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	04/21/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review, observation, staff interview, and facility policy review, the facility failed treat the resident with respect and dignity to promote and enhance their quality of life. This affected one (Resident #84) of two residents reviewed for indwelling catheters. The census was 57.Findings include:Review of Resident #84's medical record revealed she was admitted tot he facility on 04/03/26. Diagnoses included orthopedic aftercare, fall with fracture (at home), pain, dementia, osteoarthritis, and high blood pressure. Review of the physicians orders revealed orders dated 04/06/26 for an indwelling urinary catheter for urinary retention/possible bladder outlet obstruction and ensure catheter care is provider every shift.On 04/06/2026 at 9:59 A.M., Resident #84 was observed up in the TV lounge area in a wheelchair and a hospital gown. The resident's catheter bag was hanging from the wheelchair uncovered with urine exposed. Residents and staff were observed passing the area at the time of observation. On 04/06/2026 at 10:01 A.M., interview with Regional Corporate Nurse #594 verified the catheter bag was uncovered and in view. Review of the undated policy Catheter Care, Urinary revealed staff were to monitor that the urinary drainage bag was kept in a privacy bag or utilize a decorative drainage bag that does not expose the urine contents in the drainage bag. This deficiency demonstrates noncompliance investigated under Complaint Number 2596634

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident medical record, resident family interview, and staff interview, the facility failed to notify the resident representative of a change in treatments. This affected one resident (Resident #55) out of thirty-seven residents reviewed during the annual survey process. The facility census was 57. Findings include: Review of the electronic medical record revealed Resident #55 was admitted to the facility on [DATE] and had diagnoses that included cognitive communication deficit, aphasia, dementia, bilateral open-angle glaucoma, bilateral combined forms of age-related cataracts, and vitreous degeneration of the right eye. Review of Resident #55's care plan dated 09/21/18 revealed that Resident #55 was at risk for decreased visual function as he had a diagnosis of cataracts. A long-term goal listed was that Resident #55 would not experience negative consequences of vision loss. Approaches listed to help Resident #55 achieve this goal included to administer medications as ordered and to obtain ophthalmologist consultations as needed. Review of Resident #55's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed that Resident #55 had a Brief Interview for Mental Status score of 06, indicative of a severe cognitive impairment. Review of Resident #55's physician orders revealed that Resident #55 was prescribed Brimonidine (an ophthalmic solution to lower eye pressure in glaucoma) apply one drop to both eyes twice daily from 11/11/21 through 11/06/24, and Latanoprost (an ophthalmic solution prescribed to reduce high pressure inside the eye) apply one drop to both eyes daily from 11/02/23 through 11/06/24. Review of Resident #55's ophthalmology after visit summary dated 09/01/23 revealed that Resident #55 was ordered Brimonidine 0.2% one drop in both eyes twice daily, and Latanoprost 0.005% one drop in both eyes daily at bedtime. Review of Resident #55's physician orders revealed that Resident #55 was ordered Brimonidine drops 0.2% one drop to both eyes twice a day as needed for glaucoma from 11/06/24 to 11/19/25, and Latanoprost 0.005% one drop in both eyes once daily as needed for glaucoma from 11/06/24 to 11/19/25. Review of Resident #55's nursing progress notes dated 11/01/24 through 11/06/24 were silent for notification to Resident #55's representative that Resident #55's Brimonidine and Latanoprost were changed on 11/06/24 to scheduled medications to as needed medications. An interview with Resident #55's representative on 04/06/26 at 11:32 A.M. revealed that she was upset that she was not notified by the facility when Resident #55's Brimonidine and Latanoprost eye drops were changed from scheduled administrations to as needed administrations. An interview with Regional Nurse Consultant #594 on 04/13/26 at 5:19 P.M. confirmed there was no evidence that Resident #55 nor Resident #55's representative were notified when Latanoprost and Brimonidine were changed from scheduled medications to as needed medications on 11/06/24. This deficiency represents non-compliance investigated under Complaint Numbers 2596634 and 2723137.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of concern tracking logs, policy review, record review, staff interview, and resident interview, the facility failed to make prompt efforts to resolve complaints/grievances by resident/family members. This affected three residents (Residents #31, #55, and #93) of three residents reviewed for concerns and had the potential to affect all residents of the facility due to the lack of policy/procedure and system in place. The facility census was 57. Findings include: Review of facility Concern Tracking Logs revealed the logs listed the date, resident name, nature of concern, department, and date of resolution. The log did not give specifics of the nature of the concerns. Three residents (Residents #31, #55, and #93) were chosen for review of logged concerns as follows: a. On 03/02/26 it was noted that a concern for Resident #31 was submitted regarding response time. The date of resolution was 03/02/26. No further specifics were documented. Review of the record for Resident #31 revealed an admission date of 12/04/25. Review of a Minimum Data Set assessment completed 02/03/26 revealed a Brief Interview for Mental Status score of 15, indicating intact cognition. It further stated he was always incontinent of bowel and bladder and was dependent upon staff for toileting. Interview with Resident #31 on 04/06/26 at 1:18 P.M. revealed that he sometimes has to wait 2-4 hours to have his call light answered and has to lay long periods of time while wet from urine. He indicated his concerns had not been resolved. There was no documented evidence of a resolution to his concern on 03/02/26. b. On 02/09/26 it was noted that a concern for Resident #93 was submitted by her daughter regarding daily routine. The date of resolution was 02/10/26. No further specifics were documented. Review of the medical record for Resident #93 revealed nothing documented in the record regarding concerns by family on 02/09/26. On 02/10/26 the resident was transferred to the hospital due to a change in condition and did not return to the facility. There was no documented evidence of a resolution to her concern. c. On 02/16/26 it was noted that a concern for Resident #55 was submitted by family concerning missing clothes. The date of resolution was 02/19/26. No further specifics were documented. Review of the missing items policy updated 05/01/25 stated missing items are reported by residents and/or their representatives to staff who document the information on a Resident Concern Form and is signed by a resident, family member, visitor, or employee. All missing items must be investigated promptly and referred to the Director of Social Services in a timely manner. The Director of Social Services is responsible for reviewing the concern form, initiating an investigation, and following up with the resident or family. Follow up is documented on the Customer Concern Form. All documentation regarding missing or lost items shall be filed in the office of the Social Service Director. Interview with Social Services Coordinator #208 on 04/13/26 at 10:40 A.M. revealed if missing items are reported, she reports it to the Administrator and there is a form to fill out. She stated administration handles those. Interview with Administrator #404 on 04/13/26 at 10:50 A.M. revealed Social Services handles missing item reports. She stated Social Services should have a log of missing items. Interview with Administrator #404 on 04/14/26 at 8:49 A.M. revealed missing items are logged with resident concerns on the concern log. There was no evidence that a Resident Concern Form had been filled out per facility policy. There was no evidence an investigation was completed regarding the missing clothing for Resident #55. Interview with Administrator #404 on 04/14/26 at 8:49 A.M. revealed when a concern of any type is reported, a form is filled out and given to the appropriate department to follow up and resolve. She stated the resolution is documented on the concern form. Interview with Administrator #404 on 04/14/26 at 9:50 A.M. revealed there were no concern forms filled out for Residents #31, #55, and #93 and no evidence of any follow up taken on the concerns. Interview with Administrator #404 on 04/14/26 at 3:08 P.M. revealed the facility did not have a policy on following up on resident concerns that were not missing items. This deficiency represents non-compliance investigated under Complaint Numbers 2724269, 2707299, 2596634, and 2591210.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 develop baseline plans of care that included the interventions necessary to properly care for residents within 48 hours of admission. This affected three (Residents #84, #86 and #93) of 37 residents reviewed for plans of care. In addition, the facility failed to ensure that a summary of the baseline plan of care was provided to the resident or representative. This affected one (Resident #93) of 37 residents reviewed for plans of care. The census was 57.Findings include:1. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare, fall with fracture (at home), pain, dementia, osteoarthritis, high blood pressure, and gastroesophageal reflux disease (GERD). No Minimum data Set (MDS) 3.0 assessment was completed because she was a new admission. Further review of Resident #84's medical record on 04/08/26 revealed no baseline plan of care was developed within 48 hours of admission. On 04/08/26 at 12:55 P.M. interview with Regional Corporate Nurse #594 revealed the facility did not have a baseline plan of care developed within 48 hours of admission for Resident #84. 2. Review of the medical record revealed Resident #86 was admitted to the facility on [DATE] with diagnoses including displaced fracture of anterior wall of right acetabulum, Alzheimer's disease, vascular dementia, peripheral vascular disease, wedge compression fracture of T5-T6 vertebra, chronic embolism and thrombosis of left iliac vein, wedge compression fracture of fifth lumbar vertebra, unspecified fracture of right pubis, unspecified fracture of upper end of left humerus, abdominal aortic aneurysm, calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction, hyperosmolality and hypernatremia, LT femoral neck deformity, presence of right artificial hip joint, and presence of left artificial hip joint. Review of the hospital after visit summary (AVS) for Resident #86 dated 08/13/25 revealed instructions for wound care for the right and left heel to be cleansed and assessed daily, and the resident should keep boots on while in bed. Instructions went on to specify how to relieve pressure and that Resident #86 should move slightly every ten minutes while awake, avoid lying flat on back or fully on side by using pillows under one side of back and change sides every two hours. The after-visit summary also noted that Resident #86 had a left humerus fracture, a thoracic spine 5th vertebra (T5) compression fracture with 50% height loss, a lumbar spine 5th vertebra (L5) compression fracture with 35% height loss, a right acetabular fracture and right pubic rami fracture. The after-visit summary noted that hip precautions should be followed at all times and legs should not be crossed. Review of the provider progress note dated 08/13/25 revealed Resident #86 had Alzheimer's disease and was pleasantly confused but complained of pain to her lower extremities. The provider asked the nurse to give Resident #86 pain medication. Review of the care plan on file for Resident #86 last revised 08/15/25 revealed two problems listed. The first problem listed was that the resident had an identification wristband to promote safety and that the resident was at risk for infection due to Covid 19. There was no notation in the care plan regarding the wounds on the heels or the hip precautions. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #86 was dependent on staff for eating, oral hygiene, toileting, rolling left to right, moving from sitting to lying and lying to sitting. She required substantial /maximum assistance for upper body dressing, lower body dressing and putting on footwear. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #86 revealed on 08/13/26 there was progress note that simply said pull code 2005EM. There were no progress notes on 08/14/26. There was a progress note dated 08/15/26 at 11:46 summarizing an initial care conference held on that day. The note was recorded as a late entry on 08/21/25 at 11:49 A.M. and had no mention of hip precautions or heels. During an interview on 04/14/26 at 5:58 P.M. Regional Nurse Consultant #594 confirmed there was no documentation that a skin assessment was completed for Resident #86 in the baseline care plan or the medical record. During an interview on 04/15/26 at 10:14 A.M. Social Services Coordinator (SSC) #208 confirmed that her note regarding the initial care conference did not have instructions for care and was posted after the resident had discharged from the facility on 08/16/25. During an interview on 04/15/26 at 10:56 A.M., Regional Nurse Consultant #594 confirmed there was no documentation within the baseline care plan or the medical record for Resident #86 regarding resident background, preferences, personal care needs or need for hip precautions. 3. Review of the medical record revealed Resident #93 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, dysphagia, diabetes, morbid obesity, sepsis, bipolar disorder, anxiety disorder, hypertension, osteoarthritis, and peripheral vascular disease. The clinical admission assessment with an observation date of 01/24/26 stated Resident #93 had impaired short- and long-term memory and was oriented to self only. Record review revealed an initial wound grid indicating Resident #93 was admitted to the facility 01/24/26 with a Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) on the sacrum measuring 0.6 centimeters (cm) by 0.3 cm by 0.2 cm. Review of the baseline care plan with an observation date of 01/24/26, a recorded date of 01/28/26, and a completed date of 02/06/26 revealed it had not applicable marked for wound care and did not include any interventions related to pressure ulcers. The comprehensive care plan for pressure ulcers was not implemented until 02/03/26. A form titled Meet and Greet Signatures dated 01/27/26 was signed by SSC #208. The form stated the resident was unable to sign, and there was no signature of a resident representative. The form did not include any further information as to what was discussed. There was no evidence a summary of the baseline care plan was provided to the resident or resident representative. Interview with Regional Nurse Consultant #594 on 04/15/26 at 7:39 A.M. confirmed the initial clinical assessment and baseline care plan did not identify a pressure ulcer or any care required for the ulcer. She stated that the nurse who completed the assessment stated she likely made an error regarding the pressure ulcer due to having four to five admissions that day. She stated that the meet and greet is when staff go over the initial plan, but this was not documented on the meet and greet form for Resident #93 and should have been. She confirmed there was no evidence that a summary of the baseline care plan was provided to the resident or her representative. Interview with Regional Nurse #583 on 04/15/26 at 8:50 A.M. confirmed the care planning policy does not address providing a summary of the baseline care plan to the resident and/or representative. Review of the facility policy titled Care Planning-Comprehensive updated 05/01/25 revealed a baseline care plan is completed upon admission (within 48 hours) based on data available at the time of admission. The policy did not address providing a summary of the baseline care plan to the resident or representative. This deficiency represents non-compliance investigated under Complaint Numbers 2723137, 2705832, and 2596634.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, staff and resident interviews and facility policy review, the facility failed to ensure that residents who are unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal hygiene including assistance with eating, nail care, and bathing/showering. This affected seven (Residents #6, #9, #12, #61, #85, #87, and #93) of 12 residents reviewed for activities of daily living. The facility census was 57.Findings include: 1. Review of the closed medical record for Resident #93 revealed an admission date of 01/24/26 with diagnoses including cerebral infarction, dysphagia, diabetes, morbid obesity, sepsis, and osteoarthritis. Review of the Minimum Data Set (MDS) 3.0 assessment completed 01/30/26 revealed Resident #93 had short- and long-term memory problems. The resident required substantial/maximum assistance with personal hygiene and was dependent on staff for showers. The resident was always incontinent of bowel and bladder. Review of the care plan dated 02/03/26 revealed an intervention to provide Resident #93 with assistance as needed with activities of daily living. Review of point of care history and shower records revealed between 01/24/26 and 02/10/26 the resident received one bed bath on 01/28/26 and one shower on 02/09/26 (bathed twice in 18 days). Interview with Regional Nurse Consultant #594 on 04/15/26 at 7:39 A.M. revealed residents are to be bathed twice weekly. Interview with Regional Nurse #583 on 04/15/26 at 10:15 A.M. confirmed there was no evidence of any further showers/baths for Resident #93. Resident #93 was transferred to the hospital on [DATE] and did not return to the facility. 2. Review of the medical record for Resident #6 revealed an admission date of 02/28/25 with diagnoses including hemiplegia (paralysis of one side of the body), dysphagia (difficulty swallowing) following cerebral infarction (stroke), and aphasia (impaired speaking). He received all of his nutrition through a gastrostomy tube (feeding tube leading into the stomach). Review of the MDS 3.0 assessment completed 01/23/26 revealed Resident #6 had short- and long-term memory problems, had a feeding tube, and was dependent on staff for bathing and personal hygiene. Review of the care plan dated 03/21/25 revealed Resident #6 had an impaired ability to perform or participate in daily activities of daily living care. Interventions included providing assistance with all activities of daily living care as needed, providing nail care and shampooing hair with showers per weekly schedule, and encouraging and assisting the resident with oral care twice daily and as needed. Observations on 04/06/26 at 2:55 P.M. and 04/07/26 at 2:30 P.M. revealed Resident #6 was in bed. His bottom lip had large pieces of dry skin on it. On 04/08/26 at 8:05 A.M. and on 04/09/26 at 8:20 A.M. he was observed in bed. His bottom lip was dry. Interview with Certified Nursing Assistant (CNA) #385 on 04/09/26 at 11:20 A.M. confirmed Resident #6 has dry lips. He stated the staff use Chapstick for his dry lips but could not show the surveyor any Chapstick in the resident's room. Observations on 04/13/26 at 8:45 A.M. revealed Resident #6 to have long fingernails with a dark substance underneath the nails on both hands. Review of the shower records revealed Resident #6 last received a shower on 04/09/26. The section of the shower record to indicate fingernails were cleaned and trimmed if necessary was blank. Interview with CNA #385 on 04/13/26 at 8:45 A.M. revealed he gave Resident #6 his shower on 04/09/26 but did not clean or trim his nails. Interview with Regional Nurse Consultant #812 on 04/13/26 at 9:00 A.M. confirmed Resident #6's fingernails were long with a dark substance underneath. She confirmed he was dependent on staff for all care and would have needed his nails trimmed with his shower on 04/09/26. 3. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis, cognitive communication deficit, reduced mobility, and cerebral infarction. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 05/05/25 revealed Resident #9 was at risk for altered nutrition status related to variable intakes, a history of diabetes mellitus type II, a mechanically altered diet, a history of significant weight loss on 03/13/26, and a need for supplemental enteral tube feedings. A goal was for Resident #9 to receive adequate nutrition to meet her estimated nutritional needs. An approach listed was to provide Resident #9's diet as ordered. Review of the physician orders dated 09/17/25 revealed Resident #9's prescribed diet was mechanical soft food textures and thin liquids. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 07 out of 15, indicating severe cognitive impairment. Resident #9 was assessed as being dependent on staff for personal hygiene, transfers, eating, and bathing. Review of the care plan dated 03/16/26 revealed Resident #9 had impaired ability to perform or participate in daily activities of daily living care (ADL) related to hemiplegia and hemiparesis status post cerebrovascular accident. Resident #9's goal was to participate with her ADL care as much as possible, to remain clean and dry without decline. Approaches included providing assistance with ADL care and mobility as needed, and providing showers per weekly schedule. A continuous observation of the hall dining service on 04/06/26 from 4:17 P.M. to 5:15 P.M. revealed that Resident #9 was not offered her dinner meal, and therefore not offered feeding assistance with her dinner meal. An interview with CNA #242 on 04/06/26 at 5:23 P.M. revealed that no residents refused their dinner meal. An interview with Resident #9 on 04/06/26 at 5:30 P.M. confirmed that she was not offered her dinner tray; however, Resident #9 stated that she was not feeling hungry and would have refused her meal tray if she had been offered. An interview with the Administrator on 04/06/26 at 5:32 P.M. revealed that the Administrator refused to confirm that Resident #9 was not offered her dinner meal. The Administrator stated that CNA #242 had offered Resident #9 her dinner meal, and that Resident #9 had refused. An interview with Resident #9's representative on 04/07/26 at 9:18 A.M. revealed that Resident #9 does not get showers twice weekly. Review of the showers documented from 03/02/26 through 04/09/26 in the medical record revealed that Resident #9 had a shower on 03/05/26, 03/14/26, 03/21/26, 03/28/26, and 04/02/26. Review of the shower sheet book at the nursing station from 03/02/26 through 04/09/26 revealed that Resident #9 had also had a shower on 04/04/26. Review of the shower schedule 03/02/26 through 04/09/26 revealed that Resident #9 was scheduled for a shower on 03/04/26, 03/07/26, 03/11/26, 03/14/26, 03/18/26, 03/21/26, 03/25/26, 04/01/26, 04/04/26, and 04/08/26. An interview with CNA #287 on 04/09/26 at 8:43 A.M. revealed that Resident #9 does not refuse showers or baths. CNA #287 revealed that all showers given to Resident #9 would be documented in (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shower book and confirmed that Resident #9 had six instead of ten scheduled showers. 4. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, muscle weakness, and vascular dementia. Review of Resident #12's comprehensive care plan dated 09/01/22 revealed that Resident #12 had an impaired ability to perform or participate in ADL care related to weakness and cognitive deficit. A long-term goal was to have Resident #12 participate in ADL care as much as possible, to remain clean, dry and neat in appearance. An approach included providing nail care with showers per weekly schedule. Review of the MDS 3.0 assessment dated [DATE] revealed a BIMS score of 08 out of 15, indicating Resident #12 had moderate cognitive impairment. Resident #12 was assessed as being dependent on staff for personal hygiene. Observations on 04/06/26 at 9:43 A.M., 04/07/26 at 8:37 A.M. and 04/09/26 at 10:27 A.M. revealed that Resident #12's fingernails were long and had a brown substance caked underneath the nails. Interviews with Resident #12 on 04/06/26 at 9:43 A.M. and on 04/09/26 at 10:27 A.M. revealed that he preferred his nails to be short and clean. An interview with CNA #387 on 04/09/26 at 10:23 A.M. revealed Resident #12 does not refuse care. An interview with Licensed Practical Nurse (LPN) Supervisor #365 on 04/09/26 at 10:27 A.M. confirmed that Resident #12's fingernails were long and had brown substance caked under the nails. An interview with Assistant Director of Nursing (ADON) #381 on 04/09/26 at 10:29 A.M. revealed that she would file and clean Resident #12's nails for him. An observation on 04/09/26 at 2:07 P.M. revealed that Resident #12's nails were short, clean, and smooth. An interview with Resident #12 on 04/09/26 at 2:07 P.M. revealed that he was happy that his nails were trimmed and cleaned. 5. Review of the medical record for Resident #61 revealed she was admitted to the facility 12/11/25 with diagnoses including chronic obstructive pulmonary disorder (COPD), metabolic encephalopathy, diabetes, depression, congestive heart failure, high blood pressure, fibromyalgia, and cognitive communication deficit. Review of the ADL plan of care dated 03/11/26 revealed Resident #61 had impaired ability to perform or participate in daily ADL care. Provide every day, when needed or per resident request nail care with showers per weekly schedule Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #61's cognition was severely impaired (BIMS 6). She required supervision/touching assistance with eating, substantial/maximal assistance with oral hygiene, toileting, dressing, personal hygiene, and turning and repositioning and dependent on staff for showers/bathing. She was always incontinent of her bladder and frequently incontinent of her bowel and received hospice services. (continued on next page)

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	366367	A. Building B. Wing	04/21/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 04/07/26 at 10:55 A.M., 2:36 P.M. and 4:00 P.M. revealed Resident #61's fingernails were long with a brown substance up under them. On 04/08/26 at 7:55 A.M. and 2:20 P.M. her fingernails were still long with a brown substance under them. On 04/09/26 at 9:30 A.M. her fingernails remained long with brown substance under them. This was verified during an interview with Regional Nurse Consultant #583. Review of the Nail Care Finger/Toe policy and procedure dated 05/01/2025 revealed it is the policy of the facility to clean, trim and maintain nail care to enhance the residents state of well-being. 6. Review of the medical record revealed Resident #85 was admitted to the facility on [DATE] and was discharged on 08/11/26. Diagnosis included fracture of the left elbow, injured in motor vehicle accident, displaced fracture of the right tibia, osteoporosis with current pathological fractures, fracture of the right radius, wedge compression fractures, tendon disorder of the right wrist, COPD, and chronic respiratory failure. Review of the discharge MDS 3.0 assessment dated [DATE] revealed Resident #85's memory was intact. She was independent with eating, oral hygiene, toileting and personal hygiene. Supervision or touching assistance was required with showers/bathing, and she was frequently incontinent of bowel and bladder. She had one fall since admission with no injury. Further review revealed no documentation or bath or showers in the medical record. On 04/15/26 at 2:13 P.M. interview with the Administrator revealed they could find no shower/bath documentation for Resident #85 while here at the facility. 7. Review of the medical record revealed Resident #87 was admitted to the facility on [DATE] with diagnoses including fusion of spine, muscle weakness, dysphagia, generalized anxiety, major depressive disorder, hypertension, hyperlipidemia, chronic kidney disease, encephalopathy. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #87 had impaired cognition evidenced by a BIMS score of 09 out of 15. Resident #87 resident required moderate staff assistance with bathing, toileting and mobility. Review of the facility's shower record for Resident #87 revealed she received showers on the following dates: 01/28/26, 02/11/26, and 02/25/26. Resident #87 was offered, but declined showers on 01/14/26, 01/21/26 and 02/04/26. During an interview on 04/15/26 at 10:25 A.M. with Regional Nurse Consultant #583 confirmed that per the facility's records, Resident #87 only received one shower per week. This deficiency represents noncompliance investigated under Master Complaint Number 2744632 and Complaint Numbers 2724269, 2707299, 2705832, and 2603202.

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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 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 closed medical record review, hospital record review, facility policy review, and interviews, the facility failed to timely identify and seek necessary medical intervention following an acute change in condition for Resident #78. This resulted in Immediate Jeopardy, with actual serious life-threatening harm beginning on 03/12/26 at 12:34 P.M., when Resident #78 was noted to be lethargic (a reduced level of consciousness), with elevated blood glucose of 522 milligrams per deciliter (mg/dL, normal results 70-99 mg/dL). The resident's blood sugar was not re-checked for four hours and remained elevated at 353 mg/dL when it was rechecked. The resident continued with limited food and fluid intake and lethargy. The facility failed to monitor the resident, provide comprehensive assessments, and medical support for the resident. On 03/13/26 at 8:30 A.M. Resident #78 became unresponsive and could not be awakened by a sternal rub (painful physical stimuli). Certified Nurse Practitioner, (CNP) #561 was notified, and the resident was transferred and admitted to the intensive care unit of the hospital with diagnoses of severe sepsis with septic shock, acute encephalopathy, multifactorial in the setting of hypernatremia and sepsis, acute kidney injury, hyperglycemia, urinary tract infection, hypernatremia. The resident remained in the hospital receiving medical treatment until 03/25/26 and returned to the facility with hospice services. The resident passed away at the facility on 04/14/26. A concern that did not rise to the level of Immediate Jeopardy but did rise to the level of Actual Harm was identified on 08/21/25 when the facility failed to take action when Resident #88, who was cognitively impaired and required substantial to maximal assistance with toileting hygiene and was assessed as being incontinent, had not had a bowel movement documented in three days. There was no evidence Resident #88 had a bowel movement from 08/19/25 until 08/26/25. On 08/26/25, Resident #88 was discharged to the hospital due to a change in his condition. At the hospital on [DATE], Resident #88 received a computed tomography (CT) scan of his abdomen, which revealed a moderately stool-distended rectal vault with findings that he was developing stercoral colitis, a rare but serious inflammation of the colon caused by fecal impaction, which could lead to life-threatening complications if untreated. The resident received treatment and services of disimpaction while in the hospital for 11 days.In addition, concerns that did not rise to the level of Immediate Jeopardy or Actual Harm were identified related to the facility's failure to ensure treatments were provided in management of congestive heart failure (CHF), vascular wounds, change in condition related to urinary tract infections, and glaucoma. This affected nine residents (#23, #31, #55, #61, #78, #88, #90, #91 and #93) of 36 residents reviewed for quality of care and treatment. The facility census was 57 residents. On 04/09/26 at 4:35 P.M. the Administrator, (LNHA), Director of Nursing (DON), Regional Nurse Consultant #583 and Regional Nurse Consultant #594 were notified Immediate Jeopardy began on 03/12/26 when staff failed to monitor Resident #78 for an acute change in condition (including blood glucose monitoring and vital sign monitoring) and failed to notify the nurse practitioner of continuing hyperglycemia and diarrhea. The lack of comprehensive monitoring and assessment resulted in a delay in necessary medical intervention. Resident #78 was subsequently found unresponsive to painful stimuli, and was hospitalized with severe sepsis with septic shock, acute encephalopathy, multifactorial in the setting of hypernatremia and sepsis, acute kidney injury, hyperglycemia, urinary tract infection, hypernatremia. The resident was hospitalized until 03/25/26 and returned to the facility with hospice services. The resident passed away in the facility on 04/14/26 at the facility.The Immediate Jeopardy was removed on 04/10/26 when the facility implemented the following corrective actions: -On 04/09/26 Regional Nurse Consultant #594 reviewed 57 current resident records from 03/12/26 to 04/09/26 for changes in condition (including vital signs) and any concerns identified were reviewed with the medical provider. Five residents were identified with a concern and those concerns were reviewed with the medical provider. -On 04/09/26 the facility change in condition policy was reviewed by the Administrator and the DON. -As of 04/09/26 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility indicated Resident #78 would have a change in condition timely identified, a thorough assessment completed including vital signs, and notification to the physician as soon as possible with clinical findings documented in the clinical record by ADON #1 or ADON #2. The DON/designee would ensure compliance by completing audits. -The facility implemented a plan that by 04/09/26 all current residents would have a change in condition timely identified, a thorough assessment completed including vital signs, and notification to the physician as soon as possible with clinical findings documented in the clinical record by a licensed nurse. The DON/designee would ensure compliance by completing audits.-On 04/09/26 at 5:30 P.M. in-service education for licensed nurses, by the DON, via lecture began on the following topics: change in condition policy, completing an assessment of a resident with a change in condition including vital signs, and notification to the physician. By 04/09/26 at 10:00 P.M. Twenty-two nurses (100%) were educated. As of 04/09/26 the facility implemented a plan for all newly hired nurses to receive the education prior to working the floor.-On 04/09/26 at 5:30 P.M. in-service education for CNAs by the DON via lecture on reporting changes in resident condition to the charge nurse. By 04/09/26 at 10:00 P.M. 58 CNAs (100%) were educated. As of 04/09/26 the facility implemented a plan for all newly hired CNAs to receive the education prior to working the floor.-On 04/09/26 at 8:00 P.M. Ad Hoc Quality Assessment and Performance Improvement (QAPI) meeting was held with the medical director, Certified Nurse Practitioner (CNP) #561, the Administrator, DON, ADON #226, ADON #381, and Regional Nurse Consultant #564 on the action items listed in the facility corrective action plan along with a root cause analysis which determined lack of continued monitoring of a resident after identification of change in condition.- On 04/10/26 at 1:00 P.M. ADON #226 and ADON #381 completed assessments on all fifty-seven residents' current condition and obtained a full set of vital signs on all current residents. -On 04/10/26, the DON or a designee began daily audits for two weeks. After two weeks the audits would be completed three times a week for two weeks, then weekly for two weeks, and then as need to ensure residents with a change in condition was timely identified, a thorough assessment completed including vital signs and notification to the physician as soon as possible with clinical findings documented in the clinical record. This would be monitored through review of the resident nursing progress notes and vital signs. The DON/designee would conduct an observational audit on five residents three times a week for four weeks and then as needed to ensure residents were not experiencing a change in condition that was not previously identified. Any concerns identified with the audits would be forwarded to QAPI committee weekly for four weeks and as-needed for immediate follow-up. The administrator would be responsible for ongoing compliance.Although the Immediate Jeopardy was removed on 04/10/26, 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: 1.Closed record review revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, diabetes mellitus type two, hypertension, multiple sclerosis, seizures and history of stroke. