

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER The Sanctuary at Tuttle Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>Based on medical record review, resident and staff interviews, and policy review, the facility failed to honor a resident's choice for bathing opportunities. This affect one (#117) of one residents reviewed for choices. The census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #117 revealed an admission date of 04/22/25. Diagnoses included cerebral infarction, acute respiratory failure with hypoxia, dysphasia, and paralysis on both sides. Further review of the medical record revealed the resident had no cognitive deficits, required a two person assist with transferring out of bed, could sit in a wheelchair, and required a one person assist for activities of daily living.</p> <p>Interview on 05/13/25 at 10:27 A.M. with Resident #117 revealed the resident was upset due to not receiving showers or offered a bed bath. The resident confirmed she did not get routine showers two times a week and was not offered a bed bath in between shower days. Also, Resident #117 stated the staff would not do her hair because it was very long and she had to wait for her sister to visit to comb and braid her hair.</p> <p>Review of the skin monitoring and shower review sheets for Resident #117 revealed she had a shower on 04/25/25, 04/29/25, 05/02/25, and 05/09/25.</p> <p>The facility was unable to provide documentation from Resident #117's task section of the electronic medical record to confirm if more showers or any bed baths were given.</p> <p>Interview on 05/14/25 at 2:00 P.M. with the Director of Nursing (DON) and Regional Nurse #196 confirmed each resident was to be offered a shower at least two times a week and a bed bath daily. The DON and Regional Nurse #196 believed Resident #117 could be in a wheelchair, therefore, she should be getting a shower two times a week. The DON reviewed the resident's shower sheets and verified from 04/22/25 to 05/15/25 Resident #117 only received four showers with her first shower occurring on 04/25/25.</p> <p>Review of the undated facility policy titled, Bed Baths, revealed it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy titled, Resident Showers, revealed it was the practice of the facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided with showers as per request or as per facility schedule protocols and based upon resident safety. Partial baths may be given between regular shower schedules as per facility policy.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on medical record review and staff interview, the facility failed to provide residents with Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) document when therapy services were ending and the resident had skilled days remaining. This affected one (#158) of three residents reviewed for beneficiary notices. The facility census was 58.</p> <p>Findings include:</p> <p>Review of Resident #158's medical record revealed an admission date of 01/22/25. Diagnoses included anemia, atrial fibrillation, and hypertension.</p> <p>Review of the medical record for Resident #158 revealed the resident received therapy services which were set to end on 02/16/25 due to admission to hospice services. At the time of therapy services ending, Resident #158 was noted to still have skilled benefit days remaining.</p> <p>There was no evidence of the facility providing a Resident #158 with a SNF-ABN.</p> <p>Interview on 05/14/25 at 4:38 P.M. with Business Office Manager #186 verified Resident #158 should have received an SNF-ABN and did not.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and medical record review, the facility failed to provide application of splinting devices as recommended by therapy and failed to ensure physician orders were in place for use of the devices. This affected one (#35) of two residents reviewed for range of motion. The facility census was 58.</p> <p>Findings include:</p> <p>Review of Resident #35's medical record revealed she was most recently admitted on [DATE] with diagnoses that included anoxic brain damage, metabolic encephalopathy, quadriplegia, and anxiety.</p> <p>Review of Resident #35's Minimum Data Set (MDS) assessment, dated 3/31/25, revealed her cognition was severely impaired and she was dependent on staff for mobility, transfers, and eating.</p> <p>Review of Resident #35's occupational therapy discharge summary notes, dated 04/24/24, revealed discharge recommendations for Resident #35 to remain in the facility with donning (putting on) resting hand splints overnight with three to four times during the day in 30-minute increments and a splinting schedule was in place.