STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366462	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal Winchester Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility policy, the facility failed to ensure hairnets were worn properly by kitchen staff to protect food from potential contamination. This had the potential to affect all residents except one (Resident #2) who did not receive food from the kitchen due to an active NPO (nothing by mouth) order. The facility census was 112.Findings include:Observation on 02/10/26 at 7:20 A.M. revealed [NAME] #108 was wearing a hairnet that was not adequately covering their hair, leaving the back of their hair exposed to hang at approximately shoulder level while frying eggs and plating breakfast foods.Interview on 02/10/26 at 7:30 A.M. with Regional Dietitian #477 verified [NAME] #108's hairnet was not fully covering their hair while performing food service tasks. Further interview at this time revealed Regional Dietitian #477 stated the hairnet could be lower to cover the cook's hair.Review of the facility policy titled Hair Restraints approved 09/15/10 revealed hair shall be restrained to prevent physical contamination of food. Further review of this policy revealed hair restraints shall be worn by all dietary employees while on duty to cover all hair, and employees with hair that cannot be covered by a single hairnet shall wear two hairnets (one for the front and one for the back) or a scrub cap.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, the facility failed to maintain dignity during meal time. This affected one (Resident #28) of seven residents observed in the dining room. The census was 112. Findings include:Review of Resident #28's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included dementia, anxiety, and major depression. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed his cognition was severely impaired, he required substantial/maximal assistance for eating, was dependent for oral hygiene, toileting, shower/bathing, dressing and personal hygiene. On 02/11/2026 at 8:40 A.M. observation of the dining room revealed Certified Nurses Aide (CNA) #206 standing and feeding Resident #28. CNA #206 was observed to continue to stand and feed Resident #28 until 8:46 A.M. Interview on 02/11/26 at 8:46 A.M. with the Administrator confirmed CNA #206 was standing feeding Resident #28.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review, and review of the facility policy on bed hold, the facility failed to notify the resident's representative of the facility's bed hold policy in writing. This affected one resident (Resident #133) of one resident reviewed for hospitalization. The facility census was 112.Findings include:1. Review of the medical record for Resident #133 revealed an admission date of 12/03/25 and a discharge date of 01/12/26. Further review of the medical record revealed Resident #133 had diagnoses that included unspecified protein-calorie malnutrition, Type II Diabetes Mellitus, heart failure, cutaneous abscess of abdominal wall, colostomy status, and depression. Review of the five-day PPS Minimum Data Set (MDS) dated [DATE] revealed Resident #133 had moderate cognitive impairment and demonstrated physical, verbal, and other behavioral symptoms.Review of the progress note dated 01/12/26 at 05:17 P.M. revealed the facility nurse practitioner ordered Resident #133 to be evaluated in the emergency department. Further review of the progress note revealed Resident #133 and the resident representative were notified of the transfer.Review of the bed hold notice titled Canal [NAME] Rehabilitation Center, Skilled Nursing & Assisted Living Notice of Bed Hold When Leaving the Facility for Resident #133 revealed the notice of bed hold was dated 01/12/26 and prepared by Business Office Manager (BOM) #316. BOM #316 documented on the back of the bed hold notice that she spoke with Resident #133's representative on 01/12/26.Interview with Unit Manager #130 on 02/11/26 at 10:50 A.M. revealed Resident #133 had a drain for an enterocutaneous fistula. Unit Manager #130 stated that, during wound rounds, the drain was found dislodged and lying on the bed next to Resident #133. Resident #133 could not report how the drain came out.Interview with BOM #316 on 02/12/26 at 8:50 A.M. revealed the facility did not have an address for Resident #133's representative. BOM #316 stated Resident #133's representative was contacted on 01/12/26 to obtain the representative's address. BOM #316 stated the representative of Resident #133 requested a bed hold during that conversation. BOM # 133 verified the bed hold notice was not mailed to Resident #133's representative. Review of the policy titled Bed Hold Agreement effective 01/01/12 and reviewed 03/21 stated, upon discharge, the Center will attempt to review the Notice of Bed Hold with the patient/resident and/or his or her Legal Representative within 24 hours and/or next business day. The policy further stated the Center will also attempt to provide/send written notice within 24 hours and/or the next business day via mail and/or email.