increased blurring of vision or recommendations for cataract surgery. Review of the eye exam dated 04/17/25 revealed cataract surgery was recommended for Resident #82 with a follow up in four to five months. It stated to continue wearing glasses and glasses would need updated after the cataract surgery. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of the progress notes dated 08/15/25 revealed the resident was requesting to see the eye doctor and stated the cataracts were getting worse. Social Services made an appointment for 11/10/25. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/23/25 at 8:45 A.M. with Resident #82 revealed he saw an eye doctor about 4 months ago and was wondering about the follow up. He stated he was supposed to get new glasses as well. Interview on 09/24/25 at 11:06 A.M. with Social Services #139 revealed the progress note dated 08/15/25 related to Resident #82 's eye appointments. She confirmed the facility had no evidence of a timely follow up or any attempts to make appointments prior to from 04/2025 until 08/2025. Interview on 09/24/25 at 4:35 P.M. with Minimum Data Set (MDS) Nurse #208 confirmed Resident #82's care plan was not updated with changes in vision and the recommendation for cataract surgery.		

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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. An interview on 09/23/25 at 2:29 P.M. with Certified Nursing Assistant (CNA) #161 confirmed (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 medical record review, observation and staff interview, the facility failed to ensure ongoing resident centered activities program that incorporated the resident's interests, hobbies and cultural preferences. This affected one (Resident #87) of four residents observed for activities. The census was 71. Findings include: 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 he was cognitively impaired, he was dependent upon staff for oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. He also had an indwelling urinary catheter and was always incontinent of bowel. Review of the activity assessment dated [DATE] revealed he enjoyed listening to music, staff would offer one to one visits for stimulation and staff would offer bedside stimulation for cognitive difficulties two times per week. Review of the plan of care dated 09/24/25 revealed the resident needed escorted/assisted to participate in activities of interest, he was dependent on staff for activities, cognitive stimulation, social interaction due to needing bedside stimulation for sensory and tactile therapy. It noted the resident would maintain involvement in cognitive stimulation and social activities as desired through the next review with one to one bedside/in room visits and activities if the resident was unable to attend out of room activities. Resident #87 was of Haitian decent and enjoyed cultural music therapy, staff would offer music on echo in his room as desired by the resident and family. Review of the Activity in Room Visits for 07/2025 revealed in room activities were documented on 07/01, 07/06, 07/12, 07/21 and 07/27. For 08/2025 in room activities were documented on 08/02 and 08/09, sleeping was documented as an activity, on 08/11, 08/16, 08/25 and 08/31. For 09/2025 in room activities were documented on 09/03 as up in chair and music therapy on 09/05, 09/06, 09/09, 09/16, and 09/18. On 09/20 and 09/21 family visits were documented as an activity. Observation on 09/22/25 at 9:43 A.M. revealed no television/radio activity being performed. Observation on 09/23/25 at 9:10 A.M. revealed no television/radio activities were observed being performed. At 2:18 P.M. Resident #87 remained in bed, but now with his television on. Observation on 09/24/25 at 7:30 A.M. the resident was in bed on his back with no television or radio observed on. At 2:36 P.M. and 3:31 P.M. the television was on ESPN (In English). Interview on 09/24/25 at 4:55 P.M. with Activity Director (AD) #120 confirmed Resident #87 did not speak English so they usually had his echo play Haitian music. Sensory activities were to be completed twice a week and one of her assistants who worked weekends read to him in his language. AD #120 acknowledged no music was heard playing in the last three days and that the TV had been on but it was in English.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review, staff interviews, and facility policy review, the facility failed to prevent a delay in treatment for a resident requiring antibiotic use (Resident #1). This affected one resident (Residents #1) out of four residents reviewed for quality of care. The facility census was 71. Findings Include: Review of Resident #1's medical record revealed admission date of 08/14/25 with diagnoses including but not limited to pleural effusion, chronic obstructive pulmonary disease (COPD), pneumonia, depression, high blood pressure, and anxiety. Review of Resident #1's progress notes revealed on 09/10/25 at 9:33 P.M. Resident #1 showed the nurse a medication cup with brown/tan colored sputum in it. Notification was made to MedOne and an order was received for a chest X-ray and to complete a SARS-CoV-2 (COVID-19) test, with the COVID-19 test