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 06. The assessment revealed the resident was assessed to require partial or moderate (staff) assistance for eating and was completely dependent on staff for hygiene and mobility. Review of the care plan dated 04/03/26 revealed Resident #78 was at risk for alteration in blood glucose metabolism related to diabetes mellitus. The care plan included facility staff should observe the resident for signs and symptoms of hyperglycemia and notify the physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing progress notes revealed on 03/12/26 at 12:34 P.M. Registered Nurse (RN) #270 assessed Resident #78 to be very lethargic, and the resident's blood glucose was noted to be elevated at 522 milligrams per deciliter, (mg/dl). Pulse, oxygen saturation, temperature and blood pressure were not documented as being obtained/recorded at this time. RN #270 notified CNP #561, who requested the resident be given Lispro (a rapid-acting, man-made insulin used to treat type 1 and type 2 diabetes by controlling high blood sugar, particularly after meals. It works within 10–15 minutes, peaks in 30–90 minutes and lasts 2–5 hours) to resolve her high blood glucose, and facility staff were to continue to monitor the resident for the next 24 hours. Review of the vital sign documentation in the facility's medical record of Resident #78 revealed the next blood glucose reading, entered into the resident's medical record at 4:03 P.M. was elevated at 353 mg/dl. This was also the scheduled time of the insulin administration, which would have prompted the nurse for the resident's current blood glucose. Neither additional vital signs (pulse, oxygen saturation, respirations, temperature and blood pressure) nor physical assessment of the resident were completed at this time. Review of the vital sign documentation in Resident #78's medical record revealed on 03/12/26 at 8:05 P.M. the resident's blood glucose was elevated at 212 mg/dl. The resident's pulse was documented to be 85 beats per minute, (BPM) and blood pressure 123/69 millimeters of mercury (mm hg). Oxygen saturation, respirations, temperature and physical assessment were not documented as completed at this time. There were no additional vital sign monitoring, blood glucose readings, or physical assessments of the resident completed overnight on 03/12/26. The vital sign documentation in Resident #78's medical record reflected on 03/13/26 at 8:32 A.M. the resident's blood glucose was elevated at 391 mg/dl. This was also the scheduled time of Resident #78's insulin administration, which would have prompted the nurse for the resident's current blood glucose. Record review revealed no additional physical assessment or vital sign monitoring (pulse, oxygen saturation, respirations, temperature and blood pressure) were completed at this time. Review of the nursing progress note revealed on 03/13/26 at 9:54 A.M. LPN #256 found Resident #78 unresponsive and unarousable, even after attempting a sternal rub. CNP #561 was notified, who issued an order for Resident #78 to be transferred to the hospital. Review of the hospital records for Resident #78 revealed the resident was admitted to the critical care unit, with mechanical ventilation required. She was hospitalized from [DATE] until 03/25/26. During her hospital stay, she was found to be in septic shock related to pneumonia and a urinary tract infection. The resident's (hospital) course was further complicated by acute kidney injury on top of chronic kidney disease, significant electrolyte imbalances, and high blood sugar levels. The resident's treatment course included mechanical ventilation, intravenous fluids, and antibiotics. Palliative care was consulted during her stay, and the resident's family chose to continue hospice services following her discharge from the hospital. At the time of the resident's hospital stay, the hospitalist noted the resident was medically stable for discharge but remained minimally responsive and on supplemental oxygen.Review of the acute care hospital Discharge summary dated [DATE] revealed on 03/13/26, Resident #78 presented to the emergency room with altered mental status. Vital signs included a temperature of 107 degrees Fahrenheit, (normal reading 98.6 degrees Fahrenheit) and blood pressure 70/50 mm/Hg, (normal 120/80 mm/Hg). Resident #78's laboratory values included an elevated blood glucose of 349, elevated serum sodium of 172 (normal values 135-145) and elevated serum lactate 2.5 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(normal level is less than 2). During the resident's admission assessment, it was noted the resident was not even responsive to painful stimuli. The resident was intubated in the emergency department. She was diagnosed with septic shock related to a complicated urinary tract infection, metabolic encephalopathy related to hypernatremia and sepsis, hyperglycemia, severe malnutrition and acute kidney injury. The resident was also assessed to be severely dehydrated. Interview on 04/08/26 at 3:34 P.M. with CNP #561, revealed after Resident #78's abnormal blood sugar value of 522 mg/dL was reported to her and she ordered a medication intervention (lispro), her expectation was that resident's blood glucose be re-checked in an hour and the nurse would have called her back if the value continued to be elevated. She denied being notified that Resident #78 had a change in condition and was lethargic. She stated her expectation was that the nurse would have obtained a full set of vital signs once the change in condition was noted. CNP #561 revealed with this additional information she would have ordered additional monitoring tests for the resident, including a urinalysis, which would have detected the urinary tract infection the resident had. Interview with RN #270 on 04/09/26 at 9:21 AM revealed the RN confirmed on 03/12/26 she noticed Resident #78 appeared more lethargic than usual. She stated called the provider who said the resident should be closely monitored for the next 24 hours. Following her administration of the ordered intervention (lispro), she stated she re-checked the resident's blood glucose level two hours later and it was still high. She recalled checking again two hours later and it was in the 300's so she called the provider who gave no new orders at that time. She said she thought she checked the resident's vital signs (including temperature) and believed they were normal but stated she could not recall if she recorded any of these values in the resident's medical record. The RN stated even though the resident's blood glucose level had come down, the resident remained very lethargic (abnormal for the resident). RN #270 verified a second call to the provider was not recorded in the resident's medical record. Interview on 04/09/26 at 1:50 PM with Certified Nursing Assistant (CNA) #385 revealed he recalled on 03/12/26, Resident #78 was very tired. He explained the resident would normally speak to staff whenever they entered her room, but that day (03/12/26) she didn't want to talk or lift her head at all. Interview on 04/09/26 at 2:10 P.M. with CNA #387 revealed she recalled caring for Resident #78 on the morning of 03/13/26. She stated she recalled being advised in report from the night shift CNA the resident had a lot of diarrhea the previous night. She said when she visited the resident in her room, the resident appeared very sleepy and would not respond when the CNA greeted her. She stated when she returned about an hour later, the resident wouldn't wake up. She said she alerted the nurse, who indicated she had already notified the medical provider. Interview on 04/09/26 at 2:25 PM with LPN #234, who provided care for Resident #78 on 03/12/26 overnight, revealed she recalled being advised by the day shift nurse that Resident #78 had been very sleepy all day. LPN #234 revealed she was concerned the resident would barely open her eyes and would not speak to her, as she normally did. Interview on 04/09/26 at 2:36 P.M. with LPN #256 revealed she recalled being called by another staff member to Resident #78's room because the resident was unresponsive (on 03/13/26). She stated she obtained a full set of vitals from the resident to provide CNP #561. She revealed she felt Resident #78's vital signs were normal. The resident's vital signs were blood pressure of 110/63 mm hg, pulse of 108 BPM, (an abnormal reading), oxygen saturation 98%, temperature of 99.5 degrees Fahrenheit, (an abnormal reading) and blood glucose of 391 mg/dl, (an abnormal reading for Resident #78). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/15/26 at 5:26 P.M. during a subsequent interview with CNP #561 she stated she does now recall being advised by RN #270 that Resident #78 was more lethargic than usual. CNP #561 recalled telling RN #270 to continue monitoring the resident. She stated her expectation was that the nursing staff would have obtained vitals at least every shift and reported to her if they were abnormal. She said she was not made aware that the resident had (new onset) diarrhea. The CNP revealed this was information she would have liked to know because this would be considered a significant change. Review of the facility policy and procedure titled Change in the Resident's Condition or Status, updated 05/01/25 revealed it was the facility's policy the resident's medical provider was notified of changes to the resident's physical, mental or psychosocial status. Following an adequate assessment, the nurse would also document these findings in the resident's medical record. 2. Review of the closed medical record for Resident #88 revealed the resident was admitted to the facility on [DATE]. Resident #88's diagnoses included metabolic encephalopathy, benign prostatic hyperplasia, need for assistance with personal care, and cognitive communication deficit. Review of Resident #88's nursing admission assessment dated [DATE] revealed Resident #88 was incontinent of bowel. Review of Resident #88's nursing evaluation titled, GG Support Assessment, dated 07/08/25, revealed Resident #88 was assessed as requiring substantial to maximal (staff) assistance with toileting hygiene and substantial to maximal (staff) assistance with toilet transfers. Review of Resident #88's Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08, indicative of moderate cognitive impairment. Review of Resident #88's care plan dated 07/09/25 revealed Resident #88 was incontinent of bowel and at risk for constipation. The goal was for Resident #88 to have soft bowel movements at least every three days without complications such as constipation. Approaches included to administer medication per physician orders, to check and provide incontinence care as needed, to observe and record bowel movements daily, to observe for signs of constipation, and to provide physical support and assistance for toileting safety. Review of Resident #88's physician orders dated 07/05/25 through 08/26/25 revealed the resident had an order for bisacodyl, a stimulant laxative, extended release, five (5) milligrams (mg), one tablet once daily. Review of Resident #88's Medication Administration Record (MAR) dated 07/05/25 through 08/26/25 revealed Resident #88 received the bisacodyl as ordered. Review of Resident #88's physician orders dated 07/12/25 through 08/26/25 revealed an order for MiraLAX (polyethylene glycol 3350) powder, a laxative, 17 grams per dose, twice daily as needed for no bowel movement per facility protocol. Review of Resident #88's MAR dated 07/12/25 through 08/26/25 revealed the resident received the MiraLAX on 07/12/25 for constipation and on 07/13/25 for constipation. Review of Resident #88's bowel movement documentation from 08/18/25 through 08/26/25 revealed (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	it was documented Resident #88 had a small bowel movement on 08/18/25. Resident #88 was recorded as having no bowel movements from 08/19/25 through 08/26/25. Review of Resident #88's nursing progress notes and skilled nursing notes 08/19/25 through 08/25/25 revealed they were silent for Resident #88 having a bowel movement during this time period. Review of Resident #88's nursing progress note dated 08/26/25 at 10:30 A.M. authored by RN #811 revealed staff alerted RN #811 Resident #88 was non-responsive. Resident #88 was ashen and pale but responded to verbal stimuli. Resident #88 was observed to have beige creamy colored drainage in his urinary catheter bag, and the viscosity was unable to be determined. The resident's oxygen saturation was 86% on room air. Oxygen was applied at four liters per minute via nasal canula and the resident's oxygen saturation increased to 100%. The oxygen was decreased to two liters per minute, and his oxygen saturation was able to be maintained at 96%. The CNP was notified, and emergency services were called due to signs and symptoms of sepsis. A verbal report was given to the hospital destination and the note included Resident #88 remained alert during his transfer to emergency services. Review of Resident #88's hospital record dated 08/26/25 at 3:29 P.M. revealed a cat (CT) scan of Resident #88's abdomen and pelvis revealed moderately stool-distended rectal vault with findings which may reflect developing stercoral colitis. Resident #88 was diagnosed with a fecal impaction with possible stercoral colitis. Resident #88 was given intravenous antibiotics and a fecal disimpaction was ordered. Review of Resident #88's hospital record dated 08/26/25 through 09/05/25 revealed Resident #88 had his bowels disimpacted on 08/28/25 and did not require surgery for his fecal impaction. Interviews with RN Supervisor #412 on 04/14/26 at 7:08 P.M., RN Supervisor #270 on 04/15/26 at 3:51 P.M., LPN Supervisor #234 on 04/16/25 at 8:52 A.M., and LPN Supervisor #258 on 04/16/25 at 8:49 A.M. revealed none of the staff were aware Resident #88 had not had a bowel movement for eight days prior to his discharge to the hospital on [DATE]. Interview on 04/15/26 at 3:45 P.M. with Regional Nurse Consultant #594 confirmed Resident #88 did not have a documented bowel movement from 08/19/25 through 08/26/25. A follow up interview with Regional Nurse Consultant #594 on 04/15/26 at 5:33 P.M. confirmed there was no evidence in the medical record that either CNP #561 or the physician were notified Resident #88 had not had a bowel movement since 08/18/25 until the date of his discharge on [DATE].Interview with CNP #561 on 04/15/26 at 5:22 P.M. revealed she was unaware Resident #88 did not have bowel movements for eight days from 08/19/25 through 08/26/25. CNP #561 confirmed the facility did not notify her Resident #88 had not had a bowel movement from 08/19/25 through 08/25/25. CNP #561 indicated it was her expectation facility staff should notify her within three days of a resident not having a bowel movement so that she could give new orders to treat constipation. On 04/16/26 at 2:15 P.M. an interview with CNA #248, who cared for Resident #88 on 08/25/25 revealed the CNA had not realized Resident #88 was constipated on that date and the CNA did not communicate to the nurse Resident #88's last bowel movement was on 08/18/25. On 04/16/26 at 2:24 P.M., an interview with CNA #385, who cared for Resident #88 on 08/24/25 and 08/25/25 revealed the CNA had not realized Resident #88 was constipated on those dates and the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA did not communicate to the nurse Resident #88's last bowel movement was on 08/18/25. Review of the facility policy titled, Bowel Protocol, revised on 05/01/25, revealed that any resident identified by the licensed nurse as not having a bowel movement at least once in a three-day period would be considered for a laxative intervention as ordered by the physician. 3. Review of a closed medical record revealed that Resident #91 was admitted to the facility on [DATE] and had diagnoses that included chronic diastolic (congestive) heart failure and hypertension. Resident #91 was discharged from the facility on 01/08/26 to the hospital with complaints of chest pain. Review of Resident #91's hospitalization after visit summary dated 12/22/25 revealed that Resident #91 was ordered to start losartan, a medication used to treat high blood pressure (hypertension), 25 milligrams (mg), 1 tablet nightly beginning on 12/23/25. Review of Resident #91's physician orders dated 12/22/25 through 01/08/26 revealed that there was no physician orders transcribed for losartan. Review of Resident #91's Medication Administration Records dated 12/22/25 through 01/08/26 revealed that Resident #91 did not receive the medication losartan as was prescribed on Resident #91's hospital after visit summary dated 12/22/25. Review of Resident #91's nursing progress notes dated 12/22/25 through 01/08/26 were silent for any of the after-visit summary medications to be discontinued on 12/22/25, and silent for documentation on why losartan was not started on 12/23/25 as ordered. Review of Resident #91's care plan dated 12/29/25 revealed that Resident #91 had a cardiac impairment related to congestive heart failure. A long-term goal was that Resident #91 would maintain her daily routine without chest pain through the review dated. An intervention listed was to administer medications as ordered. A phone call to Resident #91's resident representative on 04/08/26 at 2:11 P.M. revealed that Resident #91's hospitalization on 01/08/26 did not result in any cardiac or cardiovascular diagnoses. Resident #91's complaints of chest pain were related to muscular strain and not related to her heart or cardiovascular health. An interview with Regional Nurse Consultant #594 on 04/09/26 at 11:48 A.M. confirmed that losartan was not started for Resident #91 on 12/23/25 and that the admitting nurse did not transcribe Resident #91's physician orders into Resident #91's medical record correctly. Review of the facility policy titled, Telephone Orders, updated on 05/01/25, revealed that the physician orders must be entered into the electronic medical record by the licensed nurse receiving the order. 4. Review of resident electronic medical record revealed that Resident #55 was admitted to the facility on [DATE] and had diagnoses that included cognitive communication deficit, aphasia, dementia, bilateral open-angle glaucoma, bilateral combined forms of age-related cataracts, and vitreous degeneration of right eye. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #55's care plan dated 09/21/18 revealed that Resident #55 was at risk for visual function as he has a diagnosis of cataracts. A long-term goal listed was that Resident #55 would not experience negative consequences of vision loss. Approaches listed to help Resident #55 achieve this goal included to administer medications as ordered, and to obtain ophthalmologist consultations as needed. Review of Resident #55's physician orders revealed that Resident #55 was prescribed brimonidine, an ophthalmic solution to lower eye pressure in glaucoma, 1 drop to both eyes twice daily from 11/11/21 through 11/06/24, and latanoprost, an ophthalmic solution prescribed to reduce high pressure inside the eye, 1 drop to both eyes daily from 11/02/23 through 11/06/24. Review of Resident #55's ophthalmology after visit summary dated 09/01/23 revealed that Resident #55 was ordered Brimonidine 0.2% 1 drop in both eyes twice daily, and latanoprost 0.005% 1 drop in both eyes daily at bedtime. Review of Resident #55's physician orders revealed that Resident #55 was ordered brimonidine drops 0.2% 1 drop to both eyes twice a day as needed for glaucoma from 11/06/24 to 11/19/25, and latanoprost 0.005% 1 drop in both eyes once daily as needed for glaucoma. Review of Resident #55's ophthalmology after visit summary dated 05/08/25 revealed that Resident #55 needs to restart brimonidine 0.2% solution left eye three times daily and to right eye twice daily, restart latanoprost 0.005% solution once daily at night in left eye, and continue dorzolamide timolol, an ophthalmic combination medication used to lower eye pressure for conditions such as open-angle glaucoma and ocular hypertension, 1 drop two times daily in both eyes. Review of Resident #55's nursing progress notes for May 2025 do not mention new orders from the ophthalmologist that were communicated via the ophthalmologist after visit summary on 05/08/25. Review of Resident #55's physician orders revealed that the ophthalmologist's orders for brimonidine 0.2% solution left eye three times daily and to right eye twice daily, latanoprost 0.005% solution once daily at night in left eye and dorzolamide timolol 1 drop two times daily in both eyes were not implemented until 11/19/25. Dorzolamide timolol was ordered as one drop to both eyes twice daily starting on 11/19/25. Review of Resident #55's Medication Administration Record for 05/01/25 through 11/19/25 revealed that Resident #55 continued to have as needed orders for brimonidine drops 0.2% 1 drop to both eyes twice a day, as needed, for glaucoma from 11/06/24 to 11/19/25, and latanoprost 0.005% 1 drop in both eyes once daily, as needed, for glaucoma. Brimonidine and latanoprost were not given from 05/01/25 through 11/18/25. Dorzolamide Timolol was not administered until the start date of 11/19/25. Review of Resident #55's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed that Resident #55 had a Brief Interview for Mental Status score of 6, indicative of severe cognitive impairment. An interview with Regional Nurse Consultant #594 on 04/13/26 at 5:19 P.M. confirmed that there was no evidence that the facility implemented the orders in the medical record for scheduled brimonidine, latanoprost, or dorzolamide timolol that were written on 05/08/25 until 11/19/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Review of the closed record for Resident #93 revealed an admission date of 01/24/26 and diagnoses including cerebral infarction, dysphagia (difficulty swallowing), diabetes, morbid obesity, asthma, lupus erythematosus, bipolar disorder, hypertension, and pain in thoracic spine. She was admitted from the hospital after treatment for a urinary tract infection, sepsis, and cerebral infarction. Review of a Minimum Data Set assessment completed 01/30/26 revealed the resident had short- and long-term memory problems, required substantial/maximal assistance with eating, toileting, dressing, and personal hygiene. She was incontinent of bowel and bladder. Review of nursing progress notes dated 02/02/26 at 2:14 A.M. revealed daughter wanted to know if resident was given Zofran (medication used for nausea), asked previous nurse but resident is still complaining of nausea and stomach pain throughout the day; daughter advised mother has not been eating well last 48 hours; loose stool 48 hours prior; checked electronic medication record and up opened medication; administered medication; vital signs stable resident warm to touch; fell asleep about 45 minutes later. (Review of the medication administration record revealed the Zofran was given on 02/01/26 at 8:24 P.M. by the nurse who wrote the nursing progress note). There was no evidence that the physician or nurse practitioner was notified of the nausea or stomach pain or that the