</p> <p>Review of Resident #35's physical therapy note, dated 06/28/24, revealed a physical therapy assistant (PTA) educated and observed Resident #35's certified nurse aide (CNA) remove bilateral knee braces and bilateral ankle/foot braces. The PTA also verbally informed Resident #35's nurse of the removal of the braces and positioning with pillows.</p> <p>Review of Resident #35's physical therapy Discharge summary, dated [DATE], revealed discharge recommendations for Resident #35 to be up in a chair with bilateral lower extremity splints for four to five hours.</p> <p>Review of Resident #35's physicians orders, dated May 2025, revealed no indication of an order for bilateral hand splints, bilateral knee braces, or bilateral ankle/foot braces.</p> <p>Observation on 05/13/25 at 10:24 A.M. revealed Resident #35 up out of bed in a Broda chair (specialty chair to aid in positioning) with no splints in place.</p> <p>Observation on 05/14/25 at 9:50 A.M. revealed Resident #35 in bed with no splints in place.</p> <p>Observation on 05/14/25 at 10:00 A.M. revealed multiple splints in a box on the floor in Resident #35's room.</p> <p>Interview on 05/14/25 at 9:00 A.M. with Physical Therapist (PT) #194 revealed Resident #35 had been in and out of the facility since her admission and he believed therapy recommended bilateral knee, bilateral ankle/foot splints, and bilateral wrist/hand/elbow splints sometime in the Summer of 2024.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/14/25 at 11:02 A.M. with Licensed Practical Nurse (LPN) #146 confirmed Resident #35 was not wearing her splints and they were in the box on the floor. LPN #146 also stated Resident #35 always refused her splints and LPN #146 stated the resident did not have a current order for splints to be applied.</p> <p>Interview on 05/14/25 at 11:04 A.M. with Resident #35 revealed she would wear her splints if offered.</p> <p>Interview on 05/14/25 at 11:10 A.M. with PT #194 revealed when therapy recommends a device or equipment for a resident, therapy educates and works with staff on usage of the device or equipment and any parameters or schedules of use are verbally given to the nurse.</p> <p>Interview on 05/14/25 at 3:01 P.M. with Registered Nurse (RN) #153 revealed Resident #35 did not use splints and the order possibly got missed with Resident #35 going out to the hospital multiple times since admission.</p> <p>Interview on 5/15/25 at 2:05 P.M. with the Director of Nursing (DON) revealed therapy notified nursing in morning meetings with any recommendations for splinting and schedules for use. Nursing should put in a doctor's order and communicate with the direct care staff on how and when to use it.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, staff interview, and review of a user guide, the facility failed to ensure residents who required transfer assistance using a mechanical lift were provided with adequate assistance to prevent accidents. This affected two (#22 and #107) of two residents observed for safe transfers. The facility census was 58.</p> <p>Findings include:</p> <p>1. Observation on 05/13/25 at 2:47 P.M. revealed Certified Nurse Aide (CNA) #149 pushing Resident #22 in her wheelchair followed by pulling a mechanical (Hoyer) lift being her. CNA #149 was observed taking Resident #22 and the Hoyer lift into the resident's room and closed the door. Continued observation revealed a short time later another staff member came to Resident #22's door and asked if CNA #149 was finished with the Hoyer lift and CNA #149 responded she was finished. Continued observation revealed CNA #149 opened Resident #22's room door where Resident #22 could be seen laying in bed.</p> <p>Interview on 05/13/25 at 3:00 P.M. with CNA #149 confirmed she used the Hoyer lift by herself to transfer Resident #22 from her wheelchair to the bed and confirmed there needed to be two staff members present when the procedure was completed.</p> <p>2. Observation on 05/13/25 at 3:07 P.M. revealed CNA #198 exited Resident #107's room with a Hoyer lift and no other staff members were observed. Resident #107 was observed sitting in her wheelchair at that time.</p> <p>Interview on 05/13/25 at 3:10 P.M. with CNA #198 revealed she used the Hoyer by herself to transfer Resident #107 to her bed to complete care, and then used the Hoyer lift to transfer the resident back into her wheelchair. CNA #198 stated it was safe and permitted to use a Hoyer lift with one staff member and it made it very easy to move residents.</p> <p>Interview on 05/14/25 at 1:19 P.M. with the Director of Nursing (DON confirmed Hoyer lift transfer of residents with only one staff member completing the transfer was not permitted.</p> <p>Review of the undated Patient Lift Safety Guide revealed that most lifts require two or more caregivers to safely operate lift and handle the resident.