STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366170	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Sanctuary at Tuttle Crossing	4880 Tuttle Road Dublin, OH 43017

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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, review of Wound Physician notes, and policy review, the facility failed to ensure pressure ulcer treatment orders were initiated and ordered timely and accurately. This affected three residents (#20, #40, and #50) of three residents reviewed for pressure ulcer care. The facility census was 59. Findings include:1.Review of the medical record for Resident #20 revealed an admission date of 11/06/25 and a transfer to the hospital date of 12/03/25. Diagnoses included but were not limited to wedge compression fracture of thoracic 11 and thoracic 12 vertebra, heart failure, type two diabetes mellitus with diabetic neuropathy, muscle weakness, repeated falls, and cognitive communication deficit. Review of Resident #20's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 indicating the resident was cognitively intact. The resident was assessed to require substantial/maximal assistance with shower/bathing, bed mobility, lying to sitting on the side of the bed, sit to stand, transfers, and required total staff dependence for toilet hygiene as well as sitting to lying. The resident was also assessed to have a stage 3 pressure ulcer on admission. Review of the plan of care dated 11/06/25 for Resident #20 revealed the resident was at risk for/had an actual alteration in skin integrity related to being admitted with impaired skin integrity of a sacral pressure area with an intervention including but not limited to providing treatments as ordered. Review of the Skin Risk assessment dated [DATE] for Resident #20 revealed the resident was at high risk for skin breakdown. Review of the pressure ulcer assessment dated [DATE] for Resident #20 revealed a sacrum stage two pressure ulcer measuring 2 cm (centimeters) by 2 cm by no depth. Review of the physician order dated 11/07/25 for Resident #20 revealed an order for barrier cream to the sacrum, coccyx and peri area twice a day and after each incontinence episode every shift. The order was discontinued on 11/21/25. Review of the Wound Physician #1500 note dated 11/11/25 for Resident #20 revealed a sacrum stage three pressure ulcer measured 2.3 cm by 1.2 cm by 0.2 cm with a treatment order for Hydrocolloid paste (triad) twice a day and as needed. Review of the Wound Physician #1500 note dated 11/18/25 for Resident #20 revealed a sacrum stage three pressure ulcer measured 2.6 cm by 2 cm by 0.2 cm with a treatment order to continue the Hydrocolloid paste (triad) twice a day and as needed. Review of Resident #20's physician order dated 11/21/25 revealed the facility initiated the order (10 days late) for the Hydrocolloid paste to sacrum, coccyx and peri area twice a day and after each incontinence. Interview on 12/16/25 at 2:45 P.M. with the Director of Nursing (DON) revealed the facility had a barrier cream and a Hydrocolloid paste (triad) in house and if they were not ordered correctly, the staff did not know which one to use. The DON verified Resident #20 received the barrier cream treatment from 11/11/25 through 11/21/25 for the sacrum stage three pressure ulcer instead of Hydrocolloid paste (triad) treatment. 2.Review of the medical record for Resident #40 revealed an admission date of 09/21/25 and a transfer to hospital date of 10/12/25. Diagnoses included but were not limited to cervical disc disorder at cervical 5 to cervical 6 with radiculopathy, pressure ulcer of sacral region stage four, type two diabetes mellitus without complications. Review of Resident #40's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. The resident was assessed to require partial/moderate assistance with bed mobility, substantial/maximal assistance with transfers and total dependence on toilet hygiene and shower/bathing. The resident was also assessed to have a stage four pressure ulcer on admission. Review of the plan of care dated 09/22/25 for Resident #40 revealed the resident was at risk for/had an actual alteration in skin integrity related to being admitted with a pressure ulcer to the sacrum with an intervention including, but not limited to, providing treatments per physician's orders. Review of the Skin Risk assessment dated [DATE] for Resident #40 revealed the resident was at high risk for skin breakdown. Review of the pressure ulcer admission assessment dated [DATE] for Resident #40 revealed a sacrum unstageable pressure ulcer measured 4 centimeters (cm) by 6 cm by undetermined depth. Review of the physician order dated 09/22/25 for Resident #40 revealed an order to clean the sacral wound with wound wash, pat dry, cover with foam border dressing and change every three days and as needed. The order was discontinued on 09/25/25. Review of the Wound Physician #1500 note dated 09/23/25 revealed Resident #40 had a sacrum stage four pressure ulcer measured 5.5 cm by 7 cm by 1 cm with a treatment order for Mesalt with a gauze dressing daily and as needed. Review of the physician order dated 09/23/25 for Resident #40 revealed an order for Mesalt with a gauze dressing daily and as needed. Interview on 12/23/25 at 9:44 A.M. with the Director of