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to develop a comprehensive, person-centered care plan that included Continuous Positive Airway Pressure (CPAP) therapy (a device that delivers air pressure using a mask to keep the airway open while sleeping). This affected one (Resident #91) of two residents reviewed for CPAP therapy. The census was 112.Findings include:1. Review of Resident #91's medical record revealed the resident was admitted on [DATE] with 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.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. Resident #91 used a non-invasive mechanical ventilator (a method of delivering oxygen using a face mask).Review of physician order's revealed an order dated 01/07/26 at 7:00 P.M. for CPAP to be applied every night shift. Observation of Resident #91 on 02/09/26 at 7:39 P.M. revealed the resident was sleeping in bed. Resident #91 was not wearing the CPAP.Observation of Resident #91 on 02/10/26 at 6:55 A.M. revealed Resident #91 was asleep in bed and did not respond to knock on the door. Resident was observed to not be wearing the CPAP.Observation of Resident #91 on 02/11/26 at 6:55 A.M. revealed Resident #91 was in bed with the lights out did respond to a knock on door. The resident was observed to not be wearing the CPAP.Interview with Certified Nursing Assistant (CNA) #479 on 02/11/26 at 6:55 A.M. verified Resident #91 not wearing the CPAP. CNA #479 stated she did not think Resident #91 used his CPAP anymore because he was also not wearing it the last time she worked.Review of Resident #91's care plan initiated on 01/06/26 revealed no care plan for Resident #91's CPAP.Interview with MDS Coordinator Registered Nurse (RN) #126 on 02/12/26 at 10:35 A.M. verified the CPAP was not care planned for Resident #91 but should have been included in the plan of care.Review of the policy titled Care Plan Comprehensive and Revision issued 08/08/22 and reviewed 02/02/26 revealed the comprehensive, person-centered care plan should describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, resident interview, staff interview, and review of facility activity calendar, the facility failed to provide meaningful activities to all residents. This affected two (Residents #44 and #101) of six residents reviewed for activities. The census was 112.Findings Include:1. Resident #44 was admitted to the facility on [DATE]. Her diagnoses were chronic kidney disease, congestive heart failure, vitamin D deficiency, disorder of muscle, hypertensive heart and chronic kidney disease, end stage renal disease, Type II Diabetes, acute respiratory failure with hypoxia, rhabdomyolysis, hypoosmolality and hyponatremia, acute kidney failure, hypothyroidism, atherosclerotic heart disease, hypotension, muscle weakness, dyspnea, hypertension, insomnia, edema, osteoarthritis, and constipation. Review of her minimum data set (MDS) assessment, dated 12/12/25, revealed she was cognitively intact. Review of Resident #44's recreational therapy assessment, dated 11/20/25, revealed her interests included: arts and crafts, cards/bingo/puzzles, community outings, computer, exercise/sports, listen to music, outside/gardening, pet therapy, reading/writing, and watching TV/movies/news. It also documented that she was interested in participating in activities. Review of Resident #44's current care plan revealed a care description of resident can make their own decisions as to which programs they would like to attend., Resident is alert and completed their own assessment. Interventions for this care plan area included: reminding resident of ongoing activities and specific locations, and remind her to check the back of the daily chronicle for activities of the day. Review of Resident #44's activity logs, dated November 2025 to January 2026, revealed no documented arts and craft activities documented as being offered, completed, or refused. Interview with Resident #44 on 02/10/2026 at 10:00 A.M. the resident stated activities on the second floor of the facility are pretty good, but not on the first floor. She stated she has to make the effort to go to the second floor if she wants activities. She confirmed there are no activities past 4:15 P.M., and even then, it's only one on one activities. She stated there was very little variety with the activities. She confirmed they do not do many arts and crafts activities and the ones they do, the residents have to provide their own supplies. She confirmed she would like more arts and crafts. Interview with Activities Director #182 on 02/17/2026 at 12:37 P.M. stated the residents must ask the activities staff to get arts and crafts supplies out if it's not on the activity schedule. She stated she would have to look at the activities calendars to see how many arts and crafts activities are