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident with a pressure ulcer received the necessary care and treatment as ordered to promote healing, prevent infection, and prevent new ulcers from developing. This affected one resident (#93) of six residents reviewed for pressure ulcers. The facility census was 57.Findings include: Review of the record for Resident #93 revealed an admission date of 01/24/26 and diagnoses including cerebral infarction, dysphagia, diabetes, morbid obesity, sepsis, bipolar disorder, anxiety disorder, hypertension, osteoarthritis, and peripheral vascular disease. The resident was transferred to the hospital on [DATE] due to a change in condition and did not return to the facility. The clinical admission assessment with an observation date of 01/24/26 stated the resident had impaired short and long term memory and was oriented to self only. It indicated the resident was incontinent of bowel and bladder and was at moderate risk of skin breakdown (even though she already had a pressure ulcer). Record review revealed an initial wound grid indicating the resident was admitted to the facility 01/24/26 with a stage three pressure ulcer on the sacrum measuring 0.6 x 0.3 x 0.2 centimeters (cm). Per the facility policy, a stage 3 pressure ulcer is an ulcer with full-thickness skin loss in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location. Undermining and tunneling may occur. Review of the baseline care plan with an observation date of 01/24/26, a recorded date of 01/28/26, and a completed date of 02/06/26 revealed it had not applicable marked for wound care and did not include any interventions related to pressure ulcers. The comprehensive care plan for pressure ulcers was not implemented until 02/03/26. (10 days after admission). Review of physician's orders revealed an order on 01/24/26 to cleanse the sacrum with normal saline, pat dry, and apply Triad (a topical, zinc-oxide-based, non-adhesive paste used to manage light-to-moderate wound exudate and protect broken skin) twice daily and as needed. However, review of the treatment administration record (TAR) revealed there was no evidence the treatment was actually started until 01/27/26, three days after it was ordered. Review of an initial wound evaluation and management summary by an outside wound provider revealed on 01/27/26 the resident was noted to have a stage three pressure ulcer on the sacrum measuring 0.6 x 0.3 x 0.2 cm with light serous exudate and 100% granulation tissue. The treatment plan included Triad cream twice daily and as needed and to off load wounds and reposition per facility protocol. Review of a Minimum Data Set assessment completed 01/30/26 revealed the resident had short and long term memory problems, was always incontinent of bowel and bladder, required substantial/maximal assistance with turning, and had a stage three pressure ulcer present upon admission. Review of nursing progress notes revealed on 01/27/26 at 10:47 P.M. it was documented that the resident's daughter was very concerned about the air mattress she was promised and the air mattress was delivered today (01/27/26). There was no evidence of any physician's orders for a pressure redistribution mattress until 01/27/26 when a low air loss mattress was ordered. It was documented as applied to the bed on 01/28/26 after the resident refused to get up on 01/27/26. Continued review of Resident #93's record revealed there was no physician's order for turning/repositioning. There was no care plan or profile card for turning/repositioning until 02/03/26 when it stated to assist resident as needed with turning and positioning frequently when in bed and/or shift weight to reposition when in chair as tolerate. The plan of care did not specify how often the resident was to be repositioned. Interview with Regional Nurse Consultant #594 on 04/15/26 at 7:39 A.M. confirmed the initial clinical assessment and baseline care plan did not identify a pressure ulcer or any care required for the ulcer. She stated that the nurse who completed the assessment stated she likely made an error regarding the pressure ulcer due to the nurse having received multiple new admissions (four to five) that day. She confirmed the resident did have a pressure ulcer on admission. She confirmed there was no (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence the treatment to the sacrum ulcer was completed for three days after ordered. She stated repositioning is a standard of care and the aides know who to turn/reposition based on their orders and care plan. She confirmed turning/repositioning was not part of the resident's care plan until 02/03/26 and there was no physician's order to turn the resident. The pressure ulcer was documented as resolved on 02/03/26. Review of the facility policy titled Pressure Injuries: Assessment, Prevention, and Treatment updated 05/01/25 revealed it is the facility's policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries, and provide care for existing pressure injuries. Interventions and preventive measures as indicated based on resident risk factors included change position at least every two hours and more frequently as needed and use pressure redistribution mattresses. This deficiency represents non-compliance investigated under Master Complaint Number 2744632 and Complaint Numbers 2705832, 2603202 and 2596624.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview, and facility policy review, the facility failed to ensure fall interventions were in place. This affected one (Resident #4) of two residents reviewed for falls. The census was 57Findings include: Review of Resident #4's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included aphasia, high blood pressure, major depression, insomnia, anemia, cerebral infarction, anxiety and history of embolism.Review of the quarterly MDS assessment dated [DATE] revealed her cognition was moderately impaired. She required supervision or touching assistance for eating, personal hygiene and turning and repositioning, partial to moderate assistance oral hygiene, toileting, substantial to maximal assistance for shower/bathing. Occasionally incontinent of urine and frequently incontinent of bowel. Review of the fall plan of care dated 05/21/21 revealed the resident was at risk for falls due to confusion/altered mental status, history of falls, and use of anti-depressants. Interventions included dycem (rubber like material known for non-slip properties) to her wheelchair, non-skid strips to the right side of the bed, bright colored tape to the call light and encourage the resident to wear her glasses.Observations on 04/07/26 at 2:25 P.M. revealed Resident #4 was not observed wearing her glasses. At 4:03 P.M., there was no dycem observed in her wheelchair.Observations on 04/08/26 at 1:24 P.M. revealed Resident #4 was observed up in her wheelchair in the dining room for activities. she had shoes on but no dycem was observed in the wheelchair. Anti-tippers were present to the resident's wheelchair. Resident #4 was not observed to be wearing her glasses. At 2:40 P.M., Resident #4 was lying in bed. There was no non-skid strips observed on the right side of the bed.Observations on 04/09/26 at 8:44 A.M. revealed Resident #4 was observed up in the dining room in wheelchair with slippers on. The resident was feeding herself breakfast. She did not have her glasses on. The resident was observed with a brake extender to the wheelchair and anti-tippers to the wheelchair. There was no dycem observed in the wheelchair. At 9:41 A.M., observation and interview revealed no non-skid strips to the right side of the bed and no dycem in wheelchair. This was verified during interview with Regional Nurse Consultant #583.Review of the facility Fall Prevention policy and procedure dated 05/01/2025 revealed staff will ensure that safety interventions are in place for each resident to reduce the risk of falls.This deficiency represents noncompliance investigated under Complaint Numbers 2723137 and 2603202.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, facility policy review and interview, the facility failed to follow physician orders for Resident #88's urinary catheter and failed to develop and implement a comprehensive and individualized plan of care for the urinary (indwelling) catheter including consistent monitoring/assessment of urinary output to prevent a significant complication from catheter use. This affected one resident (#88) of three residents reviewed for urinary catheters. The facility census was 57 residents. Actual harm occurred on 08/26/25, when Resident #88, who was cognitively impaired, was noted to have a change in condition, which included blood and pus observed in his urinary catheter bag. Subsequently, Resident #88 was transported to the hospital on [DATE], where he was admitted and diagnosed with sepsis attributed to a mispositioned urinary catheter, which resulted in a blockage. Prior to the incident, on 08/13/25 Resident #88 had returned from an outpatient urology appointment without a urinary catheter present. On 08/18/25, the Certified Nurse Practitioner (CNP), noted Resident #88 had a urinary catheter in place without physician orders. The CNP indicated in the 08/18/25 and 08/20/25 progress note that orders were given to remove the urinary catheter per urology. Staff provided catheter care between 08/14/25 and 08/26/25 but failed to monitor/record the resident's urinary output from the urinary catheter consistently (only two values recorded) during this time. On 08/22/25, an additional physician order was given to remove the urinary catheter, but this order was not completed.Findings include: Review of the closed medical record revealed Resident #88 was admitted to the facility on [DATE]. Resident #88's diagnoses included metabolic encephalopathy, benign prostatic hyperplasia, need for assistance with personal care, and cognitive communication deficit. Review of Resident #88's nursing admission assessment dated [DATE] revealed Resident #88 did not have a urinary catheter present. Resident #88 was assessed as being continent of bladder function. Review of Resident #88's nursing evaluation titled, GG Support Assessment, dated 07/05/25 revealed Resident #88 was assessed as needing partial to moderate (staff) assistance with toileting hygiene and required substantial to maximal (staff) assistance with toileting transfer. Review of Resident #88's Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 08, indicative of moderate cognitive impairment. Review of Resident #88's nursing progress note dated 07/09/25 revealed Resident #88's family voiced concern of Resident #88 not voiding much for the prior two days. New orders were obtained to scan the resident's bladder every shift for 48 hours. Review of Resident #88's nursing progress note dated 07/10/25 indicated a bladder scan at 12:00 P.M. revealed 930 milliliters (ml) of urine in the resident's bladder. A nursing progress note on 07/10/25 at 2:14 P.M. revealed Resident #88 refused to be catheterized to relieve the urine in his bladder. The physician was notified and orders were given to send Resident #88 to the hospital. Review of Resident #88's hospital record dated 07/10/25 revealed Resident #88 was diagnosed with urinary retention and a urinary tract infection. Resident #88 was treated with antibiotics, and had a urinary catheter inserted at the hospital, which remained in place at the time of his discharge back to the facility on [DATE]. Review of Resident #88's Treatment Administration Record (TAR) revealed catheter care was provided as ordered from 07/11/25 through 08/13/25. Review of Resident #88's certified nurse practitioner (CNP) visit note dated 08/12/25 and authored by CNP #561 revealed Resident #88 had benign prostatic hyperplasia, he had a urinary catheter in place and was to follow up at an outpatient urology appointment. Review of Resident #88's outpatient urology progress note dated 08/13/25 revealed Resident #88 did not require a urinary catheter. The resident was not retaining urine, as he had only 30 ml of urine in his bladder. As a result, the urologist determined the resident no longer required a urinary catheter and the catheter was removed. The urologist determined that if Resident #88 were to ever go back into urinary retention, a better option (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	would be a suprapubic catheter rather than a urethral catheter. Resident #88 and his family were given education on voiding dysfunction. The plan was made to observe Resident #88 for signs of urinary retention. Review of Resident #88's physician orders revealed that no new physician orders were entered on 08/13/25 relevant to Resident #88's urinary catheter being removed at his urology appointment. Resident #88's physician orders to provide catheter care twice daily remained in place until 08/25/25. Review of the TAR revealed on the evening of 08/13/25, Resident #88 did not receive catheter care. Starting in the day shift of 08/14/25, Licensed Practical Nurse (LPN) Supervisor # 258 documented on the TAR that Resident #88 received catheter care as ordered, despite the catheter not being present after Resident #88's urology appointment. Other licensed nurses who documented they provided catheter care to Resident #88 included Registered Nurse (RN) Supervisor #270, LPN Supervisor #234, and RN Supervisor #412. Review of Resident #88's nurse practitioner visit notes dated 08/18/25 and 08/20/25 authored by CNP #561 revealed Resident #88 was seen at the urologist office on 08/13/25 and his catheter was removed at that time. The note then included somehow his catheter has been reinserted. CNP #561's progress notes on 08/18/25 and 08/20/25 indicated an order was given to remove his catheter. However, record review revealed no physician orders were made on 08/18/25 to remove the resident's urinary catheter. Resident #88's physician orders to provide catheter care twice daily remained in place until 08/25/25. Review of Resident #88's nursing progress notes from 08/12/25 through 08/25/25 revealed they were silent for any mention of problems with Resident #88's urinary catheter or Resident #88 having any difficulty voiding. Review of the physician orders dated 08/22/25 revealed an order for Resident #88 to have his urinary catheter removed per urology and to remove all associated orders. Review of Resident #88's TAR revealed the removal of the resident's urinary catheter was not completed 08/22/25 through 08/26/25. The associated orders for catheter care remained in place on the TAR 08/22/25 through 08/25/25. Review of Resident #88's urinary output from 08/13/25 through 08/26/25 revealed the resident had urinary output recorded on 08/14/25 as 550 ml, and on 08/24/25 as 400 ml. No other urinary output was recorded in Resident #88's medical record between 08/13/25 and 08/26/25. Review of Resident #88's vital sign record revealed on 08/24/25 (no time identified), Resident #88's blood pressure was 125/78 mm/Hg, his oxygen saturation was 98%, and his temperature was 97.4 degrees Fahrenheit (F). On 08/25/25 (no time identified), Resident #88's blood pressure was 128/75 mm/Hg, his oxygen saturation was 98%, and his temperature was 97.4 degrees F. On 08/26/25 (no time identified), Resident #88's blood pressure was 90/50 mm/Hg, and his temperature was 98.3 degrees F. Review of Resident #88's physician orders dated 08/25/25 revealed Resident #88 was to have a bladder scan every eight hours and document amount. Review of Resident #88's TAR dated 08/25/25 revealed a bladder scan was documented as completed on 08/26/25 at 4:11 A.M.Review of Resident #88's nursing progress note dated 08/26/25 at 4:11 A.M. revealed a bladder scan was completed which showed 300 ml of urine in the resident's bladder. Review of Resident #88's nursing progress note dated 08/26/25 at 10:30 A.M. authored by Registered Nurse (RN) #811(this nurse was no longer employed at the facility) revealed staff alerted RN #811 that Resident #88 was non-responsive. Resident #88 was ashen and pale but responded to verbal stimuli. The note included Resident #88 was observed to have beige creamy colored drainage in his urinary catheter bag, and the viscosity was unable to be determined. The resident's oxygen saturation was 86% (low) on room air. Oxygen was applied at four liters per minute via nasal canula and the resident's oxygen saturation increased to 100%. The oxygen was decreased to two liters per minute, and his oxygen saturation was able to be maintained at 96%. The nurse practitioner was notified, and emergency services were called due to signs and symptoms of sepsis. A verbal report was given to the hospital destination. Review of Resident #88's nursing progress note authored by RN Supervisor #412 on 08/26/25 at 10:30 A.M. revealed Resident #88 was sent to the hospital due to decreased level of consciousness, confusion, and pus and blood noted at his penile meatus at the orders of CNP #561. Review of Resident #88's hospital record dated 08/26/25 at 3:29 P.M. revealed Resident #88's blood pressure upon arrival to (continued on next page)

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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

