

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  02/17/2026
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 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 medical record review, staff interview, and observations this facility failed to ensure post appointment instructions were followed this affected one (Resident #101) of one resident reviewed for follow up care. The facility also failed to ensure Thrombo-Embolism Deterrent (TED) hose were in place as ordered. This affected two (Resident #80 and #91) of the two residents reviewed for TED hose placement. The facility census was 112. Findings include:1. Review of the medical record for Resident #101 revealed an admission date of 03/24/2023 and a re-entry date of 01/28/2025. Diagnosis included chronic obstructive sleep apnea, need for assistance with personal care, and heart failure.</p> <p>Review of Resident #101's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #101 was noted to require set up or clean up assistance for oral hygiene and was noted to receive anticoagulants on a daily basis.</p> <p>Review of the plan of care dated 01/28/25 revealed Resident #101 received ancillary services as needed such as dental and podiatry services. Interventions included to coordinate with social services for scheduling of resident need to see in house specialty physicians, coordinate with specialty care physician any medications or treatment changes pre or post operations and to educate resident to communicate need of appointment with nursing and social services to be set up as needed.</p> <p>Review of the plan of care dated 02/10/25 revealed Resident #101 was at risk for oral dental health problems due to resident having her own teeth with some missing on the top and on the bottom with no partials. Interventions include to administer medications as ordered, assist/setup/task segmentation/supervision and cueing for mouth care and hygiene, coordinate arrangements for dental care, transportation as needed/as ordered, dental consult as needed, diet as ordered, provide mouth care as per activities of daily living.</p> <p>Review of Resident #101's medical record revealed no evidence of this resident having a dental appointment on 11/07/2025 nor was there any evidence or pre or post orders to follow for a dental surgery that was scheduled on 12/12/2025.</p> <p>Interview 02/17/2026 12:05 P.M. with Front Desk Coordinator #555 at the dental office claimed that Resident #101 came to the dentist office for an appointment on 07/21/2025, then another appointment on 08/11/2025 then a consult on 11/07/2025 where preoperation (preop) instructions were provided to Resident #101's daughter. When this resident returned to the dental office on 12/12/2025 for surgery, she had informed the office staff that she did eat and did take her medication that morning even though she was not supposed to. The surgery had to be canceled due to the facility not following the preop instructions. Another appointment was scheduled on 12/23/2025 where it was noted the facility</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  366462	Facility ID:  366462  If continuation sheet Page 1 of 7

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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>reached out to the dental office to have the instructions faxed to them. No issues were noted due to the surgery being pushed off.</p> <p>Interview on 02/17/2026 at 10:30 A.M. with the Director of Nursing (DON) confirmed Resident #101 had a dental procedure completed on 12/23/2025. The DON was not able to provide information about the dental appointment that was on 11/07/2025 or any knowledge of Resident #101 having dental surgery scheduled for 12/12/2025. The DON claimed when a resident has an appointment, this information is added to the resident's Treatment Administration Record (TAR) but this information was not noted in Resident #101's record. The DON also verified when a resident returns to the facility after an appointment, the nurse should have after visit information in case there are any new orders and if the resident does not have this information, then the nurse should contact the office to follow up on this.</p> <p>2. Review of Resident #91's medical record revealed the resident was admitted on [DATE] and had diagnoses that included acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, pulmonary hypertension, iron deficiency anemia, chronic venous hypertension with ulcer of bilateral lower extremity, obstructive sleep apnea, restless leg syndrome, anemia, pain, shortness of breath, and localized edema.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #91 was cognitively intact and required partial or moderate assistance for toileting, shower/bathing, and dressing. Resident #91 required substantial and maximal assistance with putting on and taking off footwear. Resident #91 required setup or clean-up assistance with personal hygiene, eating, and oral hygiene.</p> <p>Review of the physician order dated 01/07/26 at 7:00 A.M. revealed an order to apply thrombo-embolism deterrent (TED) hose (compression stockings used to prevent blood clots) to both legs every day shift for swelling/circulation.</p> <p>Observation of Resident #91 on 02/10/26 at 8:49 A.M. revealed the resident was sitting up in bed. Resident #91 did not have TED hose on either leg.</p> <p>Observation of Resident #91 on 02/11/26 at 11:30 A.M. revealed the resident was sitting in a wheelchair. Resident #91 did not have TED hose on either leg.