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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Care Center	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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, hospital record review, and review of facility policy, the facility failed to accurately and timely assess an acute change in condition (lack of assessments), failed to collaborate with the surgeon and failed to timely recognize significant changes in condition for a post-surgical resident resulting in delayed interventions. This resulted in Immediate Jeopardy and serious physical harm, injuries, and/or negative health outcomes on 06/04/26 at 12:02 P.M. when Resident #100 was seen by Vascular Surgeon #250 and the left lower extremity was assessed to have palpable femoral pulses bilaterally with no appreciable flow detected in the distal left lower extremity with no distal pulses palpable, absent sensation over the left foot with preserved sensation at a more proximal level, and clammy skin with mottled discoloration. Resident #100 was diagnosed with a distal superficial femoral artery occlusion (a blockage in the lower third of the thigh's main artery) requiring an urgent hospital admission for intravenous (IV) heparin therapy (a fast-acting blood thinner used to treat and prevent harmful blood clots) and underwent an endovascular intervention (wire-catheter based approach) on 06/06/26 to restore perfusion (the delivery of blood and its vital nutrients and oxygen to the body's tissues) to the left lower extremity. This affected one (#100) of three residents reviewed for appropriate care and services. The facility census was 97.On 06/11/26 at 3:10 P.M., the Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy which began on 06/04/26 at 12:02 P.M. when Resident #100 required urgent hospitalization and intervention to restore perfusion to the left lower extremity when staff failed to timely and accurately assess Resident #100 after the resident verbalized pain to the left lower extremity, failed to timely recognize significant changes in condition and failed to collaborate with the vascular surgeon for a post-surgical resident after Resident #100 continued to verbalize ongoing pain along with added complaints of numbness and tingling in the left lower extremity. The Immediate Jeopardy was removed on 06/15/26 at 1:00 P.M., when the facility implemented the following corrective actions:- On 06/11/26, the DON/designee completed pain assessments and vitals on all residents to determine whether unrecognized changes in condition or unmet pain management needs existed. No additional concerns were identified.- On 06/11/26, the Director of Risk Management (#405) reviewed the facility's Pain Assessment and Management and Notification of Change policies to ensure regulatory compliance and consistency with facility practice.- On 06/11/26, the [NAME] President of Clinical Services #406, Director of Risk Management #405, and [NAME] President of Operations #407 educated the Administrator and DON regarding facility expectations, regulatory requirements, and policy compliance related to pain assessment, change in condition recognition, and physician notification. - On 06/11/26 and 06/12/26, the DON/designee educated all licensed nursing staff and the Interdisciplinary Team (IDT) which included the Administrator, Medical Director #500, DON, Staff Development Coordinator (SDC) #200, Unit Manager #410, and Director of Social Services #270) that the vascular physician is the physician responsible for anticoagulant orders. - Between 06/11/26 and 06/14/26, the DON and SDC #200 educated all nursing staff on peripheral vascular disease, neglect, pain assessment and management, conducting an accurate and timely resident assessment, medication administration, notification of change in condition, guidelines for notifying physicians of (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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clinical problems, and medical record documentation policies and procedures. - Between 06/11/26 and 06/14/26, the DON/designee educated all nursing staff on the need to complete pain assessments on all residents every shift and to follow the change in condition policy to ensure timely physician notification. - Between 06/11/26 and 06/14/26, the DON/designee educated all nursing assistants on recognizing and reporting changes in resident condition and the use of eInteract (Stop and Watch Tool) within Point Click Care (electronic medical record) to facilitate timely communication with licensed nursing staff. - On 06/12/26, the Quality Assurance and Performance Improvement (QAPI) committee met and implemented a plan of action/correction.- On 06/13/26 at 3:20 P.M., Resident #100 returned to the facility. The DON reviewed Resident #100's medications and care plan, clarified the new coumadin (blood thinning medication) order, reviewed plans for laboratory testing, completed and documented a full head to toe assessment including a pain assessment. The DON viewed the resident's condition with the resident's primary nurse and Unit Manager #251.