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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366462 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/20/2025 |
| NAME OF PROVIDER OR SUPPLIER Canal Winchester Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 6800 Gender Road 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) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review, review of the facility self-reported incident (SRI), and staff interview, the facility failed to ensure all residents were treated with dignity and respect. This affected one (Resident #71) of two residents reviewed for dignity. The facility census was 102.</p> <p>Findings Include:</p> <p>Resident #71 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, acute cystitis, hypothyroidism, type II diabetes, vitamin D deficiency, hyperlipidemia, anxiety disorder, atrial fibrillation, lymphedema, chronic obstructive pulmonary disease (COPD), insomnia, chronic kidney disease, myopia, mood disorder, hypertension, depression, bipolar disorder, morbid obesity, and dependent on supplemental oxygen. Review of her Minimum Data Set (MDS) 3.0 assessment, dated 01/13/25, revealed she was cognitively intact.</p> <p>Review of SRI tracking number 256314, dated 01/21/25, revealed Resident #71 reported that Certified Nursing Aide (CNA) #110 made an inappropriate comment to her while she was assisting with her personal care. Resident #71 reported that when CNA #110 and another aide were transferring her, she became short of breath. Resident #71 reported that CNA #110 stated, if I was you, I wouldn't want to breathe either. Resident #71 reported that she felt upset and discouraged. The facility completed an investigation. During the interview with CNA #110, CNA #110 confirmed that she likes to joke around with the residents, and she did not remember making that comment to Resident #71. Interview with CNA #111 stated she was working with Resident #71 and CNA #110 on the day of the incident. She reported that they had to remove Resident #71's oxygen to safely transfer her in the mechanical lift. During that time, Resident #71 became visibly short of breath, but nothing that caused a significant health decline. She reported that CNA #110 made the comment, if you can't hold on that long then maybe you need to go to your happy place. The facility concluded their investigation, and their findings supported the allegation. CNA #110 was terminated from her employment at the facility.</p> <p>Interview with the Administrator on 02/20/25 at 4:35 P.M. confirmed they completed the investigation, and they terminated CNA #110 for making the inappropriate comment to Resident #71.</p> <p>This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on observations, medical record review, staff interview, and facility policy review, the facility failed to follow proper infection control and isolation precaution procedures. This affected four (Residents #18, #77, #80, and #81) of four residents reviewed for infection control procedures. The facility census was 102.</p> <p>Findings Include:</p> <p>Observations on 02/20/25 from 10:30 to 10:40 A.M. revealed Resident #77 and Resident #80 had personal protective equipment (PPE) carts in front of each of their rooms. But there were no signs outside of their doors indicating if they were actually on isolation precautions or what type of isolation precautions they were on.</p> <p>Interview with Licensed Practical Nurse (LPN) #103 on 02/20/25 at 10:35 A.M. confirmed Residents #77 and #80 were on contact/droplet isolation precautions for being diagnosed with influenza. The nurse confirmed there should have been signs outside the door, indicating the type of isolation precautions the residents were on as a safety mechanism for staff and visitors prior to entering their rooms.</p> <p>Observations on 02/20/25 from 10:30 A.M. to 11:00 A.M. revealed Residents #77, #80, #81, #36, #18, and #72 all had PPE carts in front of their room doors. Residents #81, #36, #18, and #72 had signs outside of their door that they were on droplet/contact isolation precautions. But, for all six resident rooms observed, they did not have any eye protection in their PPE carts for staff to use when they went into the rooms.</p> <p>Interview with LPN #103 and LPN #104 on 02/20/25 at 10:35 A.M. and 10:38 A.M. confirmed there was no eye protection in the PPE carts for Residents #77, #80, #81, and #72. They both confirmed they should be in the PPE carts for any resident that was on droplet isolation precautions, which all four residents were on droplet isolation precautions for influenza.</p> <p>Observation on 02/20/25 at 12:20 P.M., Certified Nursing Aide (CNA) #101 walked into Resident #18 room, who was on droplet/contact isolation precautions. She walked into Resident #18 room with her lunch tray, only wearing a mask; no other PPE.</p> <p>Interview with CNA #101 on 02/20/25 at 12:21 P.M. confirmed she walked into Resident #18 room with only a mask on. She confirmed Resident #18 was on droplet/contact isolation precautions and she should have worn a gown, gloves, and eye/face protection in addition to her mask when walking into her room.