</p> <p>Observation of wound care by Licensed Practical Nurse (LPN) #326 on 02/11/26 at 11:52 A.M. for Resident #91 revealed after LPN #326 completed wound care to Resident #91's left great toe and left shin. LPN #326 was observed to apply ace wrap to the resident's left shin after wound care was completed.</p> <p>Interview with LPN #326 on 02/11/26 at 4:15 P.M. verified Ace wraps were placed on Resident #91's legs, not TED hose as ordered by the physician. LPN #326 stated Resident #91 had never worn TED hose and plans to obtain an order for an Ace wrap to be applied to both legs from the physician.</p> <p>Review of the treatment administration record (TAR) for February 2026 revealed on 02/11/26 TED hose were signed off as applied by LPN #326.</p> <p>3. Review of Resident #80 revealed she was admitted to the facility on [DATE]. Diagnoses included localized edema, major depression, hypertension and acute respiratory failure.</p> <p>Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was intact.</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>She was independent with eating, she required set up/clean up assistance for oral hygiene, partial/moderate assistance for toileting, personal hygiene, turning and repositioning, and substantial/maximal assistance for shower/bathing and dressing.</p> <p>Review of the physicians orders revealed an order on 10/08/2025 for [NAME] hose to bilateral lower extremities on in morning and off in the evening every day shift for edema.</p> <p>Observations on 02/10/2026 at 9:30 A.M., 1:30 P.M., and 3:30 P.M. revealed no [NAME] hose observed on.</p> <p>Observation on 02/11/2026 at 10:20 A.M. and 2:00 P.M. revealed no [NAME] hose observed on.</p> <p>Observation on 02/11/2026 at 3:46 P.M. revealed no TED hose observed on. Concurrent interview LPN #284 verified the [NAME] hose were not on as ordered.</p> <p>Review of the treatment record for February 2026 revealed on 02/10/2026 they were signed off as applied.</p> <p>Review of the policy titled Physician and Practitioner Orders issued 07/01/22 and reviewed on 02/03/26 revealed a licensed nurse is responsible for completing cares per physician orders.</p> <p>This deficiency represents non compliance investigated under Complaint Number #2695034.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, medical record review, staff interview, and facility policy review, the facility failed to ensure transmission based precautions and personal protective equipment usage were followed as required. This had the potential to affect 21 (Residents #44, #15, #22, #27, #122, #137, #61, #138, #89, #13, #24, #114, #62, #58, #23, #115, #56, #38, #126, #90, and #66) of 112 residents in the facility. Also, the facility failed to use proper hand hygiene after administering medications and performing wound care treatment. This affected two (Residents #73 and #91) of six residents reviewed for infection control practices. The census was 112. Findings Include: 1. Observations on 02/09/26 at 7:05 P.M. revealed Certified Nursing Assistant (CNA) #116 was in Resident #61's room with a mask around their chin. CNA #116 did not have any other personal protective equipment (PPE) on while in the resident's room. Resident #61's room door was observed and had two signs on her door; one for droplet isolation precautions and one for contact isolation precautions. Also, she had a cart outside of her door that was properly stocked with PPE.</p> <p>Resident #61 was admitted to the facility on [DATE]. Her diagnoses were chronic obstructive pulmonary disease, encounter for palliative care, mild protein calorie nutrition, anxiety disorder, Parkinson's disease, conversion disorder, anemia, epilepsy, encephalopathy, dysphagia, diverticulitis of large intestine, cardiomegaly, hepatic failure, acute and chronic respiratory failure, asthma, atrial fibrillation, Type II Diabetes, hypoglycemia, hyperlipidemia, hypothyroidism, morbid obesity, major depressive disorder, lymphedema, venous insufficiency, hypertension, osteoarthritis, and cognitive communication deficit. Review of her minimum data set (MDS) assessment, dated 11/14/25, revealed she was cognitively intact.</p> <p>Review of Resident #61 physician orders, dated 02/10/26, revealed she was on contact and droplet isolation precautions due to a positive SARS CoV-2 (COVID-19) test.</p> <p>Interview with CNA #116 on 02/09/26 at 7:05 P.M. stated they did not think Resident #61 was on isolation precautions. While in the room, CNA #116 asked Resident #61 if she was on contact isolation precautions; Resident #61 stated she did not know.</p> <p>Interview with Registered Nurse (RN) #228 on 02/09/26 at 8:15 P.M. confirmed Resident #61 was on contact and droplet isolation precautions due to a newly identified positive COVID-19 test. She confirmed staff should be wearing PPE when going into her room.</p> <p>2. Observation on 02/11/26 at 12:08 P.M. revealed Housekeeping and Laundry Manager #339 donned a gown but no gloves to enter Resident #126 room to deliver his meal tray. Resident #126 had a sign on his door to reflect he was on enhanced barrier precautions. While in his room, she touched his bedside table to move items so she could place his dinner meal tray on the table. She then walked out of the room. While outside of the room, she doffed the gown and took the doffed gown across the hallway to the nurse's station to throw it away in a regular trash can. She used hand sanitizer after doffing her gown and prior to assisting with other meal trays.