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure physician orders were followed for residents who received nutritional tube feedings. This affected one (#117) of one residents reviewed for tube feedings. The census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #117 revealed an admission date of 4/22/25. Diagnoses included cerebral infarction, acute respiratory failure with hypoxia, dysphasia, and paralysis on both sides. Further review of the medical record revealed the resident had no cognitive deficits, required a two person assist with transferring out of bed, could sit in a wheelchair, and required a one person assist for activities of daily living.</p> <p>Interview on 05/13/25 at 10:34 A.M. with Resident #117 revealed when she arrived at the facility she missed two nutritional feedings. The resident stated she was very familiar with her regimen and was upset because no one would explain to her why she did not receive her nutritional feeding.</p> <p>Review of Resident #117's physician orders for April 2025 revealed on 04/22/25 the resident was ordered the nutritional supplement Nutren 2.0 complete liquid nutrition 250 milliliter (mL) bolus five times daily from 04/23/25 to 04/29/25.</p> <p>Review of Resident #117 dietician progress notes dated 04/30/25 revealed Resident #177 and her family requested continuous nutritional feedings and an order was received for Nutren 2.0 55 milliliters per hour (mL/hr) continuous with 60 mL water flushes.</p> <p>Review of Resident #117's medication administration record for 04/01/25 to 04/30/25 revealed on 04/23/25 Resident #17 did not receive her enteral feedings scheduled at 8:00 A.M., 11:00 A.M., and 12:00 P.M.; however, she did receive her feedings at 5:00 P.M. and 9:00 P.M.</p> <p>Interview with the Director of Nursing (DON) 05/14/25 and 6:08 P.M. revealed the facility had a problem with Resident #117's tube feeding pump and verified Resident #117 did not received nutritional feedings as ordered on 04/23/25 at 8:00 A.M., 11:00 A.M., and 12:00 P.M.</p> <p>Review of the undated facility policy titled, Nutritional Management, revealed the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Tube feeding or parenteral fluids will be provided in the context of the resident's overall clinical condition and resident goals/preferences.</p> <p>The facility did not have a policy on following physician's orders.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and facility policy review, the facility failed to conduct a medication regimen reviews at least monthly. This affected two (#28 and #32) of five residents reviewed for unnecessary medications. The facility census was 58.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #28 revealed an admission date of 01/24/21. Diagnoses include senile degeneration of the brain, major depressive disorder, anxiety disorder, hypertension, hyperlipidemia, hypothyroidism, and sleep apnea.</p> <p>Review of Resident #28's physician orders revealed the resident received antipsychotic, antidepressant, antianxiety, and opioid medications.</p> <p>Review of the pharmacy records revealed no documentation of the pharmacist reviewing Resident #28's medication regimen in February 2025. Additional review of the consultant pharmacist's medication regimen recommendation to the physician did not include a monthly review or recommendations for Resident #28 in February 2025.</p> <p>Interview with the Director of Nursing (DON) on 05/14/25 at 5:45 P.M. confirmed no other documentation was available to indicate Resident #28's medication regimen was reviewed for the month of February 2025.</p> <p>2. Review of Resident # 32's medical record revealed he was admitted on [DATE] with diagnoses that included intracerebral hemorrhage, schizoaffective disorder, anxiety, and hypertension.</p> <p>Review of Resident #32's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/14/25, revealed Resident #32 was severely cognitively impaired and received an antipsychotic and antidepressant medication daily.</p> <p>Review of Resident #32's physician's orders, dated 05/15/25, revealed orders for the antipsychotic olanzapine 2.5 milligrams (mg) by mouth at bedtime, and the antidepressant medications trazodone 25 mg by mouth at bedtime and sertraline 50 mg by mouth one time a day.</p> <p>Review of the pharmacy progress notes did not include documentation the pharmacist reviewed Resident #32's medications for June 2024 and February 2025.</p> <p>Review of the consultant pharmacist medication regimen review reports, dated from May 2024 to May 2025, did not include monthly reviews or recommendations for Resident #32's medication regimen for June 2024 and February 2025.</p> <p>Interview with the DON on 05/14/25 at 5:45 P.M. confirmed there was no other documentation available to indicate Resident #32's medication regimen was reviewed for the months of June 2024 and February 2025.