results being negative at 10:17 P.M. Review of the chest X-ray results dated 09/11/25 at 10:30 A.M. revealed Resident #1 had bilateral lower lobe atelectasis (complete or partial collapse of a lung or a section of lung) with possible right lower pneumonia. Review of Resident #1's progress notes revealed on 09/11/25 at 8:54 P.M. the Nurse Practitioner (NP) was notified of the chest X-ray results, there was no response from the NP noted. Further review of Resident #1's progress notes revealed on 09/12/25 at 9:49 P.M. and again on 09/15/25 at 9:03 P.M., Resident #1's chest X-ray results were communicated to MedOne with no response documented. Review of Resident #1's progress note dated 09/17/25 at 6:32 P.M. revealed an order received for Levaquin (antibiotic) tablet 250 milligrams (mg) with instructions to give two tablets by mouth one time a day for pneumonia for 7 days from 09/18/24 to date 09/24/25. Review of Resident #1's physician orders revealed an order dated 09/18/25 for Levaquin (antibiotic) tablet 250 milligrams (mg) with instructions to give two tablets by mouth one time a day for pneumonia for 7 days from 09/18/24 to 09/24/25. Review of Resident #1's Medication Administration Record (MAR) dated 09/18/25 to 09/24/25 revealed the order for Levaquin was administered as ordered. An interview on 09/25/25 at 2:01 P.M. with the Director of Nursing (DON) agreed there was a 6-day delay in receiving antibiotic treatment for Resident #1. The DON stated in some cases the facility nurse practitioner would monitor the resident and may order other medications, treatments, or labs prior to ordering an antibiotic for treatment of an acute condition which required medication use. Reviewed the facility's policy titled Notification of Changes dated 01/01/25 revealed the facility must consult with the resident's physician when there is a change requiring notification including commence a new form of treatment to deal with a problem.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **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 timely follow up for ophthalmology services for one Resident (#82) of one reviewed for ophthalmology services. Facility census was 71. Findings include: Review of the medical record for Resident #82 revealed an admission date of 08/24/20. Diagnoses included acute cystitis, sepsis, diabetes type two, cognitive communication deficit, dysphagia, and muscle weakness. Review of the plan of care dated 04/21/22 revealed the resident was at risk for visual decline and wore glasses. Interventions included encourage the resident to wear glasses, keep call light in reach, and keep glasses in a safe space. The care plan did not include any mention of changes in vision, increased blurring of vision or recommendations for cataract surgery. Review of the eye exam dated 04/17/25 revealed cataract surgery was recommended for Resident #82 with a follow up in four to five months. It stated to continue wearing glasses and glasses would need updated after the cataract surgery. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of the progress notes dated 08/15/25 revealed the resident was requesting to see the eye doctor and stated the cataracts were getting worse. Social Services made an appointment for 11/10/25. Interview on 09/23/25 at 8:45 A.M. with Resident #82 revealed he saw an eye doctor about 4 months ago and was wondering about the follow up. He stated he was supposed to get new glasses as well. Interview on 09/24/25 at 11:06 A.M. with Social Services #139 revealed the progress note dated 08/15/25 related to Resident #82's eye appointments. She confirmed the facility had no evidence of a timely follow up or any attempts to make appointments prior to from 04/2025 until 08/2025. Review of facility policy titled Ancillary Services dated 01/01/25 revealed facility shall assist residents in obtaining routine and emergency ancillary services as needed including vision services.		

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NAME OF PROVIDER OR SUPPLIER Pickerington Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Hill Road North Pickerington, OH 43147	
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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 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 oversight 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 (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Catheter care shall be performed each shift and as needed. Review of facility policy titled Comprehensive Care Plans dated 08/22/22 revealed facility shall develop and implement a comprehensive care plan for each resident. Factors identified by the interdisciplinary team in accordance with residents needs and preferences. The care plan shall describe services to be furnished, services that should be provided but were not due to resident expressing their right to refuse, specialized services resulting from the PASARR assessment, discharge goals and information, resident specific preferences and interventions related to trauma. The care plan shall be reviewed and revised after each comprehensive and quarterly assessment. This deficiency represents non-compliance investigated under Complaint Number 1260943.		