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F 0690 Level of Harm - Actual harm Residents Affected - Few	the hospital was in the 70's to the 90's systolic (hypotensive). Resident #88's creatinine level was 2.31, which was documented to be consistent with acute kidney injury, with Resident #88's baseline creatinine level at 0.8. Resident #88's urinalysis was concerning for a urinary tract infection. A computed tomography (CT) scan of Resident #88's abdomen and pelvis dated 08/26/25 at 12:28 P.M. revealed severe bladder distention with mild resultant hydronephrosis. There was a malpositioned Foley catheter inflated within the membranous urethra that required removal and repositioning. It was determined by the hospital physician Resident #88 needed to be admitted to the hospital due to acute encephalopathy, urinary tract infection, sepsis and acute kidney injury, due to life threatening organ dysfunction. Further review of Resident #88's hospital record dated 08/26/25 at 5:46 P.M. revealed Resident #88 required removal and repositioning of his urinary catheter. The resident was started on sepsis protocol, but despite this, Resident #88 had progressive shock and was admitted to the intensive care unit (ICU). Review of Resident #88's hospital records dated 08/26/25 through 09/05/25 revealed Resident #88 responded to antibiotic therapy and volume resuscitation. It was believed that his bladder outlet obstruction produced his hydronephrosis renal insufficiency, hyperkalemia and sepsis. Resident #88's creatinine level improved to 0.79 on 08/31/25. Resident #88 was subsequently discharged to an alternate extended care facility with hospice services in stable condition. Interviews with RN Supervisor #412 on 04/14/26 at 7:08 P.M., RN Supervisor #270 on 04/15/26 at 3:51 P.M., LPN Supervisor #234 on 04/16/25 at 8:52 A.M., and LPN Supervisor #258 on 04/16/25 at 8:49 A.M. revealed Resident #88 had a urinary catheter in place during the entire time they had provided care for Resident #88. The interviews revealed staff denied awareness of any (physician) orders to remove Resident #88's urinary catheter per the urologist's orders. The staff interviewed denied knowledge of any complications related to Resident #88's urinary catheter, stated they did not have knowledge of any monitoring concerns of Resident #88's urinary catheter output, they did not reinsert Resident #88's urinary catheter, nor did they obtain orders to reinsert Resident #88's catheter. An interview with Regional Nurse Consultant #594 on 04/15/26 at 3:45 P.M. revealed the facility did not have the urologist after visit summary orders for 08/13/25 available for review, the nurses never discontinued the physician orders for the catheter care on 08/13/25, that there were no progress notes indicating that nursing was aware of the orders to discontinue the urinary catheter on 08/13/25, and that there was no indication that Resident #88 had physician orders to reinsert the urinary catheter after the 08/13/25 catheter removal.An interview with Certified Nurse Practitioner (CNP) #561 on 04/15/26 at 4:07 P.M. revealed on 08/19/25, CNP #561 had reviewed Resident #88's urologist after visit summary (from the 08/13/25 visit) and CNP #561 had learned Resident #88 had passed a voiding trial in the urologist office, and therefore, Resident #88's urinary catheter had been removed. On 08/18/25, CNP #561 had observed Resident #88 had a urinary catheter in place, but she was unaware of any orders to reinsert Resident #88's urinary catheter. CNP #561 noted the facility had physician orders to remove the urinary catheter. CNP #561 revealed she reviewed the call logs to the physician office and no phone calls were made from the facility from 08/13/25 to 08/18/25 regarding obtaining any orders to reinsert Resident #88's urinary catheter. CNP #561 revealed she had brought this issue (date not provided) to the facility's attention. CNP #561 revealed staff turnover at the facility had been high, and miscommunication and subsequent care errors were a concern in August 2025. A follow up interview with Nurse Practitioner #561 on 04/15/26 at 5:22 P.M. revealed sepsis symptoms could become apparent within 24 to 48 hours, but that monitoring vital signs and urinary output was the best indicator for monitoring catheter concerns and infection concerns for residents with cognitive impairments. A follow up interview with Regional Nurse Consultant #594 on 04/15/26 at 5:33 P.M. confirmed there was not consistent monitoring of the urinary catheter output for Resident #88 from 08/13/25 through 08/26/25, there was not a comprehensive assessment of the need of Resident #88's need to reinsert a urinary catheter, that there was not evidence in the medical record why Resident #88 required a bladder scan on 08/25/25, and that the physician order for the removal of Resident #88's urinary catheter on 08/22/25 was not completed as ordered. An interview (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	with Certified Nursing Assistant (CNA) #375 on 04/16/26 at 2:00 P.M. revealed on 08/14/25, CNA #375 was the CNA who provided care for Resident #88. CNA #375 stated that she was not certain, but stated she thought it was possible the nurse on duty 08/14/25 saw that Resident #88's urinary catheter was not in place and assumed that Resident #88 had pulled it out. CNA #375 vaguely recalled the possibility the nurse who worked on 08/14/25 with CNA #375 was the nurse who reinserted Resident #88's urinary catheter on that date. Record review revealed the nurse who had provided care for Resident #88 while CNA #375 was working on 08/14/25 was LPN Supervisor #258. However, during the onsite survey investigation, interview with this LPN denied reinserting Resident #88's urinary catheter after the resident returned from the urologist appointment on 08/13/25 without a urinary catheter in place. An interview with CNA #385 on 04/16/25 at 2:22 P.M. revealed the CNA recalled Resident #88 had a urinary catheter in place the entire time he/she provided care to him (which was on 08/16/25 and 08/17/25). Review of the facility policy titled, Telephone Orders, updated on 05/01/25, revealed it was the facility policy to accept verbal orders in person or via telephone from a provider to promote the continuity of the resident's care. Orders may be reduced to writing or entering into the electronic medical record by the person receiving the order. Review of the facility policy titled, Urinary Catheter Care, updated on 05/09/25, revealed the urine volume in the drainage bag should be observed. If there was a significant increase or decrease in volume during the shift, it should be reported to the nurse. The urine in the drainage bag should be monitored for abnormal appearance, and abnormal findings should be reported to the nurse. An accurate record of the residents' daily output should be maintained. This deficiency represents non-compliance investigated under Complaint Number 2707299 and Complaint Number 2603202.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review, staff interview and policy review, the facility failed to The facility failed to ensure accurate and timely monitoring of Resident #93's weight, resulting in an undetected and unevaluated significant weight loss. This affected one (Resident #93) of four residents reviewed for nutritional status. The facility census was 57.Findings include:Review of the record for Resident #93 revealed an admission date of 01/24/26 and diagnoses including cerebral infarction, dysphagia, diabetes, morbid obesity, sepsis, bipolar disorder, anxiety disorder, hypertension, osteoarthritis, and peripheral vascular disease. Review of the admission assessment on 01/24/26 revealed Resident #93 refused to be weighed. Diet ordered: low concentrated sweets, mechanical soft diet with nectar thickened liquids. Review of the physician's order dated 01/24/26 revealed an order for weekly weights for four weeks. No evidence of further attempts to obtain weights until 02/05/26.Review of the physician's order dated 01/28/26 revealed the diet was changed to pureed with honey thickened liquids. Review of the physician's order dated the diet was changed to mechanical soft texture with honey thickened liquids; outˆofˆbed for all meals and 1:1 feeding assistance. Review of the Minimum Data Set (MDS) 3.0 assessment completed 01/30/26 revealed Resident #93 had short- and long-term memory problems and required substantial/maximum assistance with eating. Review of a dietary progress note on 02/03/26 by Dietitian #601 documented hospital weight 220 pounds (lbs), intake ranged 1-100%, and sacral wound present; recommended ProSource (protein supplement) for wound healing. On 02/05/26 a physician's order was obtained for ProSource 30 milliliters (ml) daily. Review of weight records revealed on 02/05/26 Resident #93 weighed 194 lbs, reflecting a 26ˆlb (11.8%) decrease from hospital weight; no evidence of reweigh to verify accuracy and no dietitian evaluation of the significant loss Review of a progress note by the nurse practitioner on 02/10/26 revealed Resident #93 was minimally responsive, not tracking with eyes, tremors of upper extremities; resident sent to hospital and did not return. Interview with Regional Nurse Consultant #594 on 04/15/26 at 7:39 A.M. confirmed no further attempts to weigh Resident #93 occurred between admission and 02/05/26 after the initial refusal; confirmed no further evidence of refusals to be weighed; confirmed no reweigh after the 02/05/26 significant loss was identified and no evaluation of that loss after 02/05/26. Review of the undated facility policy titled Weight/Reweigh Policy revealed a resident's weight will be monitored to evaluate the resident's nutritional status, within the parameters of the resident's overall medical condition. A resident's weight will be obtained and recorded in the medical record within 24 hours of admission. Hospital weights shall not be used in lieu of actually weighing the resident. Weekly weights will be obtained by the nursing staff for the identified residents and the weight recorded in the electronic medical record. Re-weighing of a resident will be completed by nursing staff within 24 hours of initial weight and recorded in the electronic medical record. Reweighing of a resident will occur when there is a plus/minus weight change of five pounds when the resident is over 100 pounds. The reweigh weight will be recorded in the medical record as a second weight for the resident. This deficiency represents noncompliance investigated under Master Complaint Number 2744632 and Complaint Number 2705832.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, staff interview and facility policy review, the facility failed to ensure Resident #93 was provided with adequate pain management. This affected one (Resident #93) of two residents reviewed for pain. The facility census was 57.Findings include:Review of the medical record for Resident #93 revealed an admission date of 01/24/26 with diagnoses including cerebral infarction, dysphagia, diabetes, morbid obesity, sepsis, bipolar disorder, anxiety disorder, hypertension, osteoarthritis, pain in thoracic spine, and peripheral vascular disease. Review of the clinical admission assessment with an observation date of 01/24/26 revealed Resident #93 had impaired short- and long-term memory and was alert only to self. The resident had non-verbal expressions of pain (not specified) and had a pain level of three (scale went from no pain to 10). The frequency of pain was noted to be daily. There was no evidence the resident was offered or provided with any interventions for pain relief. A baseline care plan (part of the clinical admission assessment referenced above) documented a pain goal for Resident #93's comfort to be promoted through the next 30 days. Approaches included note verbal complaints of pain and nonverbal signs of pain (restless, grimacing, withdrawal); work with therapy for pain control to enhance therapy participation; medicate for pain as per order and indication by the resident verbal or nonverbal; report pain to the physician if not relieving the resident's pain. Review of physician's orders revealed on 01/24/26 Tylenol (analgesic) 1000 milligrams (mg) was ordered every six hours as needed. There was also a physician's order 01/24/26 to assess pain every shift using a pain scale of 0-10. Review of the January 2026 medication administration record (MAR) revealed every shift pain assessments were not completed on night shift on 01/24/26, 01/25/26, and 01/26/26. It was also not completed on dayshift on 01/26/26. It was documented on every shift pain assessments that Resident #93 had a pain level of three on dayshift on 01/25/26 and a pain level of four on nightshift on 01/28/26. There was no evidence the resident was offered or provided with any interventions for pain relief. Review of the February 2026 MAR revealed the every shift pain assessments were not completed on nightshift on 02/05/26, 02/06/26, and 02/08/26. Review of a nursing progress note on 02/02/26 at 12:47 P.M. revealed staff spoke with Resident #93's daughter to address concerns following her visit last night where she stated her mother was in pain and nauseous and overall not feeling well. The resident's vital signs this morning around 9:00 A.M. included: blood pressure 120/74, pulse 81, respirations 14, and oxygen saturation 99%. The resident did not express any pain or discomfort during this time but was only oriented to person which was reported to be her new baseline by her daughter. Review of a nursing progress note on 02/10/26 at 9:42 A.M. revealed the nurse practitioner was notified of Resident #93's increased complaints of pain. A new order was received for Tylenol 1000 mg three times daily for seven days. On 02/10/26 at 2:49 P.M. a nursing progress note stated the nurse practitioner was in the facility and assessed the resident. An order was received to send the resident to the hospital for evaluation. Review of the nurse practitioner progress note on 02/10/26 revealed Resident #93 was sent to the hospital for further evaluation after she was noted to be minimally responsive and not tracking with her eyes. She had tremors noted to the upper extremities. The resident did not return to the facility. Interview with Regional Nurse Consultant #594 on 04/15/26 at 7:30 A.M. confirmed Resident #93 was assessed on admission with a pain level of three without any evidence that pain relief was offered. She stated something should have been offered for pain. She confirmed every shift pain assessments were not completed as ordered and nothing was offered or given when pain was identified on the January 2026 MAR on 01/25/26 and 01/28/26. Review of the facility policy titled Pain Assessment and Management updated 05/01/25 revealed it is the facility's policy to assess, monitor, treat, and evaluate pain to ensure effective pain management is provided. Residents who have been identified to have acute or chronic pain are to be assessed for pain in accordance with their plan of care. Residents who have been identified as experiencing pain will be treated in accordance with their plan of care. Non-pharmacological interventions should be attempted (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	first, if appropriate. This deficiency represents non-compliance investigated under Master Complaint Number 2744632 and Complaint Numbers 2705832 and 2596634.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, family, and staff interviews, nurse practitioner interview, record review, review of resident council meeting minutes, and review of the facility assessment, the facility failed to have sufficient nursing staff to meet the needs of the residents. This affected nine residents (#39, #23, #84, #54, #4, #71, #31, #93, and #88) with the potential to affect all 57 residents residing in the facility. Findings include: 1.On 04/06/26 at 8:00 A.M., the survey team entered the facility for the annual recertification and complaint survey. There were one (1) medication tech, one (1) registered nurse (RN), three (3) licensed practical nurses (LPNs), and five (5) certified nurse aides (CNAs) to provide care for 57 residents currently residing in the facility. Review of the list of Directors of Nursing in the past year revealed that the current DON was hired on 03/05/26. Review of the Resident council meeting minutes from meetings on 08/20/25, 09/17/25, 10/01/25, 02/18/26 and 03/18/26 all identified concerns with call light response time, availability of aides for showers, or aides on their phones (rather than helping residents) and staff hiding from completing the work. Review of the Facility Assessment document dated 07/18/25 revealed 27.9% of the residents were determined to be clinically complex. The Assessment noted that the facility provided all care and services as required in the requirements of participation including but not limited to assistance with ADLs, personal care services, medication administration/management, pain management, infection prevention and control, nutrition services, fall and injury prevention, pharmacy, therapy services, etc. Review of the facility Staffing Assessment revealed it was not specific to the number of staff that would be on duty. During an interview on 04/15/26 at 5:25 P.M , Certified Nurse Practitioner (CNP) #561 said her provider group had multiple meetings with the management company for the facility regarding the provider group's concerns for resident care. She attributed some of the facility's challenges to staffing turnover. Review of the job description for a Licensed Nursing Home Administrator dated 12/01/2012 revealed this position supports the development, implementation and monitoring of recruitment and retention plans which lowers turnover. Supports the development of a strong management team among department leaders and supervisory personnel to effectively meet or exceed employee and customer needs. 2. The following resident and family concerns were lodged during the survey related to facility staffing: a. Interview of Resident #39 on 04/06/26 at 1:14 P.M. revealed that the facility is understaffed. Resident #39 revealed that there is often only one nurse aide on staff at night for two halls, and that call lights can take over thirty minutes to answer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Interview with Resident #23 on 04/06/26 at 2:05 P.M. (resides on 200 hall) revealed the facility is short staffed on the weekend (dressings not done on weekend). He stated you have to wait longer at night for the call light to be answered. He stated he had waited five hours one time for his call light to be answered. During observation of a treatment for Resident #23 on 04/07/26 at 9:00 A.M. with the Assistant Director of Nursing (ADON) #381. The resident asked if a particular staff person was working as this staff person transferred him with the mechanical lift by herself. c. Interview with Resident #84's family member on 04/06/26 at 2:10 P.M. revealed when she came in on Saturday (04/04/26) Resident #84 was lying on the mattress with no sheet and covered with only a sheet and had a pillow. They have never come in to turn and reposition the resident or get her up. d. Interview of Resident #54 on 04/06/26 at 3:16 P.M. revealed she doesn't feel like there is enough staff, it takes them a long time to answer her call light. e. Interview of Resident #4 on 04/06/26 at 4:12 P.M. revealed there is not enough staff, it takes them a long time to answer the call light. f. Interview of Resident #71 on 04/07/26 at 8:57 A.M. revealed they don't have enough staff especially on afternoons. On Sunday (referring to 04/05/26) it took one to two hours for them to respond to her call light. g. Confidential interviews with residents in a special resident council meeting held on 04/08/26 revealed the residents present continued to have concerns regarding staff response to resident needs. One resident said she would see a resident sliding out of their chair and would try to help them since no staff was around. She said she was scolded for helping by a staff member but she didn't know why because she felt if she didn't help the other resident would have fallen. Another resident in the meeting noted she kept her own calendar of when she was helped with showers because she said they weren't following the shower schedule. 