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Medication Regimen Review, revealed the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of a user guide, review of manufacturer instructions, and facility policy review, the facility failed to prime an insulin pen needle prior to selecting the ordered dose and administering the medication to a resident and failed to administer antibiotic and anticoagulant medications as ordered which resulted in significant medication errors. This affected three (#26, #44, and #113) of eight residents reviewed for medication administration. The facility census was 58.</p> <p>Findings include:</p> <p>1. Review of Resident #113's medical record revealed a most recent admission date of 04/24/25. Diagnoses included infection following a surgical procedure, hypertension, muscle weakness, and diabetes mellitus type II.</p> <p>Review of Resident #113's physician orders revealed an order dated 04/24/25 for the resident to received Humalog insulin 12 units subcutaneously (SQ) before meals.</p> <p>Observation of medication administration on 05/15/25 at 2:44 P.M. revealed Registered Nurse (RN) #198 identified the order for Resident #113 to receive Humalog 12 units SQ to be administered at that time. RN #198 proceeded to obtain the resident's insulin dispensing pen, applied the injection needle to the pen, and turned the dosage dial to 12 units. RN #198 then proceeded to administer the insulin to Resident #113.</p> <p>Interview on 05/15/25 at 2:46 P.M. with RN #198 verified she did not prime Resident #113's insulin pen prior to selecting the ordered dose and believed the pen did not need primed.</p> <p>Review of an undated user guide titled, Safety Pen Needles, revealed to perform a priming test if recommended by the pen injector device manufacturer. A drop of liquid should appear on the needle tip visible through the viewing window.</p> <p>Review of the manufacturer instructions, revised 07/2023, revealed priming the insulin pen removes air from the needle and insulin cartridge that may collect during normal use and ensure the pen is working correctly. If the pen is not primed before each dose the recipient may get too little or too much insulin.</p> <p>2. Review of the medical record for Resident #26 revealed an initial admission date of 05/10/23 with a re-entry date of 12/25/23. Diagnoses included acute embolism and thrombosis of the left upper extremities veins, repeated falls, and presence of a left artificial hip joint. The resident was discharged on 05/12/25.</p> <p>Review of Resident #26's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition for daily decision making abilities as well as experiencing disorganized thinking.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note date 01/25/25 indicated Resident #26 received care at the local hospital due to a recent fall. It was found Resident #26 tested positive for influenza type A and had a urinary tract infection.</p> <p>Review of the physician orders and medication administration record (MAR) for Resident #26 revealed the ordered antibiotic Keflex 500 milligrams (mg) to give one tablet twice a day was not administered for the evening shift on 01/25/25 nor was it administered during the morning shift on 01/26/25 per the order and schedule.</p> <p>Review of the list of medications available in the facility's emergency medication box revealed there were five (5) tablets of Keflex 250 mg available.</p> <p>Interview on 05/14/25 at 1:21 P.M. with the Director of Nursing (DON) revealed the facility's emergency medication box was a storage of medication that was available at the facility for nursing staff to use when a resident had a medication ordered and the medication was not yet delivered from the facility. The DON confirmed Resident #26's Keflex was available and confirmed the two missed doses of the antibiotic on 01/25/25 and 01/26/25.</p> <p>3. Review of the medical record for Resident #44 revealed an admission date of 10/05/24. Diagnoses included cerebral infarction, peripheral vascular disease, and hypertension.</p> <p>Review of Resident #44's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had intact cognition for daily decision making abilities.</p> <p>Review of physician orders for Resident #44 revealed a order for an anticoagulant medication rivaroxaban (Xarelto) oral tablet 2.5 mg to give one tablet every 12 hours for atrial fibrillation with meals. Further review revealed the administration times were scheduled for 7:00 A.M. and 7:00 P.M.</p> <p>Review of the MAR for February 2025 revealed Resident #44's Xarelto was not administered on 02/28/25 for the 7:00 A.M. shift.</p> <p>Review of the MAR for March 2025 revealed Resident #44's Xarelto was not administered on 03/01/25 on the 7:00 P.M. shift, on 03/07/25 for the 7:00 A.M. and 7:00 P.M. shifts, and not given on 03/14/25 for the 7:00 P.M. shift.