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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 record review, observation, staff interview and review of facility policy the facility failed to ensure dietary adaptive equipment was provided for a dependent resident. This deficient practice affected one resident (Resident #20) out of two residents reviewed for adaptive equipment use. The facility census was 71. Findings Include: Review of Resident #20's medical record revealed admission date 11/14/22 with diagnoses including but not limited to high blood pressure, depression, dementia, contractures, and dysphagia. Review of the quarterly minimum data set (MDS) dated [DATE] revealed Resident #20 had impaired cognition with a brief Interview of mental status (BIMS) score of 9 out of a possible score of 15. Resident #20 required assistance with meal set and was dependent for cares. Review of Resident #20 physician orders revealed an order dated 09/03/25 for resident to utilize scoop plate and two handled cup with lid for all meals to increase functional independence. Review of Resident #20's nutritional care plan dated 09/03/25 revealed Resident #20 required adaptive equipment at meals. Review of Resident #20's dietary progress note dated 09/03/25 at 6:18 P.M. revealed Resident #20 used a scoop plate and two handled cup with lids at meals to facilitate self-feeding per therapy. Observation on 09/24/25 at 8:38 A.M. revealed Resident #20 sitting up in bed with the bedside table over the bed with breakfast tray on the table. On the breakfast tray was a two-handled cup with juice, a carton of chocolate milk with a straw in it and Resident #20 was holding a single handled brown mug of coffee with no lid in place. An interview on 09/24/25 at 9:25 A.M. with Certified Nursing Assistant (CNA) #164 confirmed Resident #20's liquids were not in a two-handled cup with a lid. CNA #164 stated all of Resident #20's liquids should be adaptive cups. Reviewed the facility's policy titled Meal Supervision and Assistance undated revealed ensure that the necessary non-food items are on the tray; especially assistive and adaptive devices. Report or replace missing items.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and facility policy and procedure review, the facility failed to ensure enteral feedings were labeled and dated when the feeding was initiated and hung for administration. This affected three (Resident #10, #39 and #81) of six residents with enteral feedings. The census was 71. Findings include: 1. Review of Resident #10's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease, heart failure, depression, anxiety, atrial fib, tracheostomy and gastrostomy. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed his cognition was intact (BIMS 15). Requires partial/moderate assistance for oral hygiene, dependent on toileting, shower/bathing, dressing, personal hygiene and substantial maximal assistance for turning and repositioning. Resident was frequently incontinent of bowel and bladder. Review of the physicians orders on 08/26/25 Enteral Nutrition of Isosource 1.5 (high-calorie, high-protein, high-fiber tube-feeding formula) at a rate of 65 milliliters (ml) per hour via pump per gastrostomy (tube through the abdominal wall into the stomach) tube to infuse 1560 ml/24 hrs. Observation on 09/22/25 at 9:00 A.M. observed the enteral feeding of Isosource 1.5 at 65 ml per hour per pump and it was not label with Resident #10's name or the date. Also a syringe was hanging undated and without the residents name. Interview on 09/22/25 at 11:35 A.M. with Registered Nurse (RN) #228 it was verified the tube feeding was not labeled with the resident name and it was undated. 2. Review of Resident #81's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure, protein calorie malnutrition, metabolic encephalopathy, adult failure to thrive, depression, old myocardial infarction, contractures and anoxic brain damage. Review of the quarterly Minimum data set assessment dated [DATE] revealed the resident's cognition was not intact, and he was rarely/never understood. Resident #81 was dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Had an indwelling urinary catheter and was always incontinent of bowel. Review of the physicians orders for 07/08/25 Enteral Nutrition via pump Isosource 1.5 at rate of 60 ml per hour via pump per nasogastric (tube through the nose down into the stomach) tube to infuse 1140ml/24 hrs. Observation on 09/22/2025 9:10 A.M. revealed Isosource 1.5 and the syringe was not labeled or dated. Interview on 09/22/25 at 11:25 A.M. with RN #228 it was verified the Isosource 1.5 and syringe were not labeled or dated for Resident #81. 