- On 06/15/26, the DON/designee reviewed the 24-hour report for any resident change in condition, timely assessments, physician notification and follow-up. The DON/designee will continue to review the 24-hour report daily during clinical huddles. - Starting the week of 06/15/26, the DON/designee will audit all pain assessments, change in condition documentation, physician notifications, responsible party notifications, and clinical follow-up documentation records. - Starting the week of 06/15/26, the DON/designee will audit the medication administration records (MAR) of nine random residents three times a week for 52 weeks. Any issues will be addressed immediately by the DON/designee.- The DON/designee will present audit results and corrective actions weekly to the QAPI Committee for a minimum of three months and thereafter as determined by the QAPI Committee until the facility demonstrates sustained substantial compliance.- On 06/15/26, between 10:00 A.M. and 11:00 A.M., interviews with Unit Manger #251, Licensed Practical Nurse (LPN) #266, LPN #301, and Registered Nurse (RN) #252 revealed education had been received over the last couple of days regarding peripheral vascular disease, neglect, pain assessment and management, conducting an accurate and timely resident assessment, medication administration, notification of change in condition, guidelines for notifying physicians of clinical problems, and medical record documentation policies and procedures.- On 06/15/26, between 10:00 A.M. and 11:00 A.M., interviews with Certified Nursing Assistant (CNA) #233, and CNA #302 verified education was received on the Stop and Watch Tool and the need to facilitate timely communication with licensed nursing staff when a resident has a change in condition.Although the Immediate Jeopardy was removed on 06/15/26, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include:Review of Resident #100's medical record revealed an admission date of 01/29/26 after a hospitalization. Diagnoses included cerebral vascular accident, peripheral artery disease (PAD), anemia, and hypertension. Review of the hospital discharge record dated 01/29/26 revealed on 01/18/26, Resident #100 underwent a left lower extremity angiogram which revealed a left superficial femoral artery (SFA) and popliteal occlusion requiring mechanical thrombectomy and stenting of the SFA and popliteal arteries along with balloon angioplasty of the left popliteal artery. Resident #100 was seen by the vascular surgeon (Vascular Surgeon #250) in February and was doing pretty well overall with normal vascular waveforms and no ongoing ischemic pain. Orders included for the nursing facility to perform vascular assessments and administer Eliquis (an oral anticoagulant used to prevent and treat blood clots) 5 milligrams (mg) twice a day. Review of the post-operative visit note dated 02/16/26 written by Vascular Surgeon #250 revealed no post-operative concerns.Review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately intact cognition. The resident was prescribed diabetic, opioid, and anticonvulsant medications. The MDS assessment did not indicate that Resident #100 was prescribed or receiving anticoagulant medications.Review of Resident #100's most recent care plan dated 05/11/26 revealed the resident was identified as having (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	peripheral vascular disease (PVD). The goal was to remain free of complications related to PVD through the review date. Interventions included compression stockings, which were ace wraps applied daily to bilateral lower extremities, elevate legs when sitting or sleeping, and encourage good nutrition and hydration. The care plan was absent for Resident #100 being prescribed an anticoagulant medication.Review of Resident #100's physician orders revealed an order dated 01/29/26 for Eliquis 5 mg to be administered twice daily. Further review of the physician orders revealed on 03/24/26 Facility Physician #200 discontinued the Eliquis 5 mg, and a new order was written for Eliquis 2.5 mg twice daily, to start on 03/25/26 due to a pharmacy recommendation related to the resident having an elevated creatinine level. Review of Resident #100's progress notes and facility physician notes dated 03/24/26 revealed Vascular Surgeon #250 was not consulted regarding lowering the dose of Eliquis.Review of Resident #100's progress note dated 05/04/26 revealed documentation that the resident failed to receive the evening dose of Eliquis 2.5 mg due to the medication not being available and on order.Review of nursing progress note dated 05/11/26 timed 10:27 A.M. revealed Resident #100 had left lower leg pain. One tablet of Oxycodone (opioid pain medication) 5 mg was administered as it was ordered as needed for pain. At 2:36 P.M., Resident #100 requested and received another dose of Oxycodone. Review of Resident #100's nursing progress note dated 05/12/26 at 5:20 P.M. revealed