</p> <p>Review of the MAR for May 2025 revealed Resident #44's Xarelto was not administered on 05/09/25 for the 7:00 A.M. and 7:00 P.M. shifts.</p> <p>Interview on 05/14/25 at 4:41 P.M. with the DON revealed the facility served dinner around 5:30 P.M. The DON confirmed Resident #44's order for Xarelto was to be administered with meals and the 7:00 P.M. dose would not have been administered early enough to be with the last meal of the day. Further interview with the DON also confirmed Resident #44's missed doses of Xarelto in February, March, and May 2025 as listed above.</p> <p>Review of the undated facility policy titled, Medication Administration, revealed to ensure the six rights of medication administration are followed including right dose, right documentation, and right time.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure resident who agreed to receive dental services was provided with the services in a timely manner. This affected one (#43) of one residents reviewed for dental services. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #43 revealed an admission date of 04/29/24. Diagnoses included cerebral infarction, alcohol dependence, intellectual disabilities, and hypertension.</p> <p>Review of the plan of care dated 04/29/24, and revised 05/09/24, revealed Resident #43 had the potential for oral dental health problems related to his own teeth. Interventions included to coordinate arrangements for dental care, transportation as needed as ordered, dental consultation and follow-up as ordered, monitor and report to the medical director any signs or symptoms or complaint of oral pain, monitor the resident for any signs or symptoms of chewing/swallowing difficulties, weight loss, fever, congestion, and report to the medical director, monitor for any oral problems, and provide oral care at least every day and more frequently as needed.</p> <p>Review of the facility document for ancillary services revealed Resident #43 was made aware of services available to him on 12/30/24 at which time he had signed the documented indicated he wished to receive those services including dental care.</p> <p>Review of Resident #43's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition for daily decision making abilities. Resident #43 was noted to have his natural teeth and was independent for oral care.</p> <p>Interview on 05/12/25 at 10:30 A.M. with Resident #43 revealed he had not seen a dentist since he had been in the facility and had been asking to see one.</p> <p>Interview on 05/15/25 at 2:30 P.M. with Human Resources (HR) #148 confirmed Resident #43 had a signed document indicating he wished to received ancillary services which had not been properly filed in his record. HR #148 stated typically when it was almost time for the dentist to come to the facility, the social worker would go around to each resident who elected to receive the service to see if they would like to be seen. HR #148 confirmed since Resident #43's paperwork was not properly filed, no one was aware Resident #43 wanted to see the dentist and confirmed he had not been seen.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER The Sanctuary at Tuttle Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, staff interview, review of a facility sanitation audit, review of a service log and quote, and review of a facility policy, the facility failed to store frozen foods at the appropriate temperatures to prevent spoilage. This had the potential to affect all 57 residents residing in the facility who received food from the facility kitchen. The facility identified one resident (Resident #117) who did not eat food from the kitchen. The census was 58.</p> <p>Findings include:</p> <p>Observation of the walk-in freezer on 05/12/25 at 8:43 A.M. revealed the freezer temperature was registering at 18 degrees Fahrenheit (F). The internal thermometer was observed to have ice build up on the internal workings of the thermometer and it was unable to be read. The door frame's seal was iced over and there was ice observed on the floor of the freezer. A thick layer of ice and frost was observed to on all three shelves and over the contents of the freezer. Further observation revealed some of the food items in the freezer were two ten-pound boxes of sausage patties, ten six-ounce bags of diced chicken, two boxes of twelve 32-ounce bags of crinkle cut carrots, 64-ounces of frozen corn, a box of spiral fries, a box of snap peas, one box of lasagna, one lasagna tray outside of the original box, and two 20-pound logs of ground beef.</p> <p>Interview with [NAME] #172 on 05/12/25 at 8:43 A.M. confirmed the presence of the icy door frame, the icy food contents inside the walk-in freezer, and the temperature of the walk-in freezer was 18 degrees F. [NAME] #172 was unable to answer what the correct temperature of the freezer should be.