

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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: 365976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, policy review, and review of a Self-Reported Incident (SRI) investigation, the facility failed to notify the physician of a resident change in condition. This affected one (#69) of three residents reviewed for change in condition. The facility census was 97. Review of the medical record for Resident #69 revealed an admission date of 06/07/21. Diagnoses included dementia with behavioral disturbance, osteoarthritis, depression, anxiety, visual hallucinations, and bilateral hearing loss. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #69 had severe cognitive impairment. Review of the SRI submitted on 07/08/25 at 8:41 A.M. revealed on 07/04/25 at 6:00 A.M., Resident #68 indicated Resident #69 stated Licensed Practical Nurse (LPN) #202 had touched her chest while trying to wake her up to give her medications. Resident #68 stated he had not seen LPN #202 touch Resident #69's chest but he wanted to believe her so he had. Resident #68 stated he had not wanted LPN #202 back in the room. Resident #68 stated Resident #69 had issues with other male caregivers when on another unit but had not known why. Review of statements dated 07/05/25 by the Administrator revealed she had received a call from LPN #410 stating Resident #68's Power of Attorney (POA) had called to say the resident no longer wanted LPN #202 in their room. The POA reported Resident #68 stated the nurse had rubbed Resident #69's chest. The Administrator called the POA who reported he no longer wanted LPN #202 in the room due to Resident #68 reporting LPN #202 had rubbed Resident #69's chest when passing medications. The Administrator informed the POA the incident would be investigated. The Administrator called LPN #202 who explained he rocked Resident #69's shoulder while calling her name several times to wake her up. LPN #202 stated he had only touched Resident #69's shoulder when trying to wake her up. The Administrator spoke with Resident #68 who reported he had not seen the incident. Resident #68 then told Resident #69 to show the Administrator where the nurse touched her on the chest. Resident #69 appeared confused then after further prompting, Resident #69 rubbed the area above her chest mirroring where Resident #68 was rubbing his chest. Review of the nurse's notes dated 07/04/25 through 07/10/25 revealed no documentation the physician was notified of an allegation of sexual abuse for Resident #69. Interview on 07/10/25 at 10:54 A.M., the Administrator verified there was no documentation of the allegation of sexual abuse allegedly occurring on 07/04/25 at 6:00 A.M. in Resident #69's medical record and no documentation the physician was notified. The Administrator revealed the nurse should have documented the incident and notification in the medical record. The Administrator revealed she had notified the physician on 07/05/25 but the notification had not been documented in the medical record. Interview on 07/14/25 at 11:38 A.M., Licensed Practical Nurse (LPN) #410 revealed around lunch time on 07/04/25, Resident #68 alleged Resident #69 had stated a male nurse had touched her chest. LPN #410 revealed she had notified the Administrator on 07/04/25 at 1:30 P.M. LPN #410 revealed she had not notified the physician and was unsure if she was supposed to notify the physician. Review of the facility policy Notification of Changes, dated 10/02/22, revealed the resident's physician would be notified when there was a change requiring notification including accidents, significant changes in physical, mental or psychosocial condition, and circumstances requiring a need to alter treatment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of a Self-Reported Incident (SRI) investigation, staff interview, and review of facility policy, the facility failed to timely report an allegation of sexual abuse. This affected one (#69) of three residents reviewed for abuse and one of one SRIs submitted since the annual comprehensive survey. The facility census was 97. Review of the medical record for Resident #69 revealed an admission date of 06/07/21. Diagnoses included dementia with behavioral disturbance, osteoarthritis, depression, anxiety, visual hallucinations, and bilateral hearing loss. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #69 had severe cognitive impairment. Review of the medical record for Resident #68 revealed an admission date of 02/23/21. Diagnoses included hemiplegia and hemiparesis, hypertension, atrial fibrillation, and type two diabetes mellitus. Review of the quarterly MDS dated [DATE] revealed Resident #68 had intact cognition. Review of an SRI submitted on 07/08/25 at 8:41 A.M. revealed on 07/04/25 at 6:00 A.M., Resident #68 indicated Resident #69 had stated Licensed Practical Nurse (LPN) #202 had touched her chest while trying to wake her up to give her medications. Resident #68 stated he had not seen LPN #202 touch Resident #69's chest but he wanted to believe her, so he had. Resident #68 stated he just had not wanted LPN #202 back in the room. Resident #68 stated Resident #69 had issues with other male caregivers when on another unit but had not known why. Review of statements dated 07/05/25 by the Administrator revealed she had received a call from LPN #410 stating Resident #68's Power of Attorney (POA) had called to say the resident no longer wanted LPN #202 in their room. The POA reported Resident #68 stated LPN #202 had rubbed Resident #69's chest. The Administrator called the POA who reported he no longer wanted LPN #202 in the room due to Resident #68 reporting LPN #202 had rubbed Resident #69's chest when passing medications. The Administrator informed the POA the incident would be investigated. The Administrator called LPN #202 who explained he rocked Resident #69's shoulder while calling her name several times to wake her up. LPN #202 stated he had only touched Resident #69's shoulder when trying to wake her up. The Administrator spoke with Resident #68 who reported he had not seen the incident. Resident #68 then told Resident #69 to show the Administrator where the nurse touched her on the chest. Resident #69 appeared confused then after further prompting, Resident #69 rubbed the area above her chest mirroring where Resident #68 was rubbing his chest. Review of the nurse's notes from 07/04/25 through 07/10/25 revealed no documentation of the incident dated 07/04/25 in the residents' medical records. Interview on 07/10/25 at 10:15 A.M., Certified Nursing Assistant (CNA) #316 revealed Resident #68 reported Resident #69 had stated LPN #202 had touched her chest. CNA #316 revealed Resident #68 had reported the incident about a week and half ago, sometime during the week before 07/04/25. CNA #316 revealed she had reported the incident to the nurse but was unable to recall which nurse. CNA #316 revealed the nurse told her she had spoken with Resident #68 and Resident #69. CNA #316 revealed she had not been interviewed regarding the allegation and had not been asked to write a statement. Interviews on 07/10/25 beginning at 10:54 A.M., the Administrator revealed LPN #202 had worked a 12-hour night shift on 07/03/25 into 07/04/25. The Administrator revealed on 07/04/25 the day shift nurse LPN #410 called her around 1:30 P.M. and stated Resident #69 told Resident #68 that LPN #202 had touched her chest. The Administrator revealed she called LPN #202 and Resident #69's family. The Administrator verified she had not reported the incident occurring on 07/04/25 to the state agency until 07/08/25. Interview on 07/10/25 at 11:06 A.M., LPN #202 revealed he was notified a resident had made an allegation of sexual abuse when he worked night shift from 07/03/25 into 07/04/25. LPN #202 revealed the Administrator called him to discuss the incident six days ago. LPN #202 denied the allegation and stated he had touched the resident's shoulder when trying to wake her up to give her medications. Interview on 07/14/25 at 11:38 A.M., LPN #410 revealed on 07/04/25 around lunch time a nursing assistant had notified her Resident #68 wanted to speak with her. LPN #410 stated Resident #68 told her his spouse was not comfortable with male nurses and had not wanted male nurses in the room anymore. LPN #410 revealed after several minutes of conversation, Resident #68 reported Resident #69 told him a male nurse had touched her chest, but he had not witnessed the incident. LPN #410 revealed Resident #68 and Resident #69's Power of Attorney (POA) had called the facility stating they no longer wanted male staff providing care for Resident #69. LPN #410 revealed she then notified the Administrator on 07/04/25 around 1:30 P.M. LPN #410 revealed she had not documented the incident in the medical record. LPN #410 also revealed she had not notified the physician because she was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, review of a Self-Reported Incident (SRI) investigation, review of staff schedules and timekeeping records, and policy review, the facility failed to prevent further potential abuse during the investigation of an allegation of sexual abuse when the alleged perpetrator was allowed to continue to work on the same unit while an investigation was in progress. This had the potential to affect 36 residents (#75, #27, #88, #15, #11, #95, #63, #9, #82, #16, #47, #64, #53, #42, #39, #61, #74, #23, #46, #85, #24, #68, #69, #89, #87, #41, #20, #19, #10, #66, #58, #8, #31, #67, #96, #36) residing the Cedarview unit. The facility census was 97. Review of the medical record for Resident #69 revealed an admission date of 06/07/21. Diagnoses included dementia with behavioral disturbance, osteoarthritis, depression, anxiety, visual hallucinations, and bilateral hearing loss. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #69 had severe cognitive impairment. Review of the medical record for Resident #68 revealed an admission date of 02/23/21. Diagnoses included hemiplegia and hemiparesis, hypertension, atrial fibrillation, and type two diabetes mellitus. Review of the quarterly MDS dated [DATE] revealed Resident #68 had intact cognition. Review of a SRI submitted on 07/08/25 at 8:41 A.M. revealed on 07/04/25 at 6:00 A.M., Resident #68 indicated Resident #69 stated Licensed Practical Nurse (LPN) #202 had touched her chest while trying to wake her up to give her medications. Resident #68 stated he had not seen LPN #2-2 touch Resident #69's chest but he wanted to believe her so he had. Resident #68 stated he just did not want LPN #202 back in the room. Resident #68 stated Resident #69 had issues with other male caregivers when on another unit but had not known why. Review of statements dated 07/05/25 by the Administrator revealed she had received a call from LPN #410 stating Resident #68's Power of Attorney (POA) had called to say the resident no longer wanted LPN #202 in their room. The POA reported Resident #68 stated the nurse had rubbed Resident #69's chest. The Administrator called the POA who reported he no longer wanted LPN #202 in the room due to Resident #68 reporting LPN #202 had rubbed Resident #69's chest when passing medications. The Administrator informed the POA the incident would be investigated. The Administrator called LPN #202 who explained he rocked Resident #69's shoulder while calling her name several times to wake her up. LPN #202 stated he had only touched Resident #69's shoulder when trying to wake her up. The Administrator spoke with Resident #68 who reported he had not seen the incident. Resident #68 then told Resident #69 to show the Administrator where the nurse touched her on the chest. Resident #69 appeared confused then after further prompting, Resident #69 rubbed the area above her chest mirroring where Resident #68 was rubbing his chest. Interviews beginning on 07/10/25 at 10:54 A.M. the Administrator revealed LPN #202 had worked a 12-hour night shift on 07/03/25 into 07/04/25. The Administrator revealed on 07/04/25 the day shift nurse LPN #410 called and told her Resident #69 told Resident #68 that LPN #202 had touched her chest. The Administrator revealed she called LPN #202 and Resident #69's family. The Administrator verified she had not reported the incident to the state agency until 07/08/25. The Administrator revealed alert and oriented residents on the unit were interviewed with no concerns. The Administrator verified the facility was still in the process of completing skin assessments for the cognitively impaired residents on the unit and the investigation had not yet been completed. The Administrator verified LPN #202 was not suspended and had worked 12-hour night shifts on 07/07/25 and 07/08/25 while the investigation continued. Interview on 07/10/25 at 11:06 A.M. LPN #202 revealed a resident had made an allegation of sexual abuse when he worked night shift from 07/03/25 into 07/04/25. LPN #202 revealed the Administrator called him to discuss the incident six days ago. LPN #202 revealed he was not suspended during the investigation and had worked on 07/07/25 into 07/08/25 and 07/08/25 into 07/09/25. Review of staffing schedules from 07/03/25 through 07/10/25 revealed LPN #202 was scheduled three shifts on the Cedarview unit, on 07/03/25 from 6:30 P.M. to 7:00 A.M., on 07/07/25 from 6:30 P.M. to 7:00 A.M., and on 07/08/25 from 6:30 P.M. to 7:00 A.M. Review of LPN #202's employee timecard revealed the nurse worked on the Cedarview unit on 07/03/25 from 6:30 P.M. through 6:36 A.M. on 07/04/25, On 07/07/25 from 6:31 P.M. through 6:53 A.M. on 07/08/25, and on 07/08/25 from 6:32 P.M. through 6:40 A.M. on 07/09/25. Review of the facility policy Abuse, Neglect and Exploitation, revised 12/2024, revealed the facility would make efforts to ensure all residents were protected from physical and psychosocial harms, as well as additional abuse, during and after the investigation. Including responding immediately to protect the alleged victim and integrity of the investigation and room or staffing changes, if necessary to protect the residents from the alleged</p>		