scheduled each month, but they perform knitting each Sunday. She did confirm the residents would have to supply their own supplies to participate in that. She also confirmed there are changes to the activity calendar on a daily basis if needed; those are reflected on the daily chronicle/newsletter that is given to each resident, each day. She stated the residents should look at the back of that chronicle to see if there are any changes or what activities are provided for that day. She confirmed they have a limited budget, so they don't buy arts and crafts supplies if it's not in the budget. She confirmed Resident #44 would complete arts and crafts [NAME] days a week if she could. Review of facility activity calendars, dated 11/01/25 to 02/17/16, revealed the following number of arts and crafts activities offered: one for November, three for December, one for January, and one for February. There was an activity named Knotting Knitters that was offered every Sunday. But, it was (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that residents were to bring their own supplies for this activity each week. 2. 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, depression, and heart failure. 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. Review of the plan of care date 01/29/2025 revealed Resident #101 declined group activity frequently, resident declines most group activity attendance and often has prepared reason, wants to do crafts in her room, talk on the phone, and watch television. Interview on 02/10/2026 at 11:00 A.M. with Resident #101 revealed she use to be a teacher and really enjoys working on all different kinds of crafts. Resident #101 stated she refused to attend a lot of the activities due to the facility not really having crafts to do. If they would have more crafts she would attend more of the facility actives. Interview on 02/17/2026 at 10:05 A.M. with Activity Director #182 revealed the facility does not have multiple craft activities, but this is also something that is determined by what the residents vote on and the activities department budget. There are multiple residents who like to make crafts and a couple residents will get together a few times a year and set up a little table outside the facility for visitors to buy their crafts and they get to keep all the money.

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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 - Minimal harm or potential for actual harm 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 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. 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. 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. 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. 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. 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 reached out to the dental office to have the instructions faxed to them. No issues were noted due to the surgery being pushed off. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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. 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. 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. 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. Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was intact. 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Observation on 02/11/2026 at 10:20 A.M. and 2:00 P.M. revealed no [NAME] hose observed on. 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. Review of the treatment record for February 2026 revealed on 02/10/2026 they were signed off as applied. 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. This deficiency represents non compliance investigated under Complaint Number #2695034.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, the facility failed to implement and/or follow physician orders to treat pressure injuries. This affected two residents, (Resident #126 and Resident #91), of four residents reviewed for pressure injury management. The facility census was 112. Findings include:1.Record review for Resident #126 revealed this resident was admitted to the facility on [DATE] with diagnoses including: diabetes mellitus, hemiplegia, hemiparesis, chronic congestive heart failure. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require self-care assistance. Resident #126 was coded with a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.)pressure ulcer and a Stage III (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure ulcer, both on the sacrum. Review of the care plan dated 01/26/26 revealed Resident #126 was at risk for skin integrity impairment due to hemiplegia and weakness. Interventions included administering treatments per physician orders. Review of Resident #126's physician orders revealed no treatment orders for the resident's pressure ulcers. Review of Resident #126's January and February 2026 treatment administration record, (TAR), revealed no orders to treat the resident's pressure ulcers. The TAR did indicate the resident had a weekly skin check completed on 01/28/26, 02/04/26 and 02/11/26. which were initialed as completed by the nurse. Review of progress note dated 01/27/26 at 11:57 A.M. revealed Resident #126 had pressure injury documented as a Stage I (Observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony prominence; may include changes in skin temperature, tissue consistency and/or sensation. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues) to the right gluteus. The injury was described as non blanchable erythema of intact skin. Wound was present on admission and unknown how long the wound had been present. Staged by in house nursing wound measured 1.72 centimeters (cm) by 0.91 cm by 0.0 cm with 100% eschar (a layer of thick, dry, black or brown necrotic (dead) tissue that forms over severe wounds, burns, or pressure ulcers). The wound had no exudate and peri wound was attached. Cleanse with normal saline, apply triad paste and leave open to air. There was a second wound to the left gluteal fold that was documented as a pressure ulcer which was present on admission and measured 1.24 cm by 1.38 cm by 0.0 cm with 100% eschar. No drainage was noted, the treatment was documented as cleanse with normal saline, apply triad paste and leave open to air. There was no wound stage indicated for the wound to the left gluteal fold. Review of progress note dated 01/29/26 at 11:27 A.M. revealed the resident has a stage II pressure ulcer to the left gluteal fold that measured 0.42 cm by 0.34 cm by 0.0 cm with 100% eschar and peri wound attached. Treatment was documented as cleanse with normal saline apply triad paste and leave open to air. The resident also had a stage III pressure ulcer to the right gluteus that measured 0.66 cm by 0.54 cm by 0.0 cm that was 60% epithelial tissue, 10% slough and 30% eschar. Peri wound (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366462	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal Winchester Care Center	6800 Gender Road Canal Winchester, OH 43110

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was documented as attached,and treatment was documented as cleanse with normal saline apply triad paste and leave open to air. Review of progress note dated 02/05/26 at 9:52 A.M revealed the resident had a stage II pressure ulcer to the left gluteal fold that measured 0.49 cm by 0.56 cm by 0.0 cm with 100% eschar and peri wound attached. Treatment was documented as cleanse with normal saline, apply triad paste and leave open to air. The resident had a stage III pressure ulcer to the right gluteus that measured 3.76 cm by 2.75 cm by 0.1cm that was 20% epithelial tissue and 80% granulation tissue and the peri wound was attached. The treatment was documented as cleanse with normal saline, apply triad paste and leave open to air. Review of the physician's Wound Assessment and Plan dated 02/05/26 revealed a stage II pressure injury, measuring 0.49 centimeter (cm) by 0.56 cm. by 0 cm, with a wound onset date of 01/26/26. Wound treatment orders read: clean the wounds with normal saline, pat dry, apply triad cream and leave open to air. The assessment also revealed a stage III pressure ulcer located in the right gluteal fold, measuring 3.76 cm. by 2.75 cm. by 0.1 cm. The wound treatment order read: cleanse with normal saline, pat dry, apply collagen sheet and cover with dry dressing every one day and as needed. Review of physician orders revealed the orders for Resident #126's wounds listed in the Wound Assessment and Plan note dated 02/05/26 were not transcribed as orders into the resident's medical record. Review of progress note dated 02/12/26 at 10:40 A.M. revealed the pressure ulcers were resolved. Interview on 02/12/2026 at 11:05 A.M. an interview with Licensed Practical Nurse, (LPN) #482 confirmed Resident #126 did not have wound care orders for the stage II and stage III pressure ulcers the resident had at admission to the facility. On 02/12/2026 at 11:13 A.M. Regional Director #451 also confirmed that Resident #126 did not have wound care orders for either pressure ulcer. Review of the facility's policy Physician and Practitioner Orders, revised 11/09/23, revealed the licensed nurse is responsible for applying and completing treatments per physician orders. 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. 