</p> <p>Interview with Dietary Supervisor #190 on 05/12/25 at 8:49 A.M. revealed the freezer had recently been serviced, but the door seal was unable to be replaced yet.</p> <p>Observation of the walk-in freezer on 05/12/25 at 9:33 A.M. revealed the temperature of the freezer was 10 degrees F.</p> <p>Interview with [NAME] #172 on 05/12/25 at 9:33 A.M. confirmed the freezer temperature was 10 degrees F.</p> <p>Observation of the walk-in freezer on 05/13/25 at 9:19 A.M. revealed the freezer temperature was 10 degrees F.</p> <p>Interview with Dietary Supervisor #190 on 05/13/25 at 9:19 A.M. confirmed the freezer temperature was 10 degrees F.</p> <p>Observation on 05/13/25 at 9:28 A.M. revealed the freezer temperature was observed to be 12 degrees F.</p> <p>Interview with [NAME] #170 on 05/13/25 at 9:31 A.M. confirmed the freezer temperature was 12 degrees F, and revealed he would not want the freezer to be at a temperature any higher than three (3) degrees F. He stated the freezer had been recently serviced, but the door frame still needed to be fixed.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with the Administrator on 05/13/25 at 9:38 A.M. confirmed the walk-in freezer temperature was 12 degrees F.</p> <p>Observation of the walk-in freezer temperature on 05/14/25 at 9:55 A.M. revealed internal temperature was 7 degrees F.</p> <p>Interview with [NAME] #172 on 05/14/25 at 9:56 A.M. revealed the chicken and vegetables from the freezer were served to the residents on 05/14/25 for lunch.</p> <p>Interview on 05/14/25 at 9:57 A.M. with [NAME] #170 revealed the facility received a quote for a new freezer seal as of 05/13/25. He stated the freezer was unable to close properly because of the layer of ice build up around the door frame.</p> <p>Interview with the Administrator on 05/14/25 revealed the facility would have someone out to give another quote on the freezer seal on 05/19/25.</p> <p>Observation of the walk-in freezer temperature on 05/14/25 at 11:30 A.M. revealed the ambient internal temperature of the freezer was 20 degrees F. The external thermometer gauge also revealed the temperature of the walk-in freezer was 20 degrees F.</p> <p>Interview with [NAME] #170 on 05/14/25 at 11:30 A.M. confirmed the temperature of the walk-in freezer was 20 degrees F.</p> <p>Interview with Dietitian #179 on 05/14/25 at 1:42 P.M. revealed the facility was keeping logs on the freezer temperatures. She stated there was a previous internal sanitation audit where some issues in the freezer had been identified.</p> <p>Review of a Food and Sanitation Audit, dated 04/30/25, and authored by Dietitian #197, revealed the foods in the freezer were not frozen solid and/or there were signs of freezer burn.</p> <p>Interview with Dietitian #197 on 05/14/25 at 4:59 P.M. revealed he noticed the food in the walk-in freezer on 04/29/25 was noticeably frosty. He stated he noticed a problem with the gasket seal.</p> <p>Review of a service log dated 05/09/25 revealed the door to the freezer was not closing and that it was, iced up on frame. The gasket was noted to be damaged and the kick plate and frame were damaged.</p> <p>Review of a service quote dated 05/13/25 revealed the walk-in freezer has a bad door frame, gasket, heater, and kick plate.</p> <p>Review of a facility policy titled, Monitoring of Cooler/Freezer Temperature, dated 2025, revealed all frozen storage must be maintained at or zero degrees Fahrenheit (F) [sic]. If temperatures are about 10 degrees F, the supervisor will be notified immediately for corrective action. The unit will be repaired as soon as possible. If the problem cannot be corrected within two hours, all food items will be relocated to another unit that can hold foods in an acceptable temperature range.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure documentation of a resident discharging from the facility against medical advice (AMA) was documented in the medical record. This affected one (#54) of three residents reviewed for discharges. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #58 revealed an admission date of 02/11/25 and a discharge date of 02/15/25. Diagnoses included chronic heart failure, muscle weakness, and chronic kidney disease.