

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  06/11/2025
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.

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interview, the facility failed to provide timely care for surgical incision staple removal for Resident #103 and Resident #109. The facility also failed to obtain physician ordered daily weights for Resident #83. This affected two residents (#103 and #109) of three residents reviewed for wound/incisional care and one resident (#83) of three residents reviewed for implementation of physician orders. The facility census was 108.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #103 revealed an admission date of 08/15/22 with diagnoses including fractured femur, sick sinus syndrome, attention deficit hyperactivity disorder (ADHD), mood disorder, cerebral infarction with associated hemiplegia and hemiparesis, anxiety disorder, depression, dependence on wheelchair, presence of pace maker, presence of artificial hip joint (left), and presence of cerebrospinal fluid (CSF) draining device.</p> <p>Review of progress notes for Resident #103 revealed Resident #103 had surgery on 04/22/25 and a post-operative (op) follow-up appointment on 05/13/25.</p> <p>Review of the most recent significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of five out of a possible 15 indicating cognitive impairment. The resident had no functional limitation in range of motion of the upper extremities but had impairment on one side of the lower extremities. The resident was assessed to have no difficulties chewing or swallowing. Resident #103 was at risk for pressure ulcers but had none. Resident #103 had a surgical incision. Resident #103 had a pressure reducing device on her bed and received surgical wound care.</p> <p>Review of the progress note dated 05/13/25 at 11:46 A.M. revealed the trauma clinic called to cancel post op appointment for today, refused to see the resident, remove staples or look at X-Ray and suggested following up with the orthopedist, Certified Nurse Practitioner was made aware.</p> <p>Review of progress note dated 05/28/25 at 9:54 A.M. revealed Licensed Practical Nurse (LPN) # 530 call the surgeons office and obtained an order to remove the staples. 22 staples were then removed with no complications.</p> <p>There was no documentation in the medical record between 05/13/25 and 05/28/25 that there were any appointments made, or any plans discussed to remove the staples.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/27/25 at 12:30 P.M. revealed Resident #103 sitting in her wheelchair in the common area with her spouse. Resident #103 was rubbing/scratching left hip area.</p> <p>Interview on 05/27/25 at 12:30 P.M. with the spouse of Resident #103 revealed Resident #103 still had the staples in her incision from surgery in April and it appears they itch at times but Resident #103 does not appear to be in pain. Resident #103's spouse has been asking if someone in the facility can remove them but they have not been removed yet.</p> <p>Interview on 05/29/25 at 8:55 A.M. with LPN #530 confirmed Resident #103 had a follow-up appointment to remove staples on 05/13/25 that was canceled by the trauma clinic and facility was told to scheduled follow-up with the surgeon. Staples were not removed until 05/28/25 and they were removed in the facility. LPN stated there were appointments scheduled and the husband, who is the POA, canceled because he wanted follow-up done in the facility. Going out to appointments increases Resident #103's confusion.</p> <p>Interview on 05/29/25 at 12:00 P.M. with the spouse of Resident #103 confirmed Resident #103 was in the van on her way to the follow-up appointment to remove her staples on 05/13/25 when the office called and canceled the appointment. The spouse stated Resident #103 becomes more confused when she leaves the facility so he asked if someone could remove her staples at the facility. The spouse has told the facility he would prefer as much of her care as possible be done in the facility to decrease the number of times Resident #103 needs to be taken outside the facility. The staples were finally removed at the facility on 05/28/25. The spouse had no knowledge of any other follow-up appointments being scheduled.</p> <p>2. Review of the closed medical record for Resident #109 revealed an admission date of 02/23/25 with a discharge date of 03/12/25. Resident #109 had diagnoses including diverticulitis, influenza, acute respiratory failure, rheumatoid arthritis, anxiety disorder, disorder of psychological development, osteoporosis, pain, presence of urogenital implants, and colostomy.</p> <p>Review of the hospital Clinical Summary Clinical Discharge Instructions dated 02/22/25 revealed the resident had a perforated diverticulum, leukocytosis, anemia due to blood loss, urinary retention, Influenza, acute respiratory failure with hypoxia, Hypertensive urgency and severe malnutrition. Wound Care Follow-up was to be set up with the wound care clinic.</p> <p>Review of the most recent MDS 3.0 assessment dated [DATE] revealed a BIMS score of 12 out of 15 indicating mild cognitive impairment. The resident was assessed to require assistance of a walker for mobility with no impairment of joint mobility in upper or lower extremities. Resident #109 had an indwelling catheter or nephrostomy tube and an ostomy. No difficulty chewing but some complaints of pain when swallowing and resident was noted to recently have significant weight loss. Resident #109 was at risk for pressure ulcers but has none. Resident received antiplatelet medications with indication present.