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. Review of Resident #91's physician orders revealed an order for right dorsum first digit specified to cleanse with normal saline, pat dry, then apply Betadine and cover with a bordered gauze dressing every night shift until resolved dated 02/05/26, and an order for left dorsum first digit specified to cleanse with normal saline, pat dry, apply wound gel then kerlix wrap every shift until resolved dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366462	A. Building B. Wing	02/17/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/05/26. Review of the Skin Issues dated 02/05/26 at 8:23 A.M. revealed Resident #91 had a stage III pressure ulcer (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present) on the left hallux (great toe) and an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) on the right hallux (great toe). Observation of Resident #91 on 02/09/26 at 7:39 P.M. revealed resident sleeping in bed. Resident #91 did not have dressings on either great toe. Blood was observed on the bottom of Resident #91's left foot. Observation of Resident #91 on 02/10/26 at 8:49 A.M. revealed resident sitting up in bed. Resident #91 did not have dressings on either great toe. Interview with Resident #91 on 02/10/26 at 8:49 A.M. revealed facility staff are applying dressings to the shin area only. Interview with Certified Nursing Assistant (CNA) #70 on 02/11/26 at 11:24 A.M. revealed CNA #70 has only seen dressings on Resident #91's shins. Observation of Resident #91 on 02/11/26 at 11:30 A.M. revealed resident sitting in a wheelchair. Resident #91 did not have dressings on either great toe. Interview with Resident #91 on 02/09/26 at 11:30 A.M. revealed the resident requested a Band Aid for his left toe but the staff did not return to the room to apply the dressing. Resident #91 stated he was unable to finish dressing until the Band Aid was applied. Interview with Licensed Practical Nurse (LPN) #326 on 02/11/26 at 11:52 A.M. verified Resident #91 did not have dressings on either great toe. LPN #326 stated treatment orders must have recently changed for Resident #91 because dressings were not previously ordered for the great toes. Review of Resident #91's orders with LPN #326 confirmed the resident had new orders for the left and right great toes dated 02/05/26. Review of physician orders revealed treatment orders for the right great toe beginning 01/07/26 and modified on 01/15/26, 01/22/26, 01/29/26, and 02/05/26. Review of physician orders revealed treatment orders for the left great toe beginning 01/07/26 and modified on 01/15/26, 01/22/26, and 02/05/26. Review of the Treatment Administration Record (TAR) for February 2026 revealed on 02/09/26, 02/10/26, and 02/11/26 treatments to the right and left great toe were documented as performed. Review of the care plan initiated on 01/06/26 revealed Resident #91 was at risk for skin alteration due to the presence of skin alterations. Interventions to decrease and minimize skin breakdown risk for Resident #91 included administering treatments per physician orders. This intervention was initiated on 01/09/26 for Resident #91.

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	366462	A. Building B. Wing	02/17/2026

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of facility nutrition policies, the facility failed to ensure one (Resident #66) did not experience a significant weight loss and failed to ensure one (Resident #92's) fluid restriction was followed. This affected two of seven residents (#14, #36, #44, #66, #92, #10, and #10) reviewed for nutrition. The facility census was 112.Findings include: 1. 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 amongst other diagnoses. 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. Review of weight measurements and physician orders contained in Resident #66's electronic medical record revealed the resident lost over 13% of their weight in a time period of less than three months between 11/10/25 (169 pounds) and 02/02/26 (146 pounds) while the resident was not on a prescribed weight loss program. Review of Resident #66's most recent care plan dated 11/28/25 revealed the resident was identified as at nutritional risk related to COPD, perianal thrombosis, chronic kidney disease, schizoaffective disorder, anxiety disorder, bipolar disorder, depression, dementia, atrial fibrillation, congestive heart failure, constipation, history of nausea and vomiting, history of bowel cancer, diet restrictions, and significant weight loss. Further review of the care plan revealed interventions for mitigating nutritional risk included document food acceptance, monitor weights per order and as needed, provide and serve diet as ordered, Registered Dietitian to evaluate and make diet change recommendations as needed, and provide nutritional supplements as ordered. Review of physician orders as of 02/11/26 in Resident #66's medical record revealed a dietary order for no added salt, regular texture with thin consistency. Further review of dietary orders for Resident #66 revealed no evidence of active orders for any dietary supplement. Observation during lunch service on 02/10/26 at 11:30 A.M. revealed Resident #66 appeared thin or underweight. Further observation at this time revealed there was no nutritional supplement on or near Resident #66's lunch tray. Observation in the kitchen on 02/11/26 at 6:09 P.M. of Resident #66's meal ticket for dinner revealed no marking to indicate that a nutritional supplement