Resident #100 requested Oxycodone due to left lower leg pain. Review of the nursing progress note dated 05/12/26 at 5:41 P.M. revealed Facility Physician #200 was notified of Resident #100's left lower leg pain and orders were received to increase the resident's dose of Gabapentin (nerve pain medication) from 100 mg three times a day to 200 mg three times a day and to complete a venous doppler to assess for a venous blood clot. The venous doppler was completed on 05/13/26 at 11:00 A.M. and the results were negative. Review of the MAR for 05/14/26 revealed Resident #100 was administered Oxycodone 5 mg at 4:12 P.M.Review of the MAR for 05/15/26 revealed Resident #100 received Oxycodone 5 mg at 3:46 A.M. Review of the nursing progress note on 05/15/26 at 12:42 P.M., revealed Resident #100 was complaining of burning pain in the left leg and requested pain medication. Oxycodone 5 mg was administered at 12:31 P.M. Facility Physician #200 was notified of the residents' pain, and an order was received to increase Gabapentin to 300 mg three times a day.Review of the nursing progress note for 05/15/26 at 3:32 P.M. documented by LPN #265 indicated Resident #100 had a normal skin assessment.Further review of the MAR for 05/15/26, revealed Resident #100 received Oxycodone 5 mg again at 4:40 P.M.Review of a nursing progress note on 05/17/26 at 8:59 A.M. revealed Resident #100 complained of severe left leg pain and requested as needed pain medication. Review of the MAR for 05/17/26 revealed Resident #100 received Oxycodone 5 mg at 8:59 A.M. and at 4:49 P.M.Review of Resident #100's progress note dated 05/18/26 revealed the resident complained of burning pain in the left leg. Oxycodone was administered at 12:42 P.M. Review of Facility Physician #200's progress note dated 05/19/26 revealed the physician found Resident #100 to have left lower leg pain and suspected a neurogenic or sciatic issue. Facility Physician #200 documented that Resident #100 had a history of PAD and the next plan will be to have the resident see neurosurgery or pain management. Facility Physician #200 ordered a second venous doppler ultrasound. The venous doppler results were negative. Review of the MAR for 05/20/26 revealed Oxycodone 5 mg was administered at 9:40 A.M.Review of the MAR for 05/22/26 revealed Oxycodone 5 mg was administered at 9:15 P.M.Review of the MAR for 05/26/26 revealed Oxycodone 5 mg was administered at 8:18 P.M.Review of a nursing progress note dated 05/27/26 at 1:06 P.M. revealed the resident's family (niece) contacted Facility Physician #200 due to Resident #100's ongoing left lower leg pain. Gabapentin was increased to 600 mg twice daily.Review of the MAR for 05/27/26 revealed both Oxycodone 5 mg and an as needed dose of Tylenol 1000 mg were administered at 1:18 P.M. Review of the nursing progress note on 05/28/26 at 4:32 P.M. revealed Eliquis 2.5 mg unavailable and on order. Review of the MAR for 05/28/26 revealed neither dose of Eliquis was administered as ordered.Review of Facility Physician #200's progress note dated 05/29/26 and timed 12:58 P.M. revealed Resident #100 was examined and had pain that was tender to (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	touch from the knee down to the ankle and around the leg with some red discoloration noted. Facility Physician #200 charted that it did not appear to be a blood flow problem or fracture but suspected radicular-type (radiating) pain from a pinched nerve in the resident's back. Facility Physician #200 noted that the resident had a follow up appointment scheduled with a vascular surgeon (on 06/04/26) regarding past blockages and stents. Facility Physician #200 ordered Doxycycline (antibiotic) 100 mg twice a day for cellulitis. Review of the nursing progress note on 05/31/26 at 7:40 P.M. revealed Eliquis 2.5 mg was not administered as it was unavailable, requested from the pharmacy but not yet delivered.Review of Resident #100's progress note dated 06/02/26 at 10:25 A.M. revealed the resident was having pain in her left lower leg, and she refused to have the physician ordered ace wraps applied. On 06/04/26, Resident #100 was accompanied by the niece to the vascular surgeon's appointment.Review of Vascular Surgeon #250's office note dated 06/04/26 and timed 12:02 P.M. revealed the resident and family informed the vascular surgeon that for the past five weeks the resident suffered from left lower extremity pain, tingling and mottled discoloration. On examination Vascular Surgeon #250 found that Resident #100 had palpable femoral pulses bilaterally with no appreciable flow detected in the distal left lower extremity with no distal pulses palpable, absent sensation over the left foot and preserved sensation at a more proximal level. The skin was clammy and had a mottled discoloration. Resident #100 was diagnosed with a distal superficial femoral artery occlusion and required an urgent hospital admission.Review of the hospital note dated 06/04/26 revealed Resident #100 had been a resident at a long-term care facility after having a