</p> <p>Review of the nurse practitioner progress note dated 02/27/25 revealed at the hospital the resident underwent an urgent sigmoid colectomy with colostomy and a Hartman's pouch. The resident was at the facility to receive skilled services with an abdominal surgical wound incision.</p> <p>Review of admission skin assessment indicated Resident #109 had an ostomy and a surgical incision.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Skin assessment dated [DATE] at 10:39 A.M. revealed left lower abdomen incision present for one month with 23 staples in place. Incision approximated (present on admission) 9.1 cm by 0.5 cm. No depth to surgical incision to abdomen with intact staples, current treatment to continue as ordered. Surrounding tissue without redness, warmth or swelling. Educated on importance of keeping dressing clean dry and intact. Notified NP and family.</p> <p>Review of physicians' orders for Resident #109 during the stay at the facility indicated there was no order written to remove staples.</p> <p>Review of the medical record for Resident #109 indicated the staples were intact and the surgical wound was healing. The wound/skin assessment pictures of the incision with staples were included in the assessment documentation. The medical record contained no documentation regarding any discussion about when the staples should be removed during the resident's entire stay at the facility.</p> <p>A telephone interview on 05/30/25 at 9:23 A.M. with Registered Nurse/Wound Clinic Nurse #620 confirmed Resident #109 was a patient but all information needs to be released through the medical records department. (05/30/25 at 9:30 A.M. Medical records secretary stated those records have not come to the medical records department yet).</p> <p>3. Review of the medical record for Resident #83 revealed an admission date of 03/11/25 with diagnoses including myocardial infarction, acute respiratory failure, metabolic encephalopathy, sepsis due to Escherichia (E.) Coli, acute kidney failure, pain, long term use of aspirin and insulin, and dysphagia.</p> <p>Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 indicating the resident was cognitively intact. The resident was assessed to require a walker for mobility assistance (limited ROM in upper extremities, lower extremities no impairment). Resident has no difficulties chewing or swallowing and was on a mechanically altered diet and therapeutic diet. Resident #83 had one stage four pressure ulcer which was present on admission or re-entry. Resident #83 had a diabetic foot ulcer and a surgical wound. Resident #83 has a pressure reducing device on her bed and was receiving pressure ulcer and surgical wound care. Resident #83 received seven days of insulin during the look back period. Resident #23 received diuretic, opioid, antiplatelet and hypoglycemic medications.</p> <p>Review of physician's orders for Resident #83 revealed on 05/21/25 new orders were added to decrease Spironolactone 25 milligram oral tablets from one tablet every morning to one half tablet every morning for high blood pressure and Torsemide 20 milligrams oral tablet every morning for edema related to congestive heart failure.</p> <p>Review of the cardiology office visit after visit summary dated 05/21/25 at 2:01 P.M. revealed the medications changes to the amount of Spironolactone and Torsemide as listed above as well as an order to weight Resident #83 daily.</p> <p>Observation on 05/27/25 at 12:00 P.M. revealed Resident #83 had some mild swelling in her ankles. Resident #83 was in the process of getting into bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/27/25 at 12:00 P.M. with Resident #83 revealed Resident #83 had a cardiology appointment last week (05/21/25) and the facility made the ordered medication changes but there was also an order for daily weights. Resident #83 has not been weighted daily. Resident #83 confirmed there was some mild swelling in her ankles but stated that it happens sometimes after she has been up walking around and it goes away when she elevates her feet.</p> <p>Interview on 05/27/25 at 12:30 P.M. with licensed practical nurse (LPN) #497 revealed it is the floor nurse's responsibility to place new orders in the system when a resident returns from the hospital or a doctor's appointment. The floor nurse is also responsible for notifying the resident or the resident's family and the facility physician when there are new orders from and after visit summary.</p> <p>Interview on 05/28/25 at 11:58 A.M. with LPN #530 confirmed when a resident received an after-visit summary with new orders the floor nurse enters the orders into the computer. Then the unit managers double check the orders for accuracy.</p> <p>Interview on 05/28/25 at 4:35 P.M. with cardiology office nurse #640 via telephone confirmed the nurse practitioner placed an order for daily weights. The order is on the office visit note sent to the facility.</p> <p>Interview on 05/29/25 at 9:03 A.M. with LPN #530 confirmed Resident #83 had an after visit summary order from 05/21/25 for daily weight after medication changes. LPN #530 confirmed Resident #83 has no order for daily weights currently and has not been weighed since 05/09/25.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165568.