STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366367	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Canal Winchester Post-Acute Rc	6725 Thrush Drive Canal Winchester, OH 43110

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

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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 observation, resident interview, staff interview, medical record review, and policy review, the facility failed to implement care planned interventions for nutritional supplements for Resident #60 to maximize the healing potential of wounds. This affected one resident (#60) of three reviewed for wounds. The facility census was 63.Findings Include:Review of the medical record for Resident #60 revealed an admission date of 08/28/25. Pertinent diagnoses included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic kidney disease stage 4 (severe), acute kidney failure, depression, anxiety disorder, muscle weakness, pressure ulcer of sacral region, unspecified stage; pressure ulcer of left heel, unspecified stage, and obesity.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #60 had moderately impaired cognition. The resident was at risk for developing pressure ulcers and she had three stage 4 pressure ulcers on admission.Review of the initial wound evaluation and management summary dated 08/29/25 revealed Resident #60 had a stage 4 pressure wound on her sacrum measuring 13 centimeters (cm) by 9.5 cm by 1 cm and a stage 4 pressure wound of the left heel partial thickness measuring 1.3 cm by 1.7 cm by 0.2 cm. The report recommended a dietary consultation due to resident's body mass index (BMI). Review of the plan of care entry dated 09/04/25 revealed the resident had three pressure injuries located on the left ischium (pelvis), sacrum and left heel. Interventions included: continue with preventative care plan measures to prevent further skin breakdown, nutritional status assessment, observe wound for any redness, warmth, drainage, odor and report to physician as needed, observe/report any non-compliance/rejection of care for wound management, perform treatment as ordered. Additionally, there was care plan entry noting resident was at risk for skin breakdown due to impaired mobility, impaired cognition, bowel incontinence, hemiplegia (weakness), renal disease, poor nutritional intake and anemia. Review of the plan of care entry dated 09/09/25 revealed Resident #60 was at risk for altered nutrition due to their diagnoses, that their intake was low and they were on a regular diet. The dietician noted the resident's wounds and recommended prosource (protein) for wound healing. Interventions included: Offer menu alternatives, monitor weight weekly and then monthly if stable, to provide diet per physician order and supplements per physician order. Review of the Wound Evaluation and Management Summary Report from 09/16/25 revealed Resident #60's stage 4 pressure wound to the sacrum was 11 cm by 12 cm by 1.5 cm with moderate serous exudate. Her left heel full thickness was 1 cm by 0.6 cm by 0.2 cm with moderate serous exudate.Review of the Wound Evaluation and Management Summary Report from 10/21/25 for Resident #60 revealed the stage 4 pressure wound to the scrum full thickness was 11 cm by 10 cm by 2.5 cm with moderate serous exudate. The wound progress was evaluated to be exacerbated due to unknown. The pressure wound of the left heel full thickness was 2.5 cm by 1.8 cm by 0.3 cm with moderate serous exudate. Review of physician orders for September 2025 and October 2025 identified no orders specific to prosource for wound healing.Review of weight records for Resident #60 revealed a weight of 164.2 pounds on 09/01/25, weight of 162.7 pounds on 09/15/25 and a weight of 138.6 pounds on 10/21/25. There were no other weights recorded in the resident's medical record.Interview on 10/22/25 at 3:00 P.M. with Resident #60 revealed she expressed frustration that her wounds weren't healing. She denied ever declining dressing changes.Interview on 10/23/25 at 12:30 P.M. with Resident #60 and her spouse revealed Resident #60 had lost weight and expressed concern that the weight loss contributed to her wounds not healing.Interview on 10/23/25 at 1:04 P.M. with Wound Physician #110 who acknowledged Resident #60's wounds had not healed. He said the biggest barrier to Resident #60's wound healing was her nutrition.Interview on 10/23/25 at 2:31 P.M. with Registered Dietician #140 who noted she had discovered the apparent significant weight loss from 09/15/25 to 10/21/25 for Resident #60 on this date. She said her first plan would be to ask facility to reweigh the resident to ensure the weight change was not an error in measurement or documentation. Secondly, she said she planned to interview Resident #60 to see if the resident was open to taking a supplement.Interview on 10/23/25 at 3:05 P.M. with the Administrator confirmed that Registered Dietician #140 had sent an e-mail to the Administrator, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 09/09/25 with a recommendation for Resident #60 to start on a nutritional supplement to promote wound healing (the same date that the care plan was updated for the prosource). The Administrator said that the DON and ADON who were working at that time were no longer with the organization and that the message was not passed on to the resident's physician.Interview on 10/23/25 at 3:25 P.M. with Primary