</p> <p>Review of Resident #58's nursing progress note dated 02/15/25 at 2:53 P.M. revealed a nurse was notified by a nurse aide that Resident #58 left with wife without signing out at the nurses' station in the red book, and notifying the nurse. The nurse saw the wife walk past the nurse's station to the resident's room. The resident's wife did not say anything to the nurse about taking the resident. The nurse was assisting another resident before being notified by the nurse aide that the resident left. The nurse aide indicated she went to go look for Resident #58 because she noticed he was no longer in his room. The nurse aide indicated when she caught up to the resident and his wife, she asked if the resident was going to be gone for the day and if he was coming back. The nurse aide said if the resident was leaving, he needed to sign out at the nurses' station in the red book. Resident #58's wife said she would be right in and signed the resident out in the book at the front desk with the time 2:15 P.M. Resident #58's wife also put home in the book as well. The Medical Director and Director of Nursing (DON) were notified of the situation.</p> <p>Interview on 05/14/25 at 11:52 A.M. with Resident #58's wife revealed she took the resident home on [DATE] and had no plan on bringing him back. Resident #58's wife claimed she did not feel the resident was receiving the care he needed while in the facility and he was begging her to take him home so she did. Resident #58's denied receiving any calls from the facility related to her husbands status.</p> <p>Interview on 05/15/2025 at 3:00 P.M. with Business Office Manager #186 confirmed Resident #58's medical record did not have information documented related to him leaving the facility AMA.</p> <p>Review of the undated transfer and discharge policy (including AMA) revealed documentation of this (AMA) notification should be entered in the nurses' notes by the nurse department. The social services designee should document any discussion held with the resident/family in the social services progress notes, if present.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of medical records, staff interview, and review of the Centers for Disease Control and Prevention (CDC) webpage, the facility failed to ensure residents with wounds were maintained on enhanced barrier precautions with appropriate orders, care plans, signage, and personal protective equipment in place when providing direct cares. This affected four (#21, #25, #46, and #111) of seven residents reviewed for infection control precautions. The census was 58.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive and dementia.</p> <p>Review of Resident #21's care plan dated 05/09/24 revealed she was at risk of infection related to diagnoses with an intervention to monitor for a skin infection.</p> <p>Review of Resident #21's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with severe cognitive impairment and had one unstageable pressure ulcer (obscured full-thickness skin and tissue loss) that was not present upon admission.</p> <p>Review of Resident #21's physician orders revealed the resident had a wound on her left heel as of 03/11/25 and there were treatment orders in place.</p> <p>Observation of Resident #21's room on 05/12/25 at 10:08 A.M. revealed there was not any enhanced barrier precautions (EBP) signage nor personal protective equipment (PPE) outside of Resident #21's room.</p> <p>Interview with Licensed Practical Nurse (LPN) #141 on 05/12/25 at 10:11 A.M. confirmed Resident #21 was not under EBPs and PPE was not readily available outside of her room.</p> <p>Interview with the Director of Nursing (DON) on 05/15/25 at 2:10 P.M. revealed EBPs were necessary for residents with chronic wounds.</p> <p>2. Review of Resident #25's medical record revealed he was admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia, congestive heart failure, atrial fibrillation, diabetes mellitus, encephalopathy, and morbid obesity.</p> <p>Review of Resident #25's care plan, dated 02/24/25, revealed no care plan for enhanced barrier precautions.</p> <p>Review of Resident #25's MDS assessment, dated 04/19/25, revealed the resident was cognitively intact and had a stage three pressure ulcer (full-thickness skin loss).</p> <p>Review of Resident # 25's physician's orders, dated 05/08/25, revealed a wound care order to cleanse the right heel with normal saline, pat dry, cover with calcium alginate, and cover with gauze island with border every day shift. Further review revealed no orders indicated for enhanced barrier precautions.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #25's wound evaluation and management summary, dated 05/12/25, revealed he had a stage three pressure ulcer to his right heel.</p> <p>Observation on 05/12/25 at 12:45 P.M. revealed Resident #25 did not have any EBPs signage or PPE located outside the resident's room.</p> <p>Interview on 05/12/25 at 12:47 P.M. with Registered Nurse (RN) #149 confirmed Resident #25 had an open wound and there were no EBPs signage or PPE in place.</p> <p>3. Review of Resident # 46's medical record revealed she was admitted on [DATE] with diagnoses that included major depressive disorder, stage four pressure ulcer of the sacral region, osteomyelitis of the sacral region, and heart failure.