3. Review of Resident #39's medical record revealed admission date 09/15/25 with diagnoses including but not limited to history of stroke, high blood pressure, depression and anxiety. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's physician orders revealed an order dated 09/16/25 for enteral nutrition via pump &ndash; Diabetisource at 50 milliliters (ml) per hour for 10 hours via percutaneous endoscopic gastrostomy (PEG) tube, start feeding at 8:00 P.M. and continue until 6:00 A.M. until 500 ml is infused and an order dated 09/15/25 for feeding tube hydration bag and set-up change daily (label with patient identifier and date) one time a day. Review of Resident #39's alteration in nutrition care plan dated 09/23/25 revealed Resident #39 received tube feeding and altered diet. An observation on 09/22/25 at 11:32 A.M. revealed in Resident #39's room a feeding tube pump attached to a pole with a bag of Diabetisource formula without a date or time when hung for administration, and a clear bag of water with no date of when hung for administration. Resident #39 was not receiving either water flushes of formula at the time of the observation. An interview on 09/22/25 at 11:40 A.M. with Licensed Practical Nurse (LPN) #104 confirmed Resident #39's Diabetisource formula bag and the water flush bag was not dated at the time of administration. A review of the facility's policy titled Enteral Tube Feeding via Continuous Pump dated 03/01/15 revealed on the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, facility failed to follow pain order parameters for Resident #61. The facility also failed to offer non-pharmacological interventions to two Residents (#8 and #61) of two reviewed for pain. Facility census was 71. Findings include: 1. Review of the medical record for Resident #61 revealed an admission date of 07/30/25. Diagnoses included pressure ulcer, diabetes, respiratory failure with hypoxia, lymphedema and anxiety. Review of physician orders on 08/01/25 revealed an order for Oxycodone HCl (opioid) tablet 5 milligram (mg) with instructions to give one every four hours as needed for pain rating of 1-4 with 30 mg daily maximum. Review of physician orders on 08/01/25 revealed an order for Morphine Sulfate (opioid) 20 mg/milliliter (ml) with instructions to give 0.5 ml by mouth every 12 hours as needed for pain of 5-10. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 14 indicating intact cognition. Review of the plan of care dated 08/12/25 revealed resident was at risk of adverse reaction related to use of narcotic medications with interventions to administer medications as ordered. Review of the medication administration record (MAR) dated 08/2025 revealed Oxycodone was given on 08/02/25, 08/04/25, 08/05/25, twice on 08/07/25, twice on 08/08/25, 08/09/25, 08/13/25, 08/16/25, 08/17/25, 08/22/25, 08/23/25, 08/27/25, 08/28/25, 08/31/25 for a pain scores of five to eight Review of the MAR dated 09/2025 revealed Oxycodone was given on 09/01/25, twice on 09/02/25, 09/03/25, 09/05/25, 09/07/25, 09/08/25, 09/09/25, 09/12/25, 09/14/25, 09/16/25, 09/21/25, 09/22/25, 09/25/25 for pain scores from five to ten and Morphine was given on 09/15/25 was given for a pain score of zero. Review of non pharmacological interventions coding for pain medications included repositioning, offer fluids, provided one to one care, offer diversional activities, massage, offer food, and music therapy. Review of the medical record found no evidence of non-pharmacological interventions being offered prior to provided pain medications. Interviews on 09/25/25 from 3:00 P.M. to 3:10 P.M. with the Director of Nursing and Regional Nurse #300 confirmed medications were documented as given outside the ordered pain parameters. Email on 09/25/25 at 3:06 P.M. with Administrator revealed a request for evidence non-pharmacological interventions, no evidence was provided. 2. Review of Resident #8's medical record revealed she was admitted tot he facility on 01/28/25. Diagnoses include acute and chronic respiratory failure, tracheostomy, encephalopathy, chronic obstructive pulmonary disease (COPD), seizures, dependence on respirators, schizoaffective disorder and depression. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was moderately impaired. She was independent with eating, required supervision or touching assistance with oral hygiene, dependent on shower/bathing, toileting, and personal hygiene. Always incontinent of bowel and bladder. Review of the physicians orders dated 06/17/24 revealed an order for Oxycodone (opioid) HCl 5 mg give one tablet by mouth every six hours as needed for pain rating of 5-10. Review of the plan of care dated 06/28/24 staff are to attempt non-pharmacologic interventions prior to medicating. Document these attempts in the medical record. Review of the medication administration record for 06/25 revealed Resident #8 received Oxycodone HCL 5 mg on 06/02, 06/05, 06/06, 06/08, 06/15, 06/18, 06/19, 06/20, 06/22, 06/23, 06/25, 06/28 and 06/29. There was no documented evidence of non pharmacological intervention attempted prior to medication administration. Review of the medication administration record for 07/25 revealed Resident #8 received Oxycodone HCL 5 mg on 07/07, 07/10, 07/13, 07/15, 07/17, 07/21, 07/24 and 07/26. There was no documented evidence of non pharmacological intervention attempted prior to medication administration. Review of the medication administration record for 08/25 revealed Resident #8 received Oxycodone HCL 5 mg on 08/15, 08/18, 08/20, 08/23, 08/25, 08/26, 08/28, 08/29 and 08/31. There was no documented evidence of non pharmacological intervention attempted prior to medication administration. Review of the medication administration record for 09/25 revealed Resident #8 received Oxycodone HCL 5 mg on 09/01, 09/03, 09/4, 09/05, 09/08, 09/09 and 09/22. There was no documented evidence of non pharmacological intervention attempted prior to medication administration. On 09/25/25 at 2:01 P.M. interview with the Director of Nursing verified Resident #8 had no documented evidence of non pharmacological interventions being attempted prior to the use of her pain medication. Review of facility policy titled Pain Management dated 08/22/22, revealed the facility shall ensure pain management was provided to residents who require such services. The facility shall recognize, evaluate and manage or prevent resident pain. Non-pharmacological interventions include environmental comfort, loosening restrictive bandages and clothing, apply splinting, exercises and cognitive and behavioral interventions. Pain medication shall be prescribed and dosed in accordance with professional standards.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and record review, facility failed to ensure resident requests were follow up on in a timely manner. This affected one Resident (#93) of four observed for call lights. Facility census was 71. Findings include Review of the medical record for Resident #93 revealed an admission date of 09/18/25. Diagnoses included osteomyelitis, necrotizing fasciitis, anorexia, and lack of coordination. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 10 indicating impaired cognition. Interview on 09/22/25 at 1:48 P.M. with Resident #93 revealed she wanted something for pain and also wanted the nurse to look at a wound on her leg. Resident was requested to activate her call light to inform staff. Observation on 09/22/25 at 1:51 P.M. Activity Aide (AA) #157 answered the call light and deactivated it. AA answered several other call lights and talked with several staff in the hallway including the assigned nurse. No staff entered residents room to address her concerns after continuous observations from 1:48 P.M. to 2:28 P.M. Interview on 09/22/25 at 2:28 P.M. with Licensed Practical Nurse (LPN) #104 revealed she had not yet been informed of resident's request for pain interventions and for the nurse to look at the wound on her leg. LPN confirmed she would talk with resident and address her concerns and headed to her room. Observation on 09/22/25 at 2:30 P.M. revealed Activity Aide #157 was assisting with BINGO at this time. Review of facility call light audits from 07/01/25 to 09/22/25 revealed audits took place from 6:00 A.M. to 7:30 P.M. and were typically answered in less than a minute to three minutes. Interview on 09/24/25 at 6:00 P.M. with Administrator revealed call light audits were done by staff sitting at the nursing station and watching the call board light up and marking down the time it was activated and the time it was deactivated. He revealed when completing audits he did not verify how long it took for the staff the provide the requested item or care need. He revealed the expectation would be to leave the light on until the need was met and confirmed staff should immediately get the appropriate staff and equipment and address the concern. He confirmed a resident should not have to wait 40 minutes for care to be provided. Interviews on 09/25/25 from 11:00A.M. to 11:30 A.M. with Residents #13, #19, and #71 revealed call lights buttons are responded to timely, but then it can take 30-60 minutes for staff to return to complete the requested task. They revealed many times no one returns to complete the task and they have to turn the call light button back on.		