</p> <p>Resident #18 was admitted to the facility on [DATE]. Her diagnoses were unspecified fracture of lower end of left femur, congestive heart failure, type II diabetes, hyperlipidemia, hypothyroidism, obstructive sleep apnea, depression, and hypertension. Review of her Minimum Data Set (MDS) 3.0 assessment, dated 02/16/25, revealed she was cognitively intact.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #18's physician orders, dated 02/18/25, revealed she was placed on contact/droplet isolation precautions for a positive influenza A test.</p> <p>Review of Resident #18's influenza care plan, dated 02/20/25, revealed an intervention was in place that stated the resident was in contact/droplet isolation in single occupant room; all services to be provided in room. Observe all staff precautions related to PPE.</p> <p>Resident #77 was admitted to the facility on [DATE]. Her diagnoses were acute respiratory failure, atrial fibrillation, anemia, influenza due to other identified influenza virus, asthma, hyperlipidemia, atherosclerotic heart disease, hypertension, and dependence on supplemental oxygen. Review of her MDS 3.0 assessment revealed it had not been completed.</p> <p>Review of Resident #77's physician orders, dated 02/18/25, revealed she was placed on contact/droplet isolation precautions for a positive influenza A test upon admission.</p> <p>Review of Resident #77's influenza care plan, dated 02/20/25, revealed an intervention was in place that stated the resident was in contact/droplet isolation in single occupant room; all services to be provided in room. Observe all staff precautions related to PPE.</p> <p>Resident #80 was admitted to the facility on [DATE]. Her diagnoses were acute influenza due to other identified influenza virus, congestive heart failure, chronic respiratory failure, Parkinson's disease, chronic obstructive pulmonary disease (COPD), and presence of other specified functional implants. Review of her MDS 3.0 assessment revealed it had not been completed.</p> <p>Review of Resident #80's physician orders, dated 02/18/25, revealed she was placed on contact/droplet isolation precautions for a positive influenza A test upon admission.</p> <p>Review of Resident #80's influenza care plan, dated 02/20/25, revealed an intervention was in place that stated the resident was in contact/droplet isolation in single occupant room; all services to be provided in room. Observe all staff precautions related to PPE.</p> <p>Resident #81 was admitted to the facility on [DATE]. His diagnoses were pneumonia, influenza due to other identified influenza virus, sepsis, type II diabetes, chronic kidney disease, shock, acute kidney failure, anemia, vitamin D deficiency, congestive heart failure, hereditary and idiopathic neuropathy, COPD, obstructive sleep apnea, Escherichia coli, pruritus, atrial fibrillation, edema, hyperglycemia, pain, obesity, hypertension, and benign prostatic hyperplasia. Review of his MDS 3.0 assessment, dated 02/07/25, revealed he was cognitively intact.</p> <p>Review of Resident #81's physician orders, dated 02/18/25, revealed he was placed on contact/droplet isolation precautions for a positive influenza A test upon admission.</p> <p>Review of Resident #81's influenza care plan, dated 02/20/25, revealed an intervention was in place that stated the resident was in contact/droplet isolation in single occupant room; all services to be provided in room. Observe all staff precautions related to PPE.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the facility Influenza Management policy, dated 01/03/24, revealed upon identification of a potential outbreak, conduct an outbreak investigation. The objectives of the outbreak investigation are to describe the situation (what is happening), determine the etiology (where did the infection start), what is the agent, where is the source, and what is the method of spread (for influenza it spread through respiratory droplet transmission). Practices to implement when clusters are identified but awaiting confirmation include implement preliminary precautions: contact and droplet precautions are implemented during care of residents with symptoms or suspected influenza, in addition to standard precautions used with all residents regardless of symptoms.</p> <p>Review of the facility Infection Control-Standard and Transmission Based Precautions policy, dated 03/04/24, revealed a nurse may initiate transmission based precautions when there's reason to believe that a resident may suffer from an infection or communicable disease. When precautionary measures are initiated, the nurse should notify the resident's attending physician, resident/legal representative, infection preventionist, and director of nursing. An isolation cart should be placed outside the resident's room to store personal protective equipment (PPE) needed for staff and visitor use. For contact precautions include hand hygiene, PPE (gloves and gown), resident care equipment dedicated to that resident, cleaning/disinfecting rooms with a focus on areas that are touched, limiting resident transport and movement outside the room to medically necessary purposes, and provide a private room with a dedicated bathroom or cohort residents who have the same infection from the same microorganism. For droplet precautions, it includes hand hygiene, gloves, gowns, mask, eye protection, and the same other procedures as contact precautions.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162734.</p> | | |