</p> <p>Interview with Dietary Manager #266 on 02/11/26 at 12:10 P.M. confirmed she saw the enhanced barrier precautions sign on Resident #126 door and confirmed that Housekeeping and Laundry Manager #339 walked into his room with only a gown and no gloves on.</p> <p>Interview with Housekeeping and Laundry Manager #339 on 02/11/26 at 12:15 P.M. confirmed she walked</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 - Few</p>	<p>Resident #91 revealed LPN #326 performed hand hygiene and donned gloves and a gown. LPN #326 removed the rolled kerlix dressing on the right shin then LPN #326 cleaned the wound bed on the right great toe with normal saline. LPN #326 applied Betadine to the wound bed on the right great toe. LPN #326 performed hand hygiene and donned gloves. LPN #326 removed the border dressing on the right shin. LPN #326 cleaned the wound beds on the right shin with normal saline. LPN #326 applied Xeroform gauze (petrolatum-impregnated mesh) to the wound beds on the right shin and then applied a border dressing on the right shin and then wrapped the right shin with an ACE wrap. LPN #326 performed hand hygiene and donned gloves. LPN #326 removed the border dressing on the left shin. LPN #326 cleaned the wound bed on the left great toe with normal saline. LPN #326 applied wound gel to a gloved finger. LPN #326 applied the wound gel to the wound bed on the left great toe. LPN #326 applied rolled gauze and tape to the left great toe. LPN #326 touched the back pocket of her scrubs with her gloved right hand to turn off her ringing cell phone. LPN #326 cleaned the wound bed on the left shin with Vashe (a type of wound cleanser). LPN #326 applied Xeroform gauze to the wound bed on the left shin. LPN #326 applied a border dressing on the left shin. LPN #326 touched her cell phone with her gloved right hand to turn off her ringing cell phone. LPN #326 performed hand hygiene and donned gloves. LPN #326 applied a border dressing to the right great toe. LPN #326 applied an Ace wrap to the left shin. LPN #326 wiped the floor with a towel. LPN #326 moved Resident #91's wheelchair. LPN #326 removed gown and gloves. LPN #326 performed hand hygiene.</p> <p>Interview with LPN # 326 on 02/11/26 at 12:20 P.M. verified hand hygiene was not consistently performed after touching soiled dressings and linens and before moving from a contaminated body site to a clean body site. LPN #326 stated she thought hand hygiene only needed to be performed between legs.</p> <p>Interview with Unit Manager #130 on 02/17/26 at 09:30 A.M. confirmed hand hygiene should have been performed before moving from a contaminated body site to a clean body site and after handling soiled dressings and linens.</p> <p>Review of the policy titled Hand Hygiene issued 08/01/22 and revised 04/14/23 revealed hand hygiene with soap and water or alcohol-based hand rub is indicated before moving from a contaminated body site to a clean body site during resident care, after handling contaminated objects or equipment, and before and after handling clean or soiled dressings or linens.</p> <p>3. Review of Resident #66's electronic medical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), schizoaffective disorder, anxiety disorder, stage three chronic kidney disease, type two diabetes mellitus, muscle weakness, personal history of neoplasm of the large intestine, and acquired absence of other specified of the digestive tract. Further review of Resident #66's electronic medical record revealed a Brief Interview for Mental Status (BIMS) score of eight (dated 11/08/25), suggesting moderate cognitive impairment.</p> <p>Review of physician orders contained in Resident #66's electronic medical record revealed an order for enhanced barrier precautions active as of 01/30/26 in the setting of a peripherally inserted central catheter (PICC) intravenous line and Jackson Pratt (JP) drain inserted in the resident's body.</p> <p>Observation on 02/12/26 at 8:42 A.M. revealed Laboratory Technician #452 entered Resident #66's room and announced to the resident that she was there to draw blood to check the resident's potassium level. Further observation at this time revealed Laboratory Technician #452 was observed drawing a blood sample from Resident #66's arm while not wearing a gown as indicated on the enhanced barrier precautions signage posted on the door to Resident #66's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/12/26 at 8:45 A.M. with Laboratory Technician #452 revealed she did not see the signage posted on the door to Resident #66's room, nor did she see the personal protective equipment (PPE) that was hanging on the back of the door. Further interview at this time revealed Laboratory Technician #452 would normally wear a gown and gloves upon entry into a resident's room for a blood draw if the resident was on enhanced barrier precautions.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions, revised 02/06/26 revealed enhanced barrier precautions involve gown and glove use during high-contact resident activities for residents known to be colonized with a Centers for Disease Control (CDC) targeted multidrug resistant organism (MDRO), as well as residents at increased risk of MDRO acquisition due to indwelling medical devices, including surgical drains and PICC lines. Further review of the policy revealed PPE will be applied prior to performing high contact resident care activities.</p> <p>This deficiency represents non compliance investigated under Complaint Number #2713145.</p>		