should be provided with the meal. Interview on 02/11/26 at 6:10 P.M. with Dietary Manager #266 revealed residents that are intended to receive nutritional supplements with their meal will have the supplement order printed on their meal ticket to notify kitchen staff when preparing meal trays. Further interview at this time verified there was no marking to designate the need for a nutritional supplement on Resident #66's meal ticket. Interview on 02/12/26 at 2:28 P.M. with Regional Dietitian #477 revealed Resident #66 had triggered recently for weight loss within the past 30 days. Further interview at this time revealed Resident #66 should have been receiving nutrition interventions including supplements such as med pass 120 (continued on next page)

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	366462	A. Building B. Wing	02/17/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	milliliters (ml) twice daily and magic cup twice daily with lunch and dinner. Regional Dietitian also identified other nutritional interventions for Resident #66 included monitoring food intakes and keeping the resident on an appetite stimulating medication that had been started while the resident was previously in the hospital. Interview on 02/12/26 at 2:42 P.M. with Regional Dietitian #477 revealed they were not able to find any active orders for nutritional supplements in Resident #66's medical record. Further interview at this time revealed Resident #66 should have had active orders for nutritional supplements as had previously been discussed, and the resident used to have orders for these supplements prior to a brief hospital stay from which the resident returned to the facility on [DATE]. Regional Dietitian #477 stated there must have been a mix up, because orders for nutritional supplements were not reinstated following the resident's return to the facility on [DATE]. Regional Dietitian #477 stated we will have to get this sorted out and reactivate nutritional orders as indicated. Review of the facility policy titled Dietary Supplements approved 01/01/12 and reviewed 10/19/21 revealed it is the center's policy that patients/residents identified as nutritionally at risk will be provided a dietary supplement during medication passes, meals, or at other times as directed per a physician's order. Further review of the policy revealed the intent of the policy is to assure optimal nutrition for all residents at all times, and dietary supplements are provided to residents who are nutritionally at risk. Additional review of the policy revealed it is the responsibility of nutrition staff to initiate or verify the appropriateness of all dietary supplements for residents, and it is the responsibility of nursing staff for obtaining and discontinuing the physician's order for dietary supplements. 2. Record review for Resident #92 revealed this resident was admitted to the facility on [DATE] with diagnoses including: hypotension, cardiomegaly, end-stage renal disease, Diabetes Mellitus Type II, major depressive disorder, muscle weakness, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require activity of daily living (ADL) assistance Review of the care plan dated 05/15/25 revealed Resident #92 received peritoneal dialysis due to end-stage renal failure. Interventions included a fluid restriction of 950 ml, consisting of 250 mL from the nursing team during day shift, and 100 mL during the night shift. Observation on 02/12/26 at 10:17 A.M. revealed Resident #92 sipping from a 500 mL water bottle and setting it on a table adjacent to her. The table also held a small glass full of water. When asked if both the water bottle and water glass on the table were hers, Resident #92 affirmed that they were. She denied the nursing staff at the facility were monitoring her fluid intake. Interview with Regional Dietician #477 on 02/12/26 at 11:17 A.M. confirmed Resident #92's current diet orders included a fluid restriction of 950 mL per day, including 600 mL allocated for meal times. Interview with Licensed Practical Nurse, (LPN) #482 on 02/12/26 at 11:25 A.M. confirmed she did not receive any information in report about any of the residents currently having a fluid restriction. She reviewed the residents' orders and she could not find any active fluid restriction orders for any residents. At 12:17 P.M. LPN #482 verified Resident #92 had water bottle and a glass of water on her table. (continued on next page)

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	366462	A. Building B. Wing	02/17/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nursing Assistant, (CNA), #268 on 02/12/26 confirmed she had no knowledge of Resident #482 having a fluid restriction. She admitted the facility nursing staff was not following it. Review of the facility's policy Fluid Restriction Guidelines revealed the nursing staff is responsible for ensuring that the fluid restriction is maintained and that the fluid limits are not exceeded.