re-cannulization of the left superior femoral artery in January 2026 and was admitted to the hospital directly from the vascular surgeon's office with a chief complaint of a left cold leg and edema. The resident had been stable on Eliquis and on examination at the vascular surgeon's office the resident was noted to have absent pulses in the left leg. The resident reports intermittent pain, cold sensation and worsening edema. The plan was to initiate a heparin (fast acting anticoagulant) infusion at high intensity with surgery the next day.Interview with Vascular Surgeon Nurse #210 on 06/09/26 at 10:53 A.M. revealed Resident #100 had an appointment on 06/04/26 and was found to have an occluded femoral artery. Vascular Surgeon Nurse #210 stated Vascular Surgeon #250 phoned the facility, and it was verified that the resident had missed some Eliquis doses due to the facility being out of stock. Vascular Surgeon Nurse #210 stated Vascular Surgeon #250 was upset regarding not being notified of the resident's leg pain and missed anticoagulant doses. Interview with the DON on 06/10/26 at 10:32 A.M. stated the facility nursing staff completed the vascular assessments but failed to document them. The DON also verified Resident #100's care plan was incomplete, and that the facility failed to recognize the resident's change in condition, complete and document skin assessments when Resident #100 complained of left lower leg pain and therefore failed to collaborate/coordinate care with Resident #100's vascular surgeon.Interview with Resident #100's niece on 06/10/26 at 12:10 P.M. revealed she had informed the facility staff on multiple occasions of the concerns regarding Resident #100's increased pain and skin discoloration and they trusted the facility physician and staff to care for her properly. The niece stated Vascular Surgeon #250 was very upset regarding the situation and informed the resident he was unsure if he could save her leg. The niece said surgery was completed on 06/06/26 and fortunately the leg was able to be saved. Telephone interview with Vascular Surgeon Certified Nurse Practitioner (CNP) #300 on 06/16/26 at 4:20 P.M. revealed when Resident #100 was examined at the office on 06/04/26 the resident's left lower extremity was found to be cold and clammy. CNP #300 stated the resident's niece was concerned and shared that the resident had been having issues with pain for several weeks and had been informed by the facility that they had been in contact with the vascular surgeon's office. CNP #300 stated she and Vascular Surgeon #250 spoke with all of their office staff and reviewed phone messages and found nothing regarding the facility contacting the office regarding Resident #100. CNP #300 said she called the facility DON and was informed that Resident #100 had missed doses of Eliquis. CNP #300 also stated the facility physician ordered venous doppler testing but failed to check for arterial blood flow. CNP (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#300 denied the facility informing them of Facility Physician #200 lowering Resident #100's Eliquis dose from 5 mg twice daily to 2.5 mg twice daily, adding if they had been consulted or had known an additional blood thinning agent would have been added and they would have seen the resident in the office sooner. Interview with Resident #100 on 06/15/26 at 11:02 A.M. revealed she was tearful regarding the lack of care but was thankful Vascular Surgeon #250 was able to save her leg. Following rehabilitation, Resident #100 plans to return home.Review of the facility policy titled Conducting an Accurate Resident Assessment, dated 05/12/26 revealed all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Qualified staff who are knowledgeable about the residents will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record.Review of the facility policy titled Notification of Changes, dated 08/05/26 revealed the purpose of the policy was to ensure the facility promptly informs the resident, consults with the resident's physician and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification.This deficiency represents non-compliance investigated under Master Complaint Number 3035044 and Complaint Number 3034892.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, medical record review, resident interview, staff review, and review of facility policy, the facility failed to ensure therapy ordered positioning equipment was utilized. This affected one (#39) of three residents reviewed for positioning and position equipment. The facility census was 97.Findings include:Review of Resident #39's medical record revealed an admission date of 08/09/24. Diagnoses included morbid obesity, diabetes mellitus, bladder cancer, and chronic kidney disease.Review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a mild cognition decline. The resident had no rejection of care and required substantial assistance for all activities of daily living except eating.Review of Resident #39's most recent care plan revealed it was silent regarding