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 03/03/2026
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, resident interview, and facility policy, the facility failed to complete wound treatments and failed to complete wound treatments as prescribed by the provider. This affected one resident (#84) of three for wound care completion. The facility census was 98.Findings include: Review of the medical record for Resident #84 revealed an admission date of 03/23/18. Diagnoses include diabetes mellitus, acute hematogenous osteomyelitis (fast bacterial infection of the bone usually caused by a blood stream bacteria lasting less than four weeks), chronic obstructive pulmonary disease (COPD), and need for assistance for personal care. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] for Resident #84 revealed he was cognitively impaired and had unhealed pressure ulcers. Review of the current physician orders from 02/26 for Resident #84 revealed wound to right ischium, cleanse with vashe cleanser, pat dry, apply honey gel or sheet, alginate, apply skin prep to around the wound and then apply silicone border foam dressing daily, wound to sacrum cleanse with vashe cleanser, apply skin prep to around the wound prior to placing the adhesive, apply transparent dressing around the wound and to hip area to protect the skin, apply green foam to wound bed and bridge to hip area with track pad, cover with green foam with transparent dressing, and cut a small list in the top of the dressing in the hip area, apply the negative-pressure wound therapy (NPWT, or wound-vac) (a type of treatment used to close wounds using soft, mild, constant suction), set the wound vac to 125 millimeters per Mercury (mmHg), change the dressing every Monday, Wednesday, and Friday, and finally a wound order for the sacrum in the event the negative pressure treatment is not able to be maintained, sacrum wet to dry normal saline dressing may be applied to the sacral wound if the NPWT is held. Review of the care plan revised 02/26 for Resident #84 revealed he was care planned for skin break down and pressure ulcers with interventions in place for treatments per order, monitor effectiveness, repositioning side to side when in bed, tilt-in-space wheelchair when out of bed and utilize for repositioning, and facility protocols for wound prevention. Review of the January 2026 Treatment Administration Record (TAR) for Resident #84 revealed the wound-vac was not applied on 01/08/26. Review of the February 2026 TAR for Resident #84 revealed the wound treatment to the right ischium was not completed on the following days: 02/04/26, 02/19/26, and 02/26/26. Further review of the February 2026 TAR revealed the wound-vac dressing was not completed on 02/25/26 and 02/27/26. Interview on 03/02/26 at 2:25 P.M. with Registered Nurse (RN) #420 verified the missing initials on the TAR for January 2026 and February 2026 for Resident #84. RN #420 stated the expectation is for the nurse to and sign out the TAR as the treatments are completed and blank initials indicate the wound care or treatment was not completed. Observation of wound care on 03/02/26 at 10:01 A.M. for Resident #84 revealed the wound-vac machine was sitting in a chair in the resident's room. Further observation revealed the dressing removed was an abdominal pad (ABD pad) (thicker, more absorbent than just gauze) with a piece of gauze and was dated 03/02/26 at 3:30 A.M. Concurrent interview with Resident #84 stated the wound-vac should be in place, and it was not and he was not able to recall the last time it was in place. Interview with Licensed Practical Nurse (LPN) #440 verified the dressing in place was not the wound-vac. Continued interview with LPN #440 stated she applied the (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

Printed: 06/05/2026
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No. 0938-0391

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 03/03/2026
NAME OF PROVIDER OR SUPPLIER Providence Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 Hayes Avenue Sandusky, OH 44870	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound-vac on 02/23/26, the last time she worked. Interview on 03/02/26 at 4:13 P.M. with Nurse Practitioner (NP) #401 stated there has been identified concerns of some wound care not being completed and this had been shared with the leadership at the facility. NP #401 further stated the ideal treatment for Resident #84 is the wound-vac and the wet to dry dressing is only there for an alternative if the equipment is not functioning correctly. NP #401 stated there has been no notifications that the wound-vac is not functioning correctly. NP #401 further stated the wound has improved despite the staff not using the wound-vac and does not feel there is harm considering the condition of the wound at the current time. Review of the facility policy titled, Pressure Injury Prevention and Management, revised 11/25 revealed the facility is committed to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Evidence based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365976	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Care Center	2025 Hayes Avenue Sandusky, OH 44870

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of facility policy, the facility failed to wear appropriate Personal Protective Equipment (PPE) while providing wound care. This affected one resident (#84) observed for wound care. The facility census was 98.Findings include: Review of the medical record for Resident #84 revealed an admission date of 03/23/18. Diagnoses include diabetes mellitus, acute hematogenous osteomyelitis (fast bacterial infection of the bone usually caused by a blood stream bacteria lasting less than four weeks), chronic obstructive pulmonary disease (COPD), and need for assistance for personal care. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] for Resident #84 revealed he was cognitively impaired and had unhealed pressure ulcers. Observation on 03/02/26 at 10:01 A.M. revealed a sign on the outside of the door of Resident #84's room that alerted all staff to Enhanced Barrier Precautions (EBP). The signage indicated for all staff and providers that a gown and gloves must be worn in all high-contact resident care activities to include wound care and catheter care and a PPE cart (cart holding all PPE easily accessible for staff and providers) was available. Observation of Resident #84 revealed he had a suprapubic catheter and a wound. Continued observation revealed Licensed Practical Nurse (LPN) #440 washed her hands and donned clean gloves, then positioned Resident #84 on his right side and proceeded to remove the old wound dressing to the sacrum and throw it into the garbage. LPN #440 then cleaned her hands and continued to cleanse the sacral wound. At 10:13 A.M. Certified Nursing Assistant (CNA) #410 entered the room, donned clean gloves and assisted LPN #440 with positioning of Resident #84 to help hold him on his side for better access to the wound. Follow up interview on 03/02/26 at 10:32 A.M. LPN #440 completed the wound dressing and verified Resident #84 was in EBP for wounds and urinary catheter. LPN #440 further verified she nor CNA #410 donned the appropriate PPE when they provided wound care to Resident #84. Review of the facility policy titled, Enhance Barrier Precautions, revised 09/25 revealed it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. An order for enhance barrier precautions will be obtained for residents with any of the following: wounds-chronic such as pressure ulcers, and indwelling medical devices such as urinary catheter devices. High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care, and wound care.