</p> <p>Review of Resident #46's MDS assessment dated , 04/14/25, revealed the resident was cognitively intact and had a stage four pressure ulcer (full-thickness skin and tissue loss).</p> <p>Review of Resident #46's wound evaluation and management summary, dated 05/12/25, revealed she has a stage four pressure ulcer to her sacrum.</p> <p>Review of Resident #46's care plan, dated 01/07/25, revealed no care plan for EBP.</p> <p>Review of Resident #46's physician's orders, dated 04/18/25, revealed a wound care order to cleanse the sacrum with normal saline, pat dry, place calcium alginate with sliver to the wound bed, and cover with gauze island with border every day shift.</p> <p>Interview on 05/12/25 at 12:47 PM with RN #149 confirmed Resident #46 had an open wound and there was no orders of care plan for EBPs.</p> <p>Interview on 05/15/25 at 2:10 P.M. with the DON confirmed EBPs are necessary for resident with urinary catheters, percutaneous endoscopic gastrostomy (PEG) tubes, intravenous (IV) sites, or chronic wounds.</p> <p>4. Review of Resident #111's medical record revealed he was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery and presence of vascular implants and grafts.</p> <p>Review of Resident #111's admission assessment dated [DATE] revealed he had a left trochanter skin alteration and a wound vacuum (vac) in place.</p> <p>Review of Resident #111's physician orders from May 2025 revealed he had a left hip wound and a wound vac ordered as a treatment intervention.</p> <p>Observation of Resident #111's room on 05/14/25 at 5:00 P.M. and on 05/15/25 at 8:57 A.M. revealed there were no EBPs signage nor PPE outside of Resident #21's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with LPN #130 on 05/14/25 at 5:03 P.M. confirmed there was no EBPs signage and no readily available PPE outside of Resident #111's room. LPN #130 revealed there was PPE available in the cabinets at the nursing station and they would need to obtain another plastic bin to store some in near his room.</p> <p>Review of the CDC webpage at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, dated 04/02/24, revealed EBPs expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for EBPs include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use including central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care including any skin opening requiring a dressing. When implementing contact precautions or EBPs, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves). For EBPs, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Also, make PPE, including gowns and gloves, available immediately outside of the resident room.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure resident call systems functioned appropriately. This affected one (#9) of two residents reviewed for call lights. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #9 revealed an admission date of [DATE]. Medical diagnoses included metabolic encephalopathy, generalized anxiety disorder, delusional disorder, obstructive sleep apnea, chronic pain, epilepsy, and obesity.</p> <p>Review of a Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 was assessed with intact cognition.</p> <p>Observation on [DATE] at 9:03 A.M. revealed Resident #9's call light button did not activate when the resident pushed the button. Resident #9 attempted to press the call light button several times without success. Further observation outside the resident's room revealed a nurse passing medications was notified and indicated she would assist Resident #9 with the call light system.</p> <p>Observation and interview on [DATE] at 9:28 A.M. revealed Resident #9's call light system continued to malfunction. Resident #9 stated the call light was still not fixed. Observation revealed Resident #9 pushed the call light button multiple times and the call light did not activate.</p> <p>Interview on [DATE] at 9:41 A.M. with Licensed Practical Nurse (LPN) #146 confirmed Resident #9's call light was not working when she attempted to push button at the resident's bedside. LPN #146 stated she would notify maintenance and the Administrator of Resident #9's malfunctioning call light.</p> <p>Interview with the Administrator on [DATE] at 10:41 A.M. confirmed Resident #9's call light system was broken. The Administrator stated Resident #9 would be offered a bedside bell or room change at that time.</p> <p>Review of facility policy titled, Call Lights: Accessibility and Timely Response, dated 2024, revealed staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. Examples include to replace the call light, provide a bell or whistle, increase frequency of rounding, room changes, etc.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165633.</p>