positioning.Review of Resident #39's physician orders found no order pertaining to positioning equipment.Review of Resident #39's Physical Therapy Treatment encounter note dated 04/21/26 signed at 2:16 P.M. revealed the resident was dependent for repositioning to ensure a straight alignment while in bed. Staff were educated on bolster placement to keep the resident centered in bed and to prevent a left lateral lean.Review of Resident #39's Physical Therapy Treatment encounter note dated 04/22/26 and signed 6:38 P.M. revealed the resident was seen regarding being discharged from therapy due to resident reaching maximal potential. The patient was provided a different wedge cushion due to the resident reporting discomfort with the previous wedge cushion provided. Resident #39 reported improved comfort. Staff training was provided on supine positioning and the use of the wedge cushion. Interview with Resident #39 on 06/09/26 at 9:22 A.M. revealed the facility staff failed to place the wedge or the bolster in her bed. The resident stated she had to ask to have the equipment positioned in her bed.Observations throughout the survey on 06/09/26 and 06/10/26 revealed when Resident #39 was bed the wedge cushion was sitting in the resident's wheelchair and the bolster was laying in her recliner. Two signs observed on Resident #39's wall above the bed contained instructions for staff regarding the placement of the wedge cushion and the bolster.Interview with Certified Nursing Assistant (CNA) #225 on 06/09/26 at 12:22 P.M. verified Resident #39 failed to have the positioning equipment in her bed. CNA #225 verified the instructions above the resident's bed and further verified when Resident #39 ins in bed the wedge cushion and bolster should be used. CNA #225 further stated the resident could ask for them if she wanted them in place.Interview with Therapy Program Manager #312 on 06/10/26 at 7:55 A.M. revealed Resident #39 was provided a wedge cushion and a bolster due to her inability to hold herself in a straight position stating Resident #39 tends to lean to the left. The pillows were fitted specifically for the resident to ensure proper body alignment. Therapy Program Director #312 stated all staff on the floor at the time were educated on the use of the wedge cushion and bolster and the signs were placed above the residents' bed to educate all staff missed. Therapy Program Director #312 confirmed the equipment was failed to being utilized.Review of the facility policy titled Medication and Treatment Orders revised 01/03/22 revealed orders for treatments will be consistent with principles of safe and effective order writing.This deficiency represents non-compliance investigated under Complaint Number 3034892.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, resident interviews, and policy review revealed the facility failed to ensure required respiratory treatments were implemented as ordered. This affected one (#39) of two residents identified for requiring continuous positive airway pressure (CPAP) devices. The facility census was 97.Findings include:Review of Resident #39's medical record revealed an admission date of 08/09/24. Diagnoses included obstructive sleep apnea, morbid obesity, diabetes mellitus, bladder cancer, and chronic kidney disease.Review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a mild cognition decline. The resident had no rejection of care and required substantial assistance for all activities of daily living except eating. The resident was documented as not requiring a non-invasive mechanical ventilator.Review of Resident #39's most recent care plan revealed it was silent regarding the need for a CPAP.Review of Resident #39's physician orders dated 01/12/26 stated the resident was to be assisted with putting on CPAP at bedtime for sleep apnea.Review of Resident #39's Treatment Administration Record (TAR) dated 05/26 and 06/26 revealed it was absent of documentation regarding the physician's order to assist the resident with applying the CPAP.Review of Resident #39's CPAP Report provided by the resident's family dated 06/01/26 through 06/08/26 revealed the machine was worn on 06/02/26 and 06/05/26. Interview with Resident #39 on 06/09/26 at 11:01 A.M. revealed her care in the facility was lacking. The staff failed to put her CPAP on nightly, and she was unable to complete the task herself. This left her lethargic and tired in the daytime. Resident #39 verified requesting assistance from facility staff for the application of the CPAP, but the assistance was not always provided. Observation on 06/10/26 at 5:42 A.M. revealed resident #36 was sleeping in bed on her back. The CPAP was sitting on her nightstand and not applied to the resident.Interview with Certified Nursing Assistant (CNA) 225 on 06/10/26 at 5:45 A.M. verified the night staff failed to assist Resident #39 with putting on her CPAP.Review of the facility policy titled Respiratory Services dated 12/29/25 revealed to place the mask interface loosely on the resident's face. Adjust the headgear straps so that the mask has a comfortable fit but seals appropriately. Ensure resident safety and comfort.This deficiency represents non-compliance investigated under Complaint Number 3034892.