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, medical record review, skin assessments and interviews, the facility failed to ensure skin breakdown prevention interventions were in place. This affected one resident (#103) of one resident reviewed for pressure ulcers. The facility census was 108.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #103 revealed an initial admission date of 08/15/22 with the latest readmission of 04/26/25 with the diagnoses including but not limited to nondisplaced intertrochanteric fracture of left femur, sick sinus syndrome, anemia, mood disorder, contracture of muscle, multiple sites, attention-deficit hyperactivity disorder, overactive bladder, cerebrovascular accident with left sided hemiplegia, anxiety disorder, insomnia, depression, adult failure to thrive, osteoarthritis, constipation, personal history of traumatic brain injury and hypertension.</p> <p>Review of the plan of care dated 12/07/22 revealed the resident was at risk for pressure ulcer formation related to generalized debility and weakness as evidenced by decreased mobility in bed and wheelchair, required staff assistance with incontinence care and turning and repositioning. Interventions included consult wound care team as needed, encourage or assist resident to turn and reposition frequently as resident tolerates as needed, encourage resident to float heels and/or wear heel boots, monitor skin daily during care for redness, excoriation, or breakdown, pressure reduction mattress on bed, preventive skin care post incontinence care daily as needed and provide surface support and pressure redistribution, position changes, and off-loading daily.</p> <p>Review of the resident's Braden scale dated 04/26/25 revealed a score of 12 indicating the resident was at risk for skin breakdown.</p> <p>Review of the plan of care dated 05/09/25 revealed the resident had actual pressure injury formation related to resident had pressure injury with risk for delayed wound healing secondary to progressing comorbidities, debility and generalized weakness with decreased physical mobility and bowel/bladder incontinence daily and pressure injury to right ankle. Interventions included encourage and assist as needed to turn and reposition per policy; use assistive devices as needed, encourage resident to float heels and/or wear heel boots and frequent turning and repositioning, monitor wound for any significant changes (decline or improvement), alert physician of any changes.</p> <p>Review of the weekly skin and wound evaluation dated 05/07/25 revealed a stage II (partial thickness with exposed dermis) pressure ulcer was identified to the resident's right medial malleolus. The wound measured 1.0 centimeters (cm) by 0.6 cm by 0.1 cm described as 100% granulation tissue and had no drainage.</p> <p>Weekly wound assessments were completed on 05/13/25, 05/20/25, 05/27/25 and 06/03/25 which included measurements of the ulcer each week and status of the ulcer (i.e. improving).</p> <p>Review of the resident's monthly physician orders for June 2025 identified orders dated 05/01/15 encourage resident to float heels, 06/01/25 cleanse wound to right medial malleolus with normal saline, pat dry, apply medi honey, cover with ABD pad and wrap with Kerlix dressing every shift for wound care.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/09/25 at 10:32 A.M., observation of Resident #103 revealed she was lying in bed on her left side in fetal position. A dressing was observed to her right ankle/foot. The right foot/ankle had no off-loading observed, including heels being floated and/or heel boots in place.</p> <p>On 06/09/25 at 12:47 P.M., an interview with Resident #103's family member revealed the resident had boots for her ankles/feet, but the aides won't put them on. The family member opened the resident's closet, moved a the resident's personal belongings until he was able to locate the resident's green heel boots. The family member stated, If they were putting them on her I wouldn't have to dig them out of the closet.</p> <p>On 06/09/25 at 12:52 P.M., an interview with Licensed Practical Nurse (LPN) #407 verified the resident had no off-loading to the pressure ulcer to her right ankle.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165568 and Complaint Number OH00164728.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</b></p> <p>Based on observation, record review, review of hospital records, facility policy review and interview, the facility failed to ensure fall risk/safety interventions were in place to prevent falls for one resident (#103) with known history of falls from bed.</p> <p>Actual harm occurred on 04/20/25 when Resident #103 who had a severe cognitive impairment and required extensive assistance from two staff for bed mobility sustained a fall out of bed resulting in hospitalization and surgical repair for a nondisplaced intertrochanteric fracture with of left femur when Certified Nursing Assistant (CNA) #800 left the room with the resident's bed in high position and the fall mat leaned against the wall to retrieve personal care supplies in the facility supply room.</p> <p>This affected one resident (#103) of three residents reviewed for falls. The facility census was 108.