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	366462	A. Building B. Wing	02/17/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow physician orders for oxygenation therapy for Resident #06 and continuous positive airway pressure, (CPAP) use for Resident #36. This affected two residents, (Residents #06 and #36) of four residents reviewed for respiratory care. The facility census was 112.Findings Include:1.Record review for Resident #06 revealed this resident was admitted to the facility on [DATE] with diagnoses including: cerebral infarction, diabetes mellitus, chronic respiratory failure with hypoxia, anxiety, depression, congestive heart failure and choric obstructive pulmonary disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require mobility and self-care assistance. Review of the care plan dated 01/02/26 revealed Resident #06 has altered respiratory status and breathing difficulty. Interventions included providing oxygen via nasal cannula at three liters per minute (LPM). Review of the physician's orders of Resident #6 revealed oxygen delivery via nasal cannula continuously at three liters per minute. Observation on 02/10/26 at 3:40 P.M. revealed Resident #6 was not wearing her oxygen at time of visit. Observation on 02/12/26 at 4:54 P.M. revealed Resident #6 was not wearing her oxygen. On 02/12/2026 at 5:36 P.M. Licensed Practical Nurse, (LPN) #482 verified that Resident #06 was not wearing her oxygen as ordered. She confirmed the oxygen should be worn by the resident at all times. 2. Review of Resident #36's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included displaced intertrochanter fracture of left femur, mild protein calorie malnutrition, congestive heart failure, atrial fibrillation, and diabetes. Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was intact. She was independent with eating, oral hygiene and personal hygiene, required partial/moderate assistance with toileting, shower/bathing, and dressing. Requires supervision/touching assistance for sit to stand, and all transfers. Frequently incontinent of urine and occasionally incontinent of bowel. Review of the physicians orders revealed an inactive order dated 09/22/25 for CPAP:during night every night shift for Bipap support (used for sleep apnea). Resident #36 was out of the facility and in the hospital on [DATE] and returned on 02/05/2026. There was no active order for the CPAP upon readmission to the facility. Interview with Regional Director #451on 02/12/26 at 3:02 P.M. verified there was not a current order for the CPAP, but did state Resident #36 had been wearing the CPAP at the facility.