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, hospital record review and review of facility policy, the facility failed to ensure Eliquis (an oral anticoagulant medication used to prevent and treat blood clots) was administered as ordered by the physician. This resulted in Immediate Jeopardy and serious physical harm, injuries, and/or negative health outcomes on 06/04/26 at 12:02 P.M. when Resident #100 was seen by Vascular Surgeon #250 and the left lower extremity was assessed to have palpable femoral pulses bilaterally with no appreciable flow detected in the distal left lower extremity with no distal pulses palpable, absent sensation over the left foot with preserved sensation at a more proximal level, and clammy skin with mottled discoloration. Resident #100 was diagnosed with a distal superficial femoral artery occlusion (a blockage in the lower third of the thigh's main artery) requiring an urgent hospital admission for intravenous (IV) heparin therapy (a fast-acting blood thinner used to treat and prevent harmful blood clots) and underwent an endovascular intervention (wire-catheter based approach) on 06/06/26 to restore perfusion (the delivery of blood and its vital nutrients and oxygen to the body's tissues) to the left lower extremity. Resident #100 started to complain of left lower leg pain and upon review of the medication administration record (MAR) Resident #100 did not receive the prescribed dose of Eliquis on 05/04/26, 05/28/26, 05/29/26, 05/31/26 and 06/02/26. This affected one (#100) of three residents reviewed for medication administration. The facility census was 97. On 06/11/26 at 3:10 P.M., the Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy which began on 06/04/26 at 12:02 P.M. when Resident #100 required an urgent hospitalization and intervention to restore perfusion to the left lower extremity after staff failed to accurately and timely administer the resident's ordered anticoagulant therapy and failed to collaborate with the vascular surgeon for a known post-surgical resident to prevent a reoccurrence of an arterial thrombosis. The Immediate Jeopardy was removed on 06/15/26 at 1:00 P.M., when the facility implemented the following corrective actions:- On 06/11/26, the DON completed an order listing report from the electronic medical record for all residents on anticoagulants and identified 26 residents. - On 06/11/26, the DON/designee completed physical and pain assessments on all residents on anticoagulant therapy. - On 06/11/26, the Administrator and DON were educated by the Director of Clinical Risk Management (#405) regarding the policies of pain management, medication orders, and notification of change. - On 06/11/26 and 06/12/26, the DON/designee audited the Medication Administration Records (MARs) for the 26 residents on anticoagulants. No other resident were identified to have missed a dose of anticoagulant medication. - On 06/11/26 and 06/12/26, the DON/designee educated all licensed nursing staff and the Interdisciplinary Team (IDT) which included the Administrator, Medical Director #500, DON, Staff Development Coordinator (SDC) #200, Unit Manager #410, and Director of Social Services #270 that the vascular physician is the physician responsible for anticoagulant orders. - On 06/12/26, the Quality Assurance and Performance Improvement (QAPI) committee met and implemented a plan of action. - On 06/12/26, the DON/designee educated all licensed nursing staff on the Medication Procurement Policy regarding any missing or out of stock medicines, including medications available from the continency box. - On 06/12/26, the DON/designee posted instructions on medication procurement in the medication room and on the medication cart regarding what to do if a medication for a resident is unavailable. - On 06/13/26 at 3:20 P.M., Resident #100 returned to the facility. The DON reviewed Resident #100's medications and care plan, clarified the new coumadin (blood thinning medication) order, reviewed plans for laboratory testing, completed and documented a full head to toe assessment including a pain assessment. The DON reviewed the resident's condition with the resident's primary nurse and Unit Manager #251. - On 06/15/26, the DON/designee reviewed the 24-hour report for any resident change in condition, timely assessments, physician notification and follow-up. The DON/designee will review the 24-hour report daily during clinical huddles. - Starting (continued on next page)

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	365976	A. Building B. Wing	06/26/2026