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of facility policy and procedure, the facility failed to act upon the pharmacy recommendations in a timely manner. This affected two (Resident #8 and Resident #60) of five residents reviewed for unnecessary medications. he census was 71. Findings include: 1. Review of Resident #8's medical record revealed she was admitted to the facility on [DATE]. Diagnoses include acute and chronic respiratory failure, tracheostomy, encephalopathy, chronic obstructive pulmonary disease (COPD), seizures, dependence on respirators, schizoaffective disorder and depression. Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was moderately impaired. She was independent with eating, required supervision or touching assistance with oral hygiene, and dependent on staff for shower/bathing, toileting, and personal hygiene. Resident #8 was always incontinent of bowel and bladder. Review of Pharmacy Medication Regime Review completed on 11/15/24 revealed Resident #8 had Effexor (antidepressant) 75 milligrams (mg) twice daily and Trazodone(antidepressant) 150 mg at bedtime. The recommendation stated Resident has taken her antidepressants since December 2023 for depression and insomnia. Psych also reports schizoaffective disorder. Last psych visit was 09/23/24 with reported mood as up and down and some hallucinations. Gradual Dose Reduction (GDR) contraindicated (CI) at the time of visit. No noted adverse effects will continue to follow. The recommendation for gradual dose reduction (GDR) at the time of the visit was not addressed until 12/11/24 and marked disagreed with the physician writing follows with psych defer management dated 12/18/24. Review of Pharmacy Medication Regime Review completed on 12/12/24 Recommendation to decrease Hydroxyzine (antihistamine) 25 mg twice a day for five days, then hydroxyzine 25 mg at bedtime for five days then stop. Not addressed by the physician until 01/10/25. Interview on 09/25/25 at 2:01 P.M. with the Director of Nursing verified the pharmacy recommendations were not followed up on in a timely manner. 2. Review of the medical record for Resident #60 revealed an admission date of 11/11/22. Diagnoses included schizophrenia, Parkinson's dementia, diabetes, dysphagia and encephalopathy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Review of the physician orders dated 11/11/22 to 04/11/25 revealed an order for Tizanidine hcl (muscle relaxant) tablet 2 mg every eight hours. Review of the physician orders dated 11/11/22 revealed an order for Buspirone hcl (anti-anxiety) 7.5 mg twice daily. Review of the physician orders dated 11/21/23 revealed an order for Seroquel (anti-psychotic) 100 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Pickerington Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg twice daily. Review of the physician orders dated 12/06/23 revealed an order for Seroquel 50 mg twice daily. Review of the physician orders dated 12/09/24 revealed an order for Lorazepam (Ativan) 1 mg twice daily. Review of Pharmacy recommendations dated 11/14/24 revealed a recommendation to complete gradual dose reduction for Seroquel 100 mg twice daily and 50 mg at 2:00 P.M. The recommendation stated this medication had been ordered since 12/2023 when it was last increased. The Physician/Nurse Practitioner addressed the form on 12/09/24 and stated disagree, due to psychiatric treatment and behaviors. Review of Pharmacy recommendations dated 11/14/24 revealed a recommendation to complete gradual dose reduction for Buspirone 7.5 mg twice daily and Ativan (anxiety) 0.5 MG twice daily. The recommendation stated this medication had been ordered since 11/2022 and 01/2024 respectively. The Physician/Nurse Practitioner addressed the form on 12/09/24 and stated disagree, due to psychiatric treatment and intermittent behaviors. Review of Pharmacy recommendations dated 03/11/25 revealed a recommendation to discontinue Tizanidine 2mg every eight hours as needed for muscle cramps. The recommendation stated this medication had not been used/administered in 90 days and asked for it to be discontinued. The Physician/Nurse Practitioner addressed the form on 04/09/25 and stated agree, discontinue Tizanidine. Interview on 09/25/25 at 2:01 P.M. with Director of Nursing confirmed the facility should have addressed the pharmacy recommendations sooner and it was an issue that had been addressed during more recent months. Review of facility policy titled Consulting Pharmacist Monthly Drug Review undated revealed the consulting pharmacist shall conduct a monthly review of resident medication regime. The Residents' attending physician must document a rationale in the residents medical record during their next visit for within (timeframe). The policy did not provide a specified timeframe outside of the next visit.		