3. The following staff concerns were lodged during the survey related to facility staffing: a. Interview with LPN Supervisor #335 on 04/07/26 at 7:50 A.M. revealed sometimes there is only one aide for the 200 hall on dayshift (currently 17 residents on 200 hall). She confirmed there are residents on that hall who require being transferred with a mechanical lift. She stated that sometimes the aide does the mechanical lift by herself. She stated she knows that there are to be two staff for a mechanical lift. b. Interview with CNA #222 on 04/08/26 at 5:38 A.M. revealed that on night shift, there are often two to three nurse aides on shift in the building. CNA #222 revealed that he provides incontinence care three times, turns and repositions dependent residents three times, and checks on residents three times in a twelve-hour shift. CNA #222 revealed that if an aide calls off with short notice, the aides and nurses may have to work short-staffed. CNA #222 revealed that at times, if there is not enough staff available, only one person assists residents who are dependent for transfers with a mechanical lift. c. Interview with LPN Supervisor #258 on 04/09/26 at 8:05 A.M. revealed she heard aides identify that they do mechanical lifts with only one staff. She stated that she knew there were supposed to be two staff for a mechanical lift. She stated there are at least three residents on 200 hall who require a mechanical lift: Residents #23, #27, and #82. She stated sometimes there is only one aide for the 200 hall on dayshift. She stated when this happens, they are unable to complete showers, turn and reposition residents every two hours, complete incontinence care every two hours, and residents (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have to wait longer for their call lights to be answered. d. Interview with CNA #385 on 04/09/26 at 11:20 A.M. revealed he works dayshift and works frequently on 200 hall. He stated if there are call offs of staff, there is sometimes only one aide on the 200 hall. He stated there are usually 2-3 aides on 200 hall. He stated if there is only one aide, they are not able to do incontinence care every two hours and it makes it hard to answer call lights timely. e. Interview with CNA #323 on 04/13/26 at 8:57 A.M. revealed that until recently, the facility was expected to work short when there were call offs; however, now that there is a new DON, the staffing has improved. Until the new DON took her position, there were not enough staff members to transfer dependent residents who required a mechanical lift safely with two staff members. 4. During the onsite survey concerns were identified residents were not provided with routine showers/baths, treatments to skin impairment, and safe transfers using a mechanical lift. These concerns were correlated to a lack of staff as noted per the interviews above. a. Review of the record for Resident #23 revealed an admission date of 01/24/26 and diagnoses including morbid obesity, diabetes, heart failure, status post severe sepsis with septic shock and sudden cardiac arrest. Review of a Minimum Data Assessment completed 01/30/26 revealed a Brief Interview for Mental Status (BIMS) score of 11 (moderately impaired cognition). It further stated the resident was dependent upon staff for bed mobility. Review of a history and physical by the physician on 03/06/26 revealed that the resident had peripheral vascular disease with chronic bilateral lower extremity wounds. The note stated the wound team was to follow. However, review of wound consultant notes for 03/10/26, 03/17/26, 03/31/26, and 04/07/26 revealed the lower legs were not addressed. Review of physician's orders revealed orders dated 03/06/26 to cleanse left and right leg with wound cleanser, apply Xeroform, pad ankles and weeping areas with ABD pads, wrap with kerlix and ace wraps daily (on dayshift). Observations on 04/06/26 at 9:50 A.M. revealed Resident #23 to be in bed. The dressings on his right and left legs were dated 04/02/26 (4 days prior). Interview with Assistant Director of Nursing #381 on 04/06/26 at 9:52 A.M. confirmed the dressings on Resident #23's legs were dated 04/02/26. She verified the dressings were ordered to be changed daily. Review of the April 2026 treatment administration record for Resident #23 revealed the treatments to the left and right leg were not documented as completed on 04/03/26. On 04/04/26 (Saturday) and 04/05/26 (Sunday) the treatments to the left and right leg were documented as completed by LPN Supervisor #258. Interview with LPN Supervisor #335 on 04/07/26 at 7:50 A.M. confirmed she worked dayshift on 04/03/26. She confirmed she did not do the treatments to Resident #23's legs that day as ordered. She stated that the 200 hall has a heavy load of treatments and she was too busy to get the treatments done for the resident. She stated that sometimes there is only one nurse for the 100 (currently 24 residents) and 200 (currently 17 residents) halls and it makes it difficult to get all the treatments and medications done. Interview with LPN Supervisor #258 on 04/09/26 at 8:05 A.M. confirmed that she documented that Resident #23's leg treatments were completed on 04/04/26 and 04/05/26 when they were not. She stated she was unable to do the treatments on one of the days because there was an admission of another resident. She stated it is difficult to get all the treatments done on the 200 hall. She stated there have been times when there are call offs of staff and she has had to work two halls at the same time (200 and 300 hall). 200 hall currently had 17 residents and 300 hall currently had 16 residents. She stated that she normally signs off that all of the treatments are done before she does rounds. Then if she does not get the work done, she would normally go back and document that it was not completed. She stated that she did not go back and indicate the treatments were not done for Resident #23's legs. In addition, review of the treatment administration record for March 2026 revealed there were five times that the left leg treatment was not documented as done and four times that the right leg treatment was not documented as done. b. Review of the medical (continued on next page)

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	366367	A. Building B. Wing	04/21/2026

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	record for Resident #31 revealed an admission date of 12/4/25 and diagnoses including Parkinson's disease, bipolar disorder, diabetes, heart failure, atrial fib, cardiac murmur, and hypertension. Review of a Minimum Data Set assessment completed 02/03/26 indicated a BIMS score of 15 (intact cognition). It documented the resident was incontinent of bowel and bladder and dependent upon staff for toileting and transfers. Interview with Resident #31 on 04/06/26 at 1:18 P.M. (resides on 200 hall) revealed he sometimes has to wait 2-4 hours to have his call light answered. He stated he mostly puts it on to get changed. He stated he has to lay for long periods of time while wet from urine. He also stated he likes to get up around 9:30 A.M. He stated they don't get him up until around 11:00 A.M. He stated the aides say it is because they don't have enough help. He stated he requires the use of a mechanical lift to get up. Review of the facility policy titled Hoyer Lift dated 05/01/25 revealed guidelines included having two staff members present when using the lift. One to operate the lift and the other to guide the resident in the sling. c. Review of the closed record for Resident #93 revealed an admission date of 01/24/26 and diagnoses including cerebral infarction, dysphagia, diabetes, morbid obesity, sepsis, and osteoarthritis. (Resided on the 200 Hall). Review of a Minimum Data Set assessment completed 01/30/26 revealed the resident had short- and long-term memory problems. The resident required substantial/maximum assistance with personal hygiene and was dependent upon staff for showers. The resident was always incontinent of bowel and bladder. Review of the plan of care dated 02/03/26 revealed an intervention to provide assistance as needed with activities of daily living. Review of point of care history and shower records revealed between 01/24/26 and 02/10/26 the resident received one bed bath on 01/28/26 and one shower on 02/09/26. (bathed twice in 18 days). Interview with Regional Nurse Consultant #594 on 04/15/26 at 7:39 A.M. revealed residents are to be bathed twice weekly and Resident #93 had not been bathed twice in 18 days. Interview with Regional Nurse #583 on 04/15/26 at 10:15 A.M. confirmed there was no evidence of any further showers/baths for Resident #93. d. Review of medical record revealed that Resident #88 was admitted to the facility on [DATE]. Resident #88's diagnoses included metabolic encephalopathy, benign prostatic hyperplasia, need for assistance with personal care, and cognitive communication deficit. Review of Resident #88's nursing evaluation titled, GG Support Assessment, dated 07/05/25 revealed that Resident #88 was assessed as needing partial to moderate assistance with toileting hygiene and required substantial to maximal assistance with toileting transfer. Review of Resident #88's hospital record dated 07/10/25 revealed that Resident #88 was diagnosed with urinary retention and a urinary tract infection. Resident #88 was treated with antibiotics, and had a urinary catheter inserted at the hospital, which remained in place at the time of his discharge back to the facility on [DATE]. Review of Resident #88's Treatment Administration Record (TAR) revealed that Resident #88's catheter care was provided as ordered from 07/11/25 through 08/13/25. Review of Resident #88's nurse practitioner visit notes dated 08/12/25 and authored by CNP #561 revealed that Resident #88 had benign prostatic hyperplasia and that he had a urinary catheter in place and was to follow up at an outpatient urology appointment. Review of Resident #88's outpatient urology progress notes dated 08/13/25 revealed that Resident #88 did not require a urinary catheter. He was not retaining urine, as he had only 30 ml of urine in his bladder. As a result, the urologist determined that he no longer required a urinary catheter. The urologist determined that if Resident #88 were to ever go back into urinary retention, a better option (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would be a suprapubic catheter rather than a urethral catheter. Resident #88 and his family were given education on voiding dysfunction. The plan was made to observe Resident #88 for signs of urinary retention. Review of Resident #88's physician orders revealed that no new physician orders were entered on 08/13/25 relevant to Resident #88's urinary catheter being removed. Resident #88's physician orders to provide catheter care twice daily remained in place until 08/25/25. Review of Resident #88's TAR revealed that on the evening of 08/13/25, Resident #88 did not receive catheter care. Starting in the day shift of 08/14/25, Licensed Practical Nurse (LPN) Supervisor # 258 signed off on the TAR that Resident #88 received catheter care as ordered, despite the catheter not being present after Resident #88's urology appointment. Other licensed nurses that provided catheter care to Resident #88 included Registered Nurse (RN) Supervisor #270, LPN Supervisor #234, and RN Supervisor #412. Review of Resident #88's nursing progress notes dated 08/12/25 through 08/19/25 were silent for any record of Resident #88 going to his urology appointment, Resident #88's catheter being removed on 08/13/25, or discontinuing Resident #88's orders for catheter care twice daily. Review of Resident #88's nurse practitioner visit notes dated 08/18/25 and 08/20/25, authored by CNP #561, revealed that Resident #88 was seen at the urologist office on 08/13/25 and his catheter was removed at that time. Somehow his catheter has been reinserted. CNP #561's progress notes on 08/18/25 and 08/20/25 indicated that an order was given to remove his catheter. Review of Resident #88's physician orders dated 08/22/25 revealed that Resident #88 was to have his urinary catheter removed per urology and to remove all associated orders. Review of Resident #88's TAR revealed that the removal of his urinary catheter was not completed 08/22/25 through 08/26/25. The associated orders for catheter care remained in place on the TAR 08/22/25 through 08/25/25. Review of Resident #88's nursing progress notes authored by RN Supervisor #412 on 08/26/25 at 10:30 A.M. revealed that Resident #88 was sent to the hospital due to decreased level of consciousness, confusion, and pus and blood noted at his penile meatus at the orders of CNP #561. Interviews with RN Supervisor #412 on 04/14/26 at 7:08 P.M., RN Supervisor #270 on 04/15/26 at 3:51 P.M., LPN Supervisor #234 on 04/16/25 at 8:52 A.M., and LPN Supervisor #258 on 04/16/25 at 8:49 A.M. revealed that Resident #88 had a urinary catheter in place during the entire time that they had provided care for Resident #88. The interviews revealed that they were unaware with any orders to remove Resident #88's urinary catheter per the urologist's orders, they did not have knowledge of any complications related to Resident #88's urinary catheter, they did not have knowledge of any monitoring concerns of Resident #88's urinary catheter output, they did not reinsert Resident #88's urinary catheter, and they did not obtain orders to reinsert Resident #88's catheter. An interview with Certified Nurse Practitioner (CNP) #561 on 04/15/26 at 4:07 P.M. revealed that the staff turnover at the facility had been high, and miscommunication and subsequent care errors were a concern in August of 2025. This deficiency represents non-compliance investigated under Master Complaint Number 2744632 and Complaint Numbers 2723137, 2705832, and 2603202.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 medications were available to be administered for Resident #74. This affected one (Resident #74) resident out of 37 residents reviewed for medications. The facility census was 57.Findings include:Medical record review revealed Resident #74 was admitted to the facility on [DATE] at 7:52 P.M. and discharged to the hospital on [DATE]. Pertinent diagnoses included multiple sclerosis, other osteonecrosis left femur, unilateral primary osteoarthritis left hip, fatigue and post-traumatic stress disorder (PTSD).Review of progress notes revealed on 01/07/26 at 7:52 P.M. Resident #74 arrived at the facility via transport from the hospital with a hip fracture. Review of physician orders for Resident #74 revealed the following orders with a start date of 01/07/26:a. acetaminophen 650 milligram (mg) tablet extended release to be given once a day along with 500 mg of acetaminophen. b. acetaminophen 500 mg to be given twice a day for painc. celecoxib 200 mg capsule to be given twice a day for paind. baclofen two 10 mg tablets to be given twice a day for muscle spasmse. gabapentin two 600 mg tablets to be given three times a day for pain f. aspirin 81 mg to be given at bedtimee. modafinil 200 mg to be given twice a day for wakefulnessf. oxycodone 5 mg tablet 1 to 2 tabs to be administered every 4 hours as needed (PRN) for painReview of a progress note dated 01/08/26 at 12:52 A.M. revealed Resident #74 did not have meds at the facility. The author noted they called the pharmacy, and the pharmacy stated that the resident wasn't in their system. The author called Medone (provider), and confirmed the resident wasn't in their system either. The author updated Medone that the resident was a new admission and got her entered into their system. Resident #74 complained of pain, Medone was contacted for a new prescription. A prescription was sent out to the pharmacy and the pharmacy was contacted to get an update on the medication status.Review of the January 2026 Medication Administration Record (MAR) for Resident #74 revealed that on 01/07/26 there was an x in place of nurse initials for both acetaminophen doses, the aspirin, baclofen and celecoxib. On 01/08/26 there was an ?x' in place of nurse initials (indicating no medication administration) for acetaminophen, aspirin, baclofen, celecoxib.Further review of the January 2026 MAR for Resident #74 revealed the nurse documented Resident #74 as having 10 out of 10 pain on 01/08/26 at 2:53 P.M. and 6 out of 10 pain on 01/09/26.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #74 was cognitively intact.During an interview on 04/13/26 at 2:20 P.M., Regional Nurse Consultant #594 confirmed that there was no indication that the resident was given Tylenol or aspirin on 04/07/25 or 04/08/26 and that they would expect those medications to be available from house stock. She also stated that usually the drop ship from the pharmacy for other medications only took six hours. During interview on 04/13/26 at 3:45 P.M. Regional Nurse Consultant #583 confirmed that Resident #74 also did not receive the celecoxib for pain or the baclofen for muscle spasms on 01/07/26 or 01/08/26.Review of facility policy titled, Medication ordering and receiving from pharmacy, dated May 2020, revealed as to not delay patient care and if available, the initial dose should be obtained from the facility's starter supply or automatic dispensing machine after the nurse checks the resident's allergies. Review of the facility policy titled, Medication Administration General Guidelines, dated May 2020, revealed if a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility are searched if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the starter box.This deficiency represents noncompliance investigated under Complaint Numbers 2656395 and 2596634.