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the week of 06/15/26, the DON/designee will audit the MARs of nine random residents three times a week for 52 weeks for any medication not administered as ordered. Any issues will be addressed immediately by the DON/designee. - The DON/designee will present audit results and corrective actions weekly to the QAPI Committee for a minimum of three months and thereafter as determined by the QAPI Committee until the facility demonstrates sustained substantial compliance.- On 06/15/26, between 10:00 A.M. and 11:00 A.M., interviews with Unit Manger #251, Licensed Practical Nurse (LPN) #266, LPN #301, Registered Nurse (RN) #252 revealed education had been received over the last couple of days regarding medication administration, what to do if a medication is unavailable, medications available in the continency box, the guidelines for notifying physicians of clinical problems, and medical record documentation. Although the Immediate Jeopardy was removed on 06/15/26, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for minimum harm that is not Immediate Jeopardy) as the facility was continuing to educate staff and was in the process of completing and reviewing audits to determine if further action is required and monitoring to ensure ongoing compliance.Findings include:Review of Resident #100's medical record revealed an admission date of 01/29/26 after a hospitalization. Diagnoses included cerebral vascular accident, peripheral artery disease (PAD), anemia, and hypertension.Review of the hospital discharge record dated 01/29/26 revealed on 01/18/26, Resident #100 underwent a left lower extremity angiogram which revealed a left superficial femoral artery (SFA) and popliteal occlusion requiring mechanical thrombectomy and stenting of the SFA and popliteal arteries along with balloon angioplasty of the left popliteal artery. Orders included to administer Eliquis 5 milligrams (mg) twice daily. Review of the post-operative visit note dated 02/16/26 written by Vascular Surgeon #250 revealed Resident #100 was doing pretty well overall and had normal vascular waveforms with no ongoing ischemic pain. Review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately intact cognition. The resident was prescribed diabetic, opioid, and anticonvulsant medications. The MDS assessment did not indicate that Resident #100 was prescribed or receiving anticoagulant medications. Review of Resident #100's most recent care plan dated 05/11/26 revealed the resident was identified as having peripheral vascular disease (PVD). The goal was to remain free of complications related to PVD. Interventions included compression stockings which were ace wraps applied daily to bilateral lower extremities, elevate legs when sitting or sleeping, and encourage good nutrition and hydration. The care plan was absent for Resident #100 being prescribed anticoagulant medication.Review of Resident #100's physician orders revealed an order dated 01/29/26 for Eliquis 5 mg to be administered twice daily. Further review of the physician orders revealed on 03/24/26 the Eliquis dose was lowered to 2.5 mg twice daily, to start on 03/25/26. The order was written by Facility Physician #200 based off of a pharmacy recommendation due to the resident having an elevated creatinine level. Review of Resident #100's progress notes and facility physician notes dated 03/24/26 revealed Vascular Surgeon #250 was not consulted regarding lowering the dose of Eliquis.Review of Resident #100's medical record revealed a progress note dated 05/04/26 stating that the resident failed to receive the evening dose of Eliquis 2.5 mg due to the medication not being available and on order.Review of the nursing progress note on 05/28/26 at 4:32 P.M. Eliquis 2.5 mg was unavailable and on order. Review of the MAR for 05/28/26 revealed neither dose of Eliquis 2.5 mg was administered as ordered. Review of Resident #100's MAR dated May 2026 revealed on 05/04/26 the evening dose of Eliquis 2.5 mg was not administered as the medication was unavailable and on order. Further review of the MAR revealed on 05/28/26 both doses of Eliquis 2.5 mg failed to be administered due to the medication being on order, on 05/29/26 the evening dose was documented as refused and on 05/31/26 the evening dose was missed due to the medication was yet to be delivered. Review of Resident #100's progress note dated 06/02/26 at 10:25 A.M. revealed the resident was having so much pain in her left lower leg that she refused to have the physician ordered ace wraps applied. Review of the MAR for June 2026 revealed on 06/02/26 the evening dose of Eliquis 2.5 mg was not administered as the dose was on order.On (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to 2.5 mg twice daily, adding if they had been consulted or had known an additional blood thinning agent would have been added and they would have seen the resident in the office sooner.Review of the facility policy titled Medication Administration dated 11/05/25 revealed to report any discrepancies to the nurse manager. Review of the facility policy titled Medication and Treatment Orders dated 05/12/26 revealed drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. This deficiency represents non-compliance investigated under Complaint Number 3035044.