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #103 revealed an initial admission date of 08/15/22 with the latest readmission of 04/26/25 with diagnoses including nondisplaced intertrochanteric fracture of left femur, anemia, mood disorder, contracture of muscle multiple sites, attention-deficit hyperactivity disorder, overactive bladder, cerebrovascular accident (CVA) with left sided hemiplegia, anxiety disorder, insomnia, depression, adult failure to thrive, osteoarthritis, constipation, personal history of traumatic brain injury and hypertension.</p> <p>Review of the plan of care dated 12/07/22 revealed Resident #103 was at risk for falls and had potential for injury related to confusion, deconditioning, gait/balance problems, incontinence, unaware of safety needs, CVA with left sided hemiplegia, cerebral aneurysm, depression, anxiety, overactive bladder, adult failure to thrive, muscle weakness as well as effects of medications as ordered. Interventions included anticipate needs every shift, assure resident placed in middle of bed at all times, bed against the wall, bed to be in low position when in bed, Dycem to seat of Broda chair, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage resident to participate in activities that will promote exercise, physical activity for strengthening and improved mobility, fall evaluation per facility protocol, labs as ordered, monitor for changes in gait and/or ambulation, assist with ambulation as needed, monitor for any medication side effects and recent change in medication, abnormal labs, signs/symptoms infection and pain as an increased risk for falls, report abnormal findings to physician, neuro-checks as ordered, nonskid socks when wearing shoes while out of bed, notify family, physician and Director of Nursing (DON) of any fall type incident as soon as possible, therapy to evaluate and treat as ordered or as needed, remind resident to request assistance for transfers if resident is alert and able to comprehend instructions, resident needs activities that minimize the potential for falls while providing diversion and distraction, review information on past falls and attempt to determine cause of falls, record possible root causes, alter remove any potential causes if possible, educate resident/family/caregivers/interdisciplinary team (IDT) as to causes and vision consult as needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was dependent on staff for bed mobility.</p> <p>Review of the fall investigation dated 03/20/25 revealed the resident had a fall from her bed and was found to have no injuries.</p> <p>Review of the resident's fall risk evaluation dated 03/28/25 revealed the resident was at risk for falls.</p> <p>Review of the progress note dated 04/20/25 at 5:22 P.M., authored by Licensed Practical Nurse (LPN) #407 revealed Resident #103 was found on the floor by her bed lying on her left side. The note indicated the resident had been put back to bed after lunch. The entry documented the bedside mat was not in place at the time of the fall. The resident complained of pain to her left hip at a pain level of three out of 10 with 10 being the worst pain possible. The resident was given as needed pain medication. Certified Nurse Practitioner (CNP) #801 was notified and a new order was obtained for a left hip x-ray. The resident's husband was made aware of the incident and the staff were educated to make sure all fall precautions were always in place.</p> <p>Review of the fall investigation dated 04/20/25 revealed the resident had a fall from her bed when the staff member removed the mat, placed the mat against the wall and left the room to get disposable wipes from the supply room. Review of the Director of Nursing (DON) comment revealed the resident's fall interventions were not in place. Education was completed with staff, like residents identified and assessed for falls and falls were being audited.</p> <p>Review of left hip, unilateral with pelvis x-ray results dated 04/20/25 revealed a comminuted intertrochanteric fracture was identified on the left. Mild inferior lateral displacement of the distal fracture fragment was noted. The fracture does not involve the articular surface. Moderate to severe degenerative changes were noted. The surrounding soft tissues were normal. Orthopedic hardware was noted on the right. Conclusions: Intertrochanteric fracture, as detailed above, age undetermined.</p> <p>Review of the progress note dated 04/21/25 at 9:20 A.M., authored by LPN #530 revealed CNP #801 was notified of the x-ray results, and a new order was obtained to transfer the resident to the emergency room (ER).</p> <p>Review of Resident #103's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident was dependent on staff for bed mobility.</p> <p>Review of a hospital Discharge summary dated [DATE] revealed Resident #103 arrived to the emergency department (ED) with the chief complaint of left hip pain following a fall at the skilled nursing facility (SNF). Following imaging the resident was found to have a closed displaced supracondylar fracture of distal end of left femur with intracondylar extension and a closed wedge compression fracture of the thoracic four (T4) vertebra. The hospital course included a [NAME] resection arthroplasty (used to resect the femoral head, to relieve pain and the source of infection.) of the left hip.