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents were free of significant medication errors and that medications were given in accordance with physician's orders. This affected one resident (Resident #83) of 37 sampled residents. The facility census was 57. Findings Include:Review of Resident #83's hospital records (prior to admission to the facility) revealed he was diagnosed with Clostridioides difficile (C. diff), (a bacterium causing severe diarrhea, fever, and colon inflammation often triggered by antibiotic use) on 04/02/26. He was placed on Contact plus precautions in the hospital on [DATE]. Contact plus precautions were noted as enhanced infection control measures used, alongside standard precautions, to prevent the spread of highly contagious pathogens, particularly C. diff. He was started on antibiotic treatment Vancomycin 125 milligrams every six hours for the C. diff on 04/02/26 which was to conclude on 04/15/26. Review of the record for Resident #83 revealed a facility admission date of 04/05/26 with diagnoses including acute and subacute infective endocarditis (infection of the heart's inner lining). Review of physician's orders revealed an order on 04/05/26 upon admission for Vancomycin 125 milligrams every six hours for 37 doses. Review of the point of care history in the resident's record revealed he was incontinent of bowel on 04/05/26 at 1:28 P.M. and 5:44 P.M. and on 04/06/26 at 1:45 A.M. and 4:09 P.M. Review of the medication administration record for April 2026 revealed the Vancomycin was scheduled to be given at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. Review revealed the Vancomycin was not given four doses, on 04/05/26 at 4:00 P.M. or 8:00 P.M. or on 04/06/06 at 8:00 A.M. or 12:00 P.M. The nurses documented that the medication was not given as it was not available. On 04/06/26 the times to give the medication were changed to 5:00 A.M., 11:00 A.M., 5:00 P.M., and 11:00 P.M. The first dose of Vancomycin was given by the facility on 04/06/26 at 5:00 P.M. There was no evidence the physician was notified that the Vancomycin was not available to treat the C-diff. Interview with Regional Nurse Consultant #594 on 04/08/26 at 10:50 A.M. revealed the facility did not have Vancomycin available in their medication starter kit. She stated the pharmacy would be able to drop ship the medication to the facility within six to eight hours. She stated the admitting nurse should have called the pharmacy on 04/05/26 to have the medication drop shipped and did not. She stated the pharmacy did not receive a call to send the medication until 04/06/26. She confirmed Resident #83 missed four doses of the antibiotic to treat C-diff. and there was no evidence the physician was notified that the medication was not available. She stated she would check to make sure extra doses were added to ensure he got the full prescribed amount. This deficiency represents noncompliance investigated under Complaint Numbers 2656395 and 2596634.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility assessment, review of the Administrator Job Description, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This affected 21 residents (#39, #23, #84, #54, #4, #71, #78, #88, #31, #55, #91, #93, #6, #9, #12, #61, #85, #87, #83, #81, #86) and had the potential to affect all 57 residents residing in the facility.Findings include:1.During the course of the annual and complaint survey conducted from 04/06/26 to 04/21/26, the survey team requested information from the facility regarding the administration and leadership changes of the facility.Review of information provided to the survey team on 04/09/26 at 3:46 P.M. revealed the facility had five changes in Administrator since 06/08/23: 06/08/23 to 10/18/24 Administrator #60110/08/24 to 11/10/24 Administrator #60211/11/24 to 11/29/24 Administrator #60312/04/24 to 11/13/25 Administrator #60411/13/25 to 01/26/26 Administrator #60501/27/26 to current date (04/09/26) Current AdministratorNo additional information was provided by the Current Administrator during the survey to support the facility was being administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The information provided to the survey team further revealed there had been seven changes in Director of Nursing (DON) since 06/13/25: 03/20/18 to 06/13/25 DON #60106/24/25 to 07/21/25 DON #60208/25/25 to 09/09/25 Agency DON #60309/10/25 to 09/30/25 Agency DON #60409/30/25 to 01/09/26 DON #60501/09/26 to 03/01/25 Agency DON #60603/02/26 to 03/27/26 Agency DON #60703/05/26 to current date (04/09/26) Current DONNo additional information was provided by the Current DON during the survey to support the facility was being administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. a.The facility failed to have systems in place and administrative oversight to ensure sufficient direct care nursing staff was in place and available to meet the needs of the residents. See findings at F725. Review of the Resident Council Meeting minutes from meetings conducted on 08/20/25, 09/17/25, 10/01/25, 02/18/26 and 03/18/26 all included resident concerns with call light response time, availability of CNA staff for showers, or CNAs being on their phones (rather than helping residents).Review of the Facility Assessment document dated 07/18/25 revealed 27.9% of the residents were determined to be clinically complex. The assessment noted the facility provided all care and services as required in the requirements of participation including but not limited to assistance with activities of daily living (ADL) care, personal care services, medication administration/management, pain management, infection prevention and control, nutrition services, fall and injury prevention, pharmacy, therapy services, etc.Review of the facility Staffing Assessment revealed it was not specific to the number of staff that would be on duty or required to be on duty to meet the total care needs of the residents admitted and/or retained by the facility.b.The following resident and family concerns were voiced during the survey related to facility staffing: Interview with Resident #39 on 04/06/26 at 1:14 P.M. revealed concerns the facility was understaffed. Resident #39 revealed there was often only one nurse aide (CNA) on staff at night for two halls, and that call lights could take over thirty minutes to answer.Interview with Resident #23 on 04/06/26 at 2:05 P.M. revealed concerns the facility was short staffed on the weekend (with an example of dressings/wound care not done on weekend). He stated you have to wait longer at night for the call light to be answered. The resident shared he had waited five hours (date not provided) for his call light to be answered. During observation of a treatment for Resident #23 on 04/07/26 at 9:00 A.M. with Assistant Director of Nursing (ADON) #381, the resident asked if a particular staff person was working as this staff person transferred him with the mechanical lift by herself (which was attributed (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to a lack of staff).Interview with Resident #84's family member on 04/06/26 at 2:10 P.M. revealed when she came in on Saturday (04/04/26) Resident #84 was lying on the mattress with no sheet and covered with only a sheet and had a pillow. The family member voiced concerns there had been no staff to come in to turn and reposition the resident or get her up.Interview with Resident #54 on 04/06/26 at 3:16 P.M. revealed the resident voiced concerns she didn't feel like there was enough staff, it routinely takes staff a long time to answer her call light.Interview with Resident #4 on 04/06/26 at 4:12 P.M. revealed concerns there were not enough staff, it takes staff a long time to answer the call light. Interview with Resident #71 on 04/07/26 at 8:57 A.M. revealed a concern there was not enough staff especially on afternoons. On Sunday (referring to 04/05/26) it took one to two hours for staff to respond to her call light.Confidential interviews with residents in a special resident council meeting held on 04/08/26 revealed the residents present continued to have concerns regarding staff response to resident needs. One resident said she would see a resident sliding out of their chair and would try to help them since no staff were around. She said she was scolded for helping by a staff member but she didn't know why because she felt if she didn't help the other resident would have fallen. Another resident in the meeting noted she kept her own calendar of when she was helped with showers because she said staff weren't following the shower schedule due to a lack of staff.c. The following staff concerns were lodged during the survey related to facility staffing: Interview with LPN Supervisor #335 on 04/07/26 at 7:50 A.M. revealed sometimes there was only one aide for the 200 hall on dayshift (currently 17 residents on 200 hall). She confirmed there were residents on this hall (including Resident #23) who required being transferred with a mechanical lift. She stated that sometimes the CNA does the mechanical lift by herself. She stated she knows there were to be two staff for a mechanical lift. Interview with CNA #222 on 04/08/26 at 5:38 A.M. revealed on night shift, there were often two to three CNAs on shift in the building. CNA #222 revealed that due to this he could only provide incontinence care three times, turning and repositioning of dependent residents three times, and checks on residents three times during a 12 hour shift. CNA #222 revealed that if a CNA called off with short notice, the CNAs and nurses work short-staffed. CNA #222 revealed at times, if there was not enough staff available, only one person assists residents who are dependent for transfers with a mechanical lift.Interview with LPN Supervisor #258 on 04/09/26 at 8:05 A.M. revealed she heard CNA staff identify they do mechanical lifts with only one staff. She stated that she knew there were supposed to be two staff for a mechanical lift. She stated there were at least three residents on 200 hall who required a mechanical lift for transfers. She stated sometimes there was only one aide for the 200 hall on dayshift. She stated when this happened, they were unable to complete showers, turn and reposition residents every two hours, complete incontinence care every two hours, and residents had to wait longer for their call lights to be answered. Interview with CNA #385 on 04/09/26 at 11:20 A.M. revealed he worked dayshift and worked frequently on the 200 hall. He stated if there are call offs of staff, there was sometimes only one CNA on the 200 hall. He stated if there was only one CNA, the CNA was not able to do incontinence care every two hours and it makes it hard to answer call lights timely. Interview with CNA #323 on 04/13/26 at 8:57 A.M. revealed that until recently, the administration expected staff to work short when there were call offs. Some improvement had been noted with the current DON. However, until the new DON took her position (03/05/2026), there were not enough staff members to transfer dependent residents who required a mechanical lift safely with two staff members. During an interview on 04/15/26 at 5:25 P.M , Certified Nurse Practitioner (CNP) #561 shared her provider group had multiple meetings with the management company for the facility regarding the provider group's concerns for resident care. She attributed some of the facility's challenges to staffing turnover. During the onsite survey, no additional information was provided by facility administrative staff to support the concerns from the provider group had been addressed and/or resolved.2. As a result of the lack of consistent and necessary administrative oversight and due to the increased frequency of administrative changes, the following concerns were identified. The facility's inaction caused serious (continued on next page)

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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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	harm and had the likelihood of causing serious harm or injury to all residents.a. The facility failed to ensure effective systems and administrative oversight were in place to timely identify and seek necessary medical intervention following an acute change in condition for Resident #78.On 03/12/26 at 12:34 P.M., Resident #78 was noted to have lethargy (a reduced level of consciousness), and elevated blood glucose of 522 milligrams per deciliter (mg/dL, normal results 70-99 mg/dL). The resident's blood sugar was not re-checked for four hours and remained elevated at 353 mg/dL when it was rechecked. The resident continued with limited food and fluid intake and lethargy. On 03/13/26 at approximately 8:30 A.M. Resident #78 became unresponsive and could not be awakened by a sternal rub. The nurse notified Certified Nurse Practitioner, (CNP) #561 and the resident was transferred and admitted to the intensive care unit of the hospital with diagnoses of severe sepsis with septic shock, acute encephalopathy, multifactorial in the setting of hypernatremia and sepsis, acute kidney injury, hyperglycemia, urinary tract infection, hypernatremia. The resident remained in the hospital until 03/25/2026 and returned to the facility with hospice services. The resident passed away at the facility on 04/14/26. See findings under F684.b. On 08/21/25 the facility failed to have systems and administrative oversight in place to ensure staff took action when Resident #88, who was cognitively impaired and required substantial to maximal assistance with toileting hygiene and was assessed as being incontinent, had not had a bowel movement documented in three days. There was no evidence Resident #88 had a bowel movement from 08/19/25 until 08/26/25. On 08/26/25, Resident #88 was discharged to the hospital due to a change in his condition. At the hospital on [DATE], Resident #88 received a computed tomography (CT) scan of his abdomen, which revealed a moderately stool-distended rectal vault with findings that he was developing stercoral colitis, a rare but serious inflammation of the colon caused by fecal impaction, which could lead to life-threatening complications if untreated. The resident received treatment and services of disimpaction while in the hospital for 11 days. See findings under F684. In addition, the facility failed to have systems and administrative oversight in place to ensure physician orders were followed for Resident #88 related to the resident's urinary status and urinary catheter. The facility failed to develop and implement a comprehensive and individualized plan of care for the urinary (indwelling) catheter including consistent monitoring/assessment of urinary output to prevent a significant complication from catheter use. See findings under F690. c. The facility failed to have systems in place and administrative oversight to ensure treatments were provided in management of congestive heart failure (CHF), vascular wounds, change in condition related to urinary tract infections, and glaucoma for Residents #23, #31, #55, #78, #88, #91 and #93) of 36 residents reviewed for quality of care and treatment See findings under F684. d. The facility failed to have systems in place and administrative oversight to ensure residents (#6, #9, #12, #61, #85, #87, and #93) who were unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal hygiene including assistance with eating, nail care, and bathing/showering. See findings under F677.e. The facility failed to have systems in place and administrative oversight to ensure Resident #83, with a pressure ulcer received the necessary care and treatment as ordered to promote healing, prevent infection, and prevent new ulcers from developing. See findings under F686. f. The facility failed to have systems in place and administrative oversight to ensure accurate and timely monitoring of Resident #93's weight, resulting in an undetected and unevaluated significant weight loss. See findings under F692.g. The facility failed to have systems in place and administrative oversight to ensure an infection prevention and control program was in place that provided a safe and sanitary environment that helped to prevent the development and transmission of communicable diseases and infections for Residents #31, #81, #83, #84, and #86. See findings under F880. Review of the job description for a Licensed Nursing Home Administrator dated 12/01/2012 revealed the position supported the development, implementation and monitoring of recruitment and retention plans which lowers turnover. The job description also included the position supported the development of a strong management team among department leaders and supervisory personnel to (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	effectively meet or exceed employee and customer needs.This deficiency demonstrates noncompliance investigated under Complaint Numbers 2603202, 2656395, 2724269, 2723137.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 a complete and accurate medical record for five (Residents #9, #23, #74, #84 and #88) of 37 sampled residents reviewed in the course of the survey. The facility census was 57.Findings include:1. Medical record review revealed Resident #74 was admitted to the facility on [DATE] at 7:52 P.M. and discharged to the hospital on [DATE]. Pertinent diagnoses including multiple sclerosis, other osteonecrosis left femur, unilateral primary osteoarthritis left hip, fatigue and post-traumatic stress disorder (PTSD). Review of physician orders for Resident #74 revealed an order dated 01/07/26 for Modafinil 200 milligrams to be given twice a day to promote wakefulness. Review of a progress note dated 01/08/26 at 12:52 A.M. revealed Resident #74 did not have meds at the facility. The author noted they called the pharmacy, and the pharmacy stated that resident wasn't in their system. The author called the provide and confirmed that the resident wasn't in their system either. The author updated the provider that the resident was a new admit and got her entered into their system. Resident #74 complained of pain. The provider was contacted for a new prescription. The prescription was sent to the pharmacy, and staff contacted pharmacy to get an update on medication status. The resident's Gabapentin (nerve pain medication) was on the next tote. Staff requested a pull code for Oxycodone (opioid pain medication) and Gabapentin. Unable to get a pull code for Oxycodone. A pull code was obtained for the Gabapentin. Review of the January 2026 Medication Administration Record (MAR) for Resident #74 revealed that on 01/07/26, 01/08/26, 01/09/26, the morning of 01/10/26, the morning and evening of 01/12/26, and the morning and evening of 01/15/26, the nurses charted that the Modafinil was not administered because it was unavailable. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #74 was cognitively intact and required substantial/maximum assistance with showering/bathing, lower body dressing, putting on/taking off footwear and was dependent on staff for toileting, rolling left and right and transfers. Further review of the January 2026 MAR for Resident #74 revealed that the Modafinil was signed off as having been administered on the evening of 01/10/26, during the morning and evening administration on 01/13/26 and during the morning and evening medication administration on 01/14/26. During an interview on 04/09/26 at 1:38 P.M., Regional Nurse Consultant #594 said she was unable to locate documentation of the Modafinil administration (Modafinil is a controlled substance requiring additional tracking). The Regional Nurse Consultant said she then spoke with the pharmacy and confirmed the facility never received the Modafinil from the pharmacy to administer to Resident #74. Regional Nurse Consultant #594 then verified that five nurses had indicated that they had administered the medication to Resident #74 and should not have documented that a medication was administered when it wasn't. She noted those nurses were no longer employed at the facility, and one was an agency nurse. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Medication Administration General Guidelines, dated May 2020, revealed if a dose of regularly scheduled medicine is withheld, refused, not available or given at a time other than the scheduled time (i.e., the resident is not in the facility at scheduled dose time, a starter dose of antibiotic is needed, etc.) that dosage administration is flagged and documented accordingly. 2. Review of a resident record revealed that Resident #9 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis, cognitive communication deficit, reduced mobility, and cerebral infarction. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 07 out of 15, indicating severe cognitive impairment. Resident #9 was assessed as being dependent on staff for personal hygiene, toileting hygiene, transfers, and bathing. Review of the care plan dated 03/16/26 revealed Resident #9 had impaired ability to perform or participate in daily activities of daily living (ADL) care related to hemiplegia and hemiparesis status post cerebrovascular accident. Resident #9's goal was to participate with her ADL care as much as possible, to remain clean and dry without decline. Approaches included to provide assistance with ADL care and mobility as needed, and providing showers per weekly schedule. Review of the showers documented from 03/02/26 through 04/09/26 in Resident #9's medical record revealed that Resident #9 had a shower on 03/05/26, 03/14/26, 03/21/26, 03/28/26, and 04/02/26. Review of the shower sheet book at the nursing station from 03/02/26 through 04/09/26 revealed that Resident #9 also had a shower on 04/04/26. Review of the shower schedule 03/02/26 through 04/09/26 revealed Resident #9 was scheduled for a shower on 03/04/26, 03/07/26, 03/11/26, 03/14/26, 03/18/26, 03/21/26, 03/25/26, 04/01/26, 04/04/26, and 04/08/26. An interview with Certified Nursing Assistant (CNA) #287 on 04/09/26 at 8:43 A.M. revealed that Resident #9 does not refuse showers or baths. CNA #287 revealed that all showers given to Resident #9 would be documented in the shower book. CNA #287 confirmed that Resident #9 had six instead of ten scheduled showers. Observation of presented shower sheets on 04/09/26 at 2:45 P.M. revealed that there were additional shower sheets filled out for 03/02/26, 03/09/26, 03/11/26 and 03/18/26 which were all initialed with the same initials (the initials of CNA #242), no nurse signature, and in the same handwriting on the same sheet. Additionally, the 04/04/26 shower sheet that had been observed and confirmed previously with CNA #287 on 04/09/26 at 8:43 A.M. now had an additional entry listed for 04/08/26 and initialed by CNA #353. An interview with CNA #353 on 04/09/26 at 3:15 P.M. confirmed that the shower sheet that she had filled out for 04/08/26 was filled out on 04/09/26 when the Director of Nursing (DON) approached her earlier that day. CNA #353 stated that she did not actually give Resident #9 her shower; however, she did assist a nursing aide in transferring Resident #9 into a shower chair on 04/08/26, so CNA #353 signed the shower sheet dated 04/08/26 on 04/09/26, under the suggestion of the DON. An interview with the DON on 04/09/26 at 3:15 P.M. confirmed that she had filled out the 03/02/26, 03/09/26, 03/11/26, and 03/18/26 shower sheets for Resident #9, initialing the shower sheets with CNA #242's initials. The DON stated that she had called CNA #242 at home on [DATE] and asked her (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if she had given Resident #9 showers on those dates. 3. Review of medical record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, benign prostatic hyperplasia, need for assistance with personal care, and cognitive communication deficit. Review of the MDS 3.0 comprehensive assessment dated [DATE] revealed Resident #88 had a BIMS score of 08 out of 15, indicating moderate cognitive impairment. Resident #88 had a urinary catheter present. Review of Resident #88's outpatient urology progress notes dated 08/13/25 revealed Resident #88 no longer required a urinary catheter. He was not retaining urine, as he had only 30 milliliters (ml) of urine in his bladder. As a result, the urologist determined that he no longer required a urinary catheter. The urologist determined that if Resident #88 were to ever go back into urinary retention, a better option would be a suprapubic catheter rather than a urethral catheter. Resident #88 and his family were given education on voiding dysfunction. The plan was made to observe Resident #88 for signs of urinary retention. Review of Resident #88's Treatment Administration Record (TAR) revealed that on the evening of 08/13/25, Resident #88 did not receive catheter care. Starting on the day shift of 08/14/25, Licensed Practical Nurse (LPN) Supervisor #258 signed off on the TAR that Resident #88 received catheter care as ordered, despite the catheter not being present after Resident #88's urology appointment. Other licensed nurses that documented that they provided catheter care to Resident #88 included Registered Nurse (RN) Supervisor #270, LPN Supervisor #234, and RN Supervisor #412. Review of Resident #88's nursing progress notes dated 08/12/25 through 08/19/25 were silent for any record of Resident #88 going to his urology appointment, Resident #88's catheter being removed on 08/13/25, or discontinuing Resident #88's orders for catheter care twice daily. Review of Resident #88's physician orders revealed that no new physician orders were entered on 08/13/25 relevant to Resident #88's urinary catheter being removed at his urology appointment. No physician orders were made on 08/18/25 to remove his urinary catheter. Resident #88's physician orders to provide catheter care twice daily remained in place until 08/25/25. An interview with Certified Nurse Practitioner (CNP) #561 on 04/15/26 at 4:07 P.M. revealed that on 08/19/25, CNP #561 reviewed Resident #88's urologist's after visit summary dated 08/13/25, and CNP #561 learned that Resident #88 had passed a voiding trial in the urologist office, and therefore, Resident #88's urinary catheter was removed. An interview with Regional Nurse Consultant #594 on 04/15/26 at 3:45 P.M. confirmed that they did not have the urologist after visit summary orders for 08/13/25 available for review as part of the medical record, the nurses never discontinued the physician orders for the catheter care on 08/13/25, there were no progress notes indicating that nursing was aware of the orders to discontinue the urinary catheter on 08/13/25, and that there was no indication that Resident #88 had physician orders to reinsert the urinary catheter after the 08/13/25 catheter removal. 4. Review of the record for Resident #23 revealed an admission date of 01/24/26 with diagnoses including morbid obesity, diabetes, heart failure, status post severe sepsis with septic shock and sudden cardiac arrest. Review of a MDS 3.0 assessment completed 01/30/26 revealed a BIMS score (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 11 out of 15, indicating moderately impaired cognition. It further stated Resident #23 was dependent upon staff for bed mobility. Review of the history and physical by the physician dated 03/06/26 revealed Resident #23 had peripheral vascular disease with chronic bilateral lower extremity wounds. Review of the physician's orders revealed orders dated 03/06/26 to cleanse the left and right legs with wound cleanser, apply Xeroform, pad ankles and weeping areas with abdominal (ABD) pads, wrap with Kerlix gauze and Ace wraps daily (on dayshift). Observation on 04/06/26 at 9:50 A.M. revealed Resident #23 was in bed. The dressings on his right and left legs were dated 04/02/26 (four days prior). Interview with Assistant Director of Nursing (ADON) #381 on 04/06/26 at 9:52 A.M. confirmed the dressings on Resident #23's legs were dated 04/02/26. She stated the dressings were ordered to be changed daily. Review of the April 2026 TAR for Resident #23 revealed the treatments to the left and right legs were documented as completed on 04/04/26 and 04/05/26 by LPN Supervisor #258. Interview with LPN Supervisor #258 on 04/09/26 at 8:05 A.M. confirmed that she documented that Resident #23's leg treatments were completed on 04/04/26 and 04/05/26 when they were not. She stated she was unable to do the treatments on one of the days because there was an admission of another resident. She stated it was difficult to get all the treatments done on the 200 hall. She stated there have been times when there were staff call-offs and she had to work two halls at the same time (200 and 300 hall). She stated that she normally signs off that all of the treatments were done before she does rounds. Then if she does not get the work done, she would normally go back and document that it was not completed. She stated that she did not go back and document that the treatments were not done for Resident #23's legs. 5. Review of Resident #84's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included orthopedic aftercare, fall with fracture (at home), pain, dementia, osteoarthritis, high blood pressure, and gastroesophageal reflux disease (GERD). No MDS was completed because she was a new admission. Review of the orders on admission dated 04/03/26 revealed orders for Resident #84 to wear bilateral thigh high thrombo-Embolic Deterrent (TED) hose for three weeks then discontinue, Oxybutynin 5 (milligrams) mg (anticholinergic medication to treat overactive bladder) twice daily. Resident #84 was also admitted with a urinary catheter and orders to cleanse the right hip with normal saline, pat dry and apply a dry dressing daily and as needed. Review of the MAR for April 2026 revealed the Oxybutynin 5 mg was not documented as administered in the evening (7:00 P.M. to 11:00 P.M. dose) on 04/04/26 and 04/05/26. Review of the TAR for April 2026 revealed the bilateral thigh high TED hose were not documented as on for 04/03/26, 04/04/26 and 04/05/26. Catheter care was not documented as provided for 04/03/26, 04/04/26, and 04/05/26. The dressing change was not documented as completed on 04/05/26 and 04/06/26. On 04/09/2026 at 1:40 P.M. interview with Regional Nurse Consultant #594 verified the treatments and medications were not documented as completed. This deficiency substantiates Complaint Number 2723137 and Complaint Number 2603202.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interview and policy review, the facility failed to maintain an infection prevention and control program that provided a safe and sanitary environment that helped to prevent the development and transmission of communicable diseases and infections. This affected five (Residents #31, #81, #83, #84, and #86) 37 sampled residents sampled in the course of the survey. The facility census was 57. Findings include:1. Review of the record for Resident #83 revealed an admission date of 04/05/26 with diagnoses including acute and subacute infective endocarditis (infection of the heart's inner lining). The admission nursing note stated Resident #83 was admitted on [DATE] at 12:10 P.M. from the hospital with a peripherally inserted central line (PICC) and was going to be on intravenous (IV) antibiotics until 05/07/26. Review of hospital records revealed Resident #83 was diagnosed with Clostridioides difficile (C. diff), a bacterium causing severe diarrhea, fever, and colon inflammation often triggered by antibiotic use on 04/02/26. He was placed on Contact plus precautions in the hospital on [DATE]. Contact plus precautions are enhanced infection control measures used, alongside standard precautions, to prevent the spread of highly contagious pathogens, particularly C. diff. He was started on antibiotic treatment for the C. diff on 04/02/26 which was to conclude on 04/15/26. Review of the point of care history in Resident #83's record revealed he was incontinent of bowel on 04/05/26 at 1:28 P.M. and 5:44 P.M. and on 04/06/26 at 1:45 A.M. and 4:09 P.M. During the initial tour of the facility on 04/06/26 at approximately 10:00 A.M., no signage for contact precautions was observed outside Resident #83's room. Record review revealed that a physician's order was obtained and started for contact precautions on 04/06/26 (the day after admission to the facility). Interview with Regional Nurse Consultant #594 on 04/08/26 at 10:50 A.M. confirmed Resident #83 was not placed on contact precautions until 04/06/26. She confirmed he should have been placed on contact precautions on admission on [DATE]. Observations on 04/06/26 at 2:47 P.M. revealed Certified Nursing Assistant (CNA) #420 entered Resident #83's room. She did not apply a gown when entering the room (gloves only). There was a sign outside the room indicating contact precautions and indicating that staff were to wear a gown and gloves when entering the room. She remained in the room for approximately five minutes. When she exited the room, she stated that, while in the room, she fixed his feet, raised the bed, moved his bedside table, and removed juice glasses from his room (she was observed to have two glasses in her hands). She confirmed she did not wear a gown into the room to provide care. She stated he was new and she did not know he was on contact precautions even though there was a sign outside the door indicating contact precautions. Interview with Regional Nurse Consultant #594 on 04/08/26 at 10:50 A.M. confirmed staff were to wear a gown when entering Resident #83's room. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions updated 07/01/25 revealed in addition to standard precautions, implement contact precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Examples of infections requiring contact precautions include diarrhea associated with C. diff. The policy stated to wear a gown when entering the resident's room and remove the gown before leaving the resident's environment. After removing the gown, do not allow clothing to contact potentially contaminated surfaces. Signs will be used to alert staff of the implementation of contact precautions. Place a sign on the door or outside the resident's room to inform visitors of appropriate personal protective equipment to wear prior to entering the resident's room. 2. Review of the record for Resident #31 revealed a nursing note on 04/14/26 at 7:12 A.M. which stated physician's orders had been obtained to complete a chest x-ray and swab for influenza and respiratory syncytial virus (RSV). The note stated the resident would be placed on droplet (continued on next page)

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	366367	A. Building B. Wing	04/21/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions until the test results were obtained. A physician's order was obtained on 04/14/26 for droplet precautions. Interview with Regional Nurse Consultant #594 on 04/14/26 at 7:30 A.M. revealed Resident #31 was placed on droplet precautions as a precaution due to complaints of a cough. She confirmed testing was being completed to rule out influenza and RSV. Observations on 04/14/26 at 8:05 A.M. revealed a sign outside Resident #31's door which stated he was on droplet precautions, and staff should wear a mask and gloves to enter the room. Observations revealed Minimum Data Set (MDS) Nurse #379 in Resident #31's room. She was not wearing a mask or gloves. When she exited the room, she confirmed she did not wear a mask or gloves while in the room. She stated she thought the sign outside the door was for enhanced barrier precautions (EBP) and not droplet precautions. She confirmed the sign did say droplet precautions. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions updated 07/01/25 revealed, in addition to standard precautions, implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning. Examples of infections requiring droplet precautions include but are not limited to: Influenza and mycoplasma pneumonia. 3. On 04/14/26 at 10:09 A.M. observation of incontinence care to Resident #81 by CNA #385 and CNA #387 revealed they washed their hands and put on gloves, explained the procedure to Resident #81, and removed the resident's brief. CNA #385 washed down the right side of the groin, changing position of the washcloth and washed down the left side of the groin, then spread the labia and washed downward. CNA #385 the rinsed in the same order with a new washcloth. Resident #81 was turned on her right side, and CNA #385 washed from front to back changing positions on the washcloth. There were smears of bowel movement (BM) noted on the washcloth. CNA #385 then rinsed from front to the back changing position on the washcloth and patted dry. CNA #385 and CNA #387 removed their gloves and put on new gloves without washing their hands. CNA #385 placed cream on Resident #81's coccyx and buttocks. CNA #385 and CNA #387 removed their gloves and put on new gloves without washing their hands and put on a new brief. On 04/14/26 at 10:35 A.M. interview with CNA #385 and CNA #387 verified they had not washed their hands in between glove changes. Review of the facility Hand Washing-Hygiene policy dated 05/01/2024 revealed it is the facility policy for employees to conduct proper hand hygiene that will aid in the prevention and transmission of infectious disease. Hand washing with soap and water/alcohol/antimicrobial hand rub be used between after removing gloves. 4, Review of Resident #84's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included orthopedic aftercare, fall with fracture (at home), pain, dementia, osteoarthritis, high blood pressure, and gastroesophageal reflux disease (GERD). No MDS 3.0 assessment was completed because she was a new admission. Further review revealed no documentation as of 04/09/26 the tuberculosis (TB) test (skin test to test if an individual has been exposed to tuberculosis) had been completed. An interview on 04/09/26 at 1:40 P.M. with the Regional Corporate Nurse #594 verified the TB test was not completed within 48 hours of admission per facility policy for Resident #84. Review of the facility Tuberculosis Screening: Administration and Interpretation of Tuberculin Skin Tests dated 05/01/2025 revealed a qualified healthcare professional will inject the purified derivative intradermally on the forearm within 48 hours of admission. 5. Review of the medical record revealed Resident #86 was admitted to the facility on [DATE]. Diagnoses included displaced fracture of anterior wall of right acetabulum, Alzheimer's disease, vascular dementia, peripheral vascular disease, wedge compression fracture of T5-T6 vertebra, chronic embolism and thrombosis of left iliac vein, wedge compression fracture of fifth lumbar vertebra, unspecified fracture of right pubis, unspecified fracture of upper end of left humerus, abdominal aortic aneurysm, calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction, hyperosmolality and hypernatremia, LT femoral neck deformity, presence of right artificial hip joint, and presence of left artificial hip joint. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #86 was dependent on staff for eating, oral hygiene, toileting, rolling left to right, moving from sitting to lying and lying to sitting. She required substantial /maximum assistance for upper body dressing, lower body dressing and putting on footwear. Review of the physician orders for Resident #86 revealed an order dated 08/14/25 for Mantoux step one (tuberculosis test) to be administered that day. Review of the Medication Administration Record (MAR) for August 2025 for Resident #86 revealed a blank space with no nurse sign off in the section where Mantoux was to be documented as administered. There was no documentation within the MAR to explain why the tuberculosis test was not administered. Review of the progress notes for August 2025 for Resident #86 revealed no notes that indicated why the tuberculosis test was not administered. During an interview on 04/15/26 at 8:15 A.M., Regional Nurse Consultant #594 confirmed that there was no documented evidence that Resident #86 had been given Mantoux step 1. Review of the facility policy titled, Tuberculosis Infection Control Program, dated 05/01/25 revealed the facility's TB infection Control Program includes the early identification, isolation and transfer of individuals with active tuberculosis. The program incorporates screening and surveillance of residents and employees for latent tuberculosis infection. This deficiency represents non-compliance investigated under Complaint Number 2707299.