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NAME OF PROVIDER OR SUPPLIER Pickerington Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Hill Road North Pickerington, OH 43147	
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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and review of facility policy, the facility failed to ensure timely follow up for dental services for one Resident (#32) of three reviewed for dental services. 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. Resident #32's payer source was Medicare. Review of the plan of care dated 02/06/25 revealed the resident had an impaired dental status as evidenced by dentures. It noted the resident lost some/all natural teeth with interventions to arrange for dental consults and follow up visits by dentistry as needed. Review of dental visit note dated 03/28/25 revealed the resident wore dentures. Review of progress note dated 07/15/25 revealed the resident returned from a hospital stay back to the facility and the resident's dentures had gone missing while he was at the hospital. Review of speech therapy notes dated 07/16/25 revealed Resident #32's dentures were lost during a hospital stay and stated the resident was requesting a diet downgrade to mechanical soft. Speech therapy was consulted to evaluate. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 11 indicating impaired cognition. Interview and observation on 09/22/25 at 10:39 A.M. with Resident #32 revealed he was missing his dentures. He revealed they were lost when he was at the hospital and was wondering if the facility was getting his dentures back. Resident #32 stated he had been asking to see the social services staff, but she had not spoken with him. Interview on 09/24/25 at 8:35 A.M. with Regional Administrator #350 confirmed the facility had no documentation that staff followed up with Resident #32 related to dental services after his dentures were lost. He revealed the facility requested an emergency request for a dental visit to address the concerns or resident getting new dentures. Interview on 09/24/25 at 11:06 A.M. with Social Services #139 revealed the facility was informed of the missing dentures when he returned from the hospital on [DATE], but she thought the resident would not want his dentures replaced and confirmed she did not speak with him about the replacement of his dentures. Review of facility policy titled Ancillary Services dated 01/01/25 revealed facility shall assist residents in obtaining routine and emergency ancillary services as needed including routine and emergency dental services.		

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

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NAME OF PROVIDER OR SUPPLIER Pickerington Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Hill Road North Pickerington, OH 43147	
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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident and staff interviews and policy review, facility failed to ensure mail was available to residents on Saturdays. This affected three residents (#13, #19 and #71) out of four residents interviewed in the resident council, and had the potential to affect all facility residents. Facility census was 71. Findings include: Interviews during the resident council meeting on 09/25/25 from 11:00A.M. to 11:30 A.M. with Residents #13, #19 and #71 complained they did not receive any mail on Saturdays. They stated it was delivered on Saturday, but no one got it from the mailbox and passed it out. They all reported they only got mail Monday through Friday. Interview on 09/25/25 at 11:35 A.M. with Receptionist #167 revealed she worked Monday through Friday and got the mail from the mailbox in front of the building and put mail for staff in their mailboxes and mail for residents in the Activities mailbox to be passed out by activity staff. The receptionist revealed she did not work on the weekends and no one checks the mailbox on the weekends. She stated she would get Saturday and Monday mail on Monday and place it in the Activities mailbox to be passed out. Interview on 09/25/25 at 7:00 P.M. with Regional Administrator #350 revealed activities staff worked on the weekends and residents could go get their own mail at the front desk. Regional Administrator was not aware only the Receptionist took the mail physically out of the mailbox and sorted it for activities staff to pass out to residents. Review of facility policy titled Resident Rights dated 06/01/24, revealed the resident had the right to receive mail.		