</p> <p>On 04/25/25 the resident's plan of care was updated to include floor bed next to bed when resident in bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 04/26/25 at 8:17 P.M., authored by LPN #472 revealed the resident was re-admitted to the facility with a surgical incision to the left hip and a bruise on the front of the left thigh. The entry documented the resident had screamed out in pain when the nurse and aide tried to change her incontinence brief. The on-call physician was notified and a new order for pain medication was obtained. The entry documented the resident's bed was in the lowest position.</p> <p>Review of the physician progress note dated 05/02/25 revealed the resident was being seen for fall with hip fracture and weakness. The resident was hospitalized from [DATE] to 04/26/25 after a fall and found to have a left intertrochanteric and subtrochanteric hip fracture. The hospital course included a repair of the left hip on 04/24/25. The resident was also found to have a wedge compression fracture of the thoracic T4 with no surgical intervention.</p> <p>On 06/09/25 at 10:11 A.M., an interview with LPN #530 revealed she was notified of the residents' fall the day the fall occurred. The LPN revealed she was informed the resident rolled out of bed when CNA #800 failed to ensure the bed was in the lowest position and the fall mat was in place.</p> <p>On 06/09/25 at 10:32 A.M., observation of Resident #103 revealed the resident was lying in bed on her left side in fetal position. The resident had non-skid socks in place. The resident's bed was observed to be in the lowest position and the bed mattress was next to the bed.</p> <p>On 06/09/25 at 12:38 P.M., an interview with LPN #407 revealed he was the nurse on duty when Resident #103 rolled out of bed. The LPN revealed CNA #800 laid the resident down after lunch and was providing incontinence care. The LPN revealed the CNA left the room to retrieve disposable wipes from the supply room and the bed was not in the low position and the floor mat was leaned against the wall. The LPN revealed the resident rolled out of her bed while the CNA left the room and verified the resident's fall interventions were not in place at the time of the incident. The LPN revealed he notified management immediately and educated the staff on making sure fall interventions were in place at all times.</p> <p>Review of the facility policy titled, Fall Management Guidelines, implemented 12/13/23 revealed a fall is defines as unintentionally coming to resident on the ground, floor or other level with or without injury to the resident, but not as a result of an overwhelming external force. The facility staff with the input of the attending physician, will implement a resident centered comprehensive care plan that addresses the fall management program, the goal for fall management, individualized interventions to address the resident's modifiable fall risk factors, interventions to try to minimize the consequences of risk factors that are not modifiable and the plan for reduction of risk and or risk for injury.</p> <p>The deficient practice was corrected on 05/04/25 when the facility implemented the following corrective actions:</p> <p>&amp;bull;</p> <p>On 04/20/25 at approximately 3:30 P.M. Resident #103 sustained a fall incident. An immediate resident assessment was completed by LPN #407. The resident was medicated for complaints of left hip pain with as needed analgesic. The resident's physician and power of attorney (POA) were notified of the incident and a new order for an x-ray of the resident's left hip was obtained. LPN #407 educated Certified Nursing Assistant (CNA) #800 on ensuring fall precautions were in place.</p> <p>(continued on next page)</p>		

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  06/11/2025
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>&amp;bull;</p> <p>On 04/21/25, the left hip x-ray results were received and communicated to the resident's physician and POA. The DON began the fall investigation and met with the resident. The resident was transferred to the local emergency room (ER) for further evaluation. The DON interviewed LPN #407 related to the fall incident.</p> <p>&amp;bull;</p> <p>On 04/22/25, the DON interviewed CNA #800 and education was provided to CNA #800 on ensuring fall interventions were in place.</p> <p>&amp;bull;</p> <p>From 04/23/25 through 04/28/25, fall risk residents were identified and audits completed for fall evaluations by Unit Manager #456 and #530. Resident Kardex's were modified as needed. The DON educated nursing staff on having fall interventions in place. The facility began audits on fall interventions in place and was ongoing.</p> <p>&amp;bull;</p> <p>On 04/28/25, Quality Assurance Performance and Improvement (QAPI) was signed by the Medical Director and all Department Heads. Fall intervention audits were to be completed on the following schedule: four times a week for four weeks, then three times a week for three weeks, two times a week for two weeks, one time a week for two weeks, and once a week ongoing.</p> <p>&amp;bull;</p> <p>Review of the facility timeline of corrective action and interview with Administrator revealed the facility identified corrective actions were completed as of 05/04/25.</p> <p>&amp;bull;</p> <p>On 06/09/25, interviews conducted from 10:11 A.M. to 2:40 P.M. with the DON, Registered Nurse (RN) #514, LPN #407, #443, #530 and CNA #487 and #552 revealed they had all received education by management staff on or around 04/23/25 through 04/28/25 regarding ensuring resident fall interventions were in place at all times.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166328.</p>		