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	366462	A. Building B. Wing	02/17/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to timely and thoroughly address all pharmacy recommendations. This affected two (Residents #7 and #3) of five residents reviewed for pharmacy recommendations. The census was 112.Findings Include:1. Resident #7 was admitted to the facility on [DATE]. His diagnoses were acute respiratory failure, non-displaced intertrochanteric fracture of left femur, disorder of muscle, acute pulmonary edema, other acute osteomyelitis, cardiomyopathy, hypokalemia, peripheral vascular disease, congestive heart failure, atrial fibrillation, chronic kidney disease (stage IV), atherosclerotic heart disease, hypo-osmolality and hyponatremia, Type II Diabetes, ischemic cardiomyopathy, anxiety disorder, shortness of breath, depression, obesity, insomnia, muscle weakness, hypertension, edema, and umbilical hernia. Review of his minimum data set (MDS) assessment, dated 01/19/26, revealed he was cognitively intact. Review of Resident #7 pharmacy recommendation, dated 04/19/25, had a recommendation to review the use of Insulin Glargine (long acting insulin) 12 units and Insulin Lispro(rapid acting) (sliding scale for the need of both of medications. The recommendation was to stop Insulin Aspart (fast acting) and continue the other medications as ordered. The recommendation form was marked for disagree with the recommendation, but the justification stated, duplicate; there was no actual justification for the response. Also, there was no provider signature or date as to if/when the recommendation was reviewed. Review of Resident #7's pharmacy recommendation, dated 05/24/25, revealed the same pharmacy recommendation as 04/19/25. There was a hand written note that the facility will repeat the A1C laboratory/blood draw in July 2025. It was signed by the provider on 06/09/25. Review of Resident #7's laboratory results, dated 08/06/25, revealed there were no A1C laboratory test obtained in July 2025 as indicated on the pharmacy recommendation. Review of Resident #7 pharmacy recommendation, dated 06/27/25, revealed the same recommendations as 04/19/25 and 05/24/25. This recommendation was agreed upon by the provider and signed on 06/30/25. Review of Resident #7 pharmacy recommendation, dated 09/30/25, revealed the same recommendations as 04/19/25, 05/24/25, and 06/27/25, revealed the pharmacy recommendation form was marked with disagree and other and the typed justification of blood glucose (BG)/A1C at goal for age (79), repeat A1C in three months. It was signed by the provider on 10/02/25. Review of Resident #7 pharmacy recommendation, dated 12/31/25, revealed the same recommendation as 04/19/25, 05/24/25, 06/27/25, and 09/30/25. The pharmacy recommendation was not addressed on this form. But, on a provider progress note, dated 01/29/26, the nurse practitioner agreed to discontinue the Insulin Aspart. Review of Resident #7 physician orders, dated October 2024 to January 2026, revealed he was never ordered to take Insulin Aspart sliding scale dose. He was ordered Insulin Lispro sliding scale from 10/17/24 to 01/08/26, which was when he was discharged to the hospital. Insulin lispro sliding scale was reinstated on 01/12/26, but then discontinued again on 01/29/26, which would align with the pharmacy recommendation and provider order to discontinue it on 01/29/26. There was no order to (continued on next page)

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	366462	A. Building B. Wing	02/17/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stop Insulin Lispro sliding scale on 06/27/25, when the provider agreed with the pharmacy recommendation to stop Insulin Aspart sliding scale. Interview with Director of Nursing (DON) on 02/17/26 at 3:10 P.M. confirmed there was no provider signature or date on the 04/19/25 pharmacy recommendation as required. Also, he confirmed Resident #7's A1C was not drawn and run until 08/06/25 instead of July 2025 as ordered/expected from the pharmacy recommendation on 05/24/25. He confirmed Resident #7 never had an order for Insulin Aspart and that the facility never clarified with the pharmacy or provider if that was a clerical error, or if the recommendation should have been for the discontinuation of the insulin lispro sliding scale. He confirmed the pharmacy recommendation on 06/27/25 was not addressed to clarify which portion of the recommendation the provider agreed with. He agreed the nurse practitioner wrote in her note on 01/29/26, that she wanted the Insulin Aspart to be discontinued, even though he was not ordered Insulin Aspart. He agreed the recommendation to discontinue Insulin Aspart on all four pharmacy recommendations were probably a clerical error and should have been Insulin Lispro since they both were sliding scale. 2. Review of Resident #3's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included dementia, depression, anxiety, insomnia, high blood pressure and pain. Review of the admission minimum data set assessment dated [DATE] revealed her cognition was not intact, she was dependent for eating, oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Frequently incontinent of bowel and bladder. Received antipsychotics, antianxiety, antidepressants and anticoagulants. Review of Pharmacy Recommendation on 11/07/25 revealed the resident has an order for Morphine (opioid) 20 milligrams (mg) per milliliter (ml) oral solution. Give 0.25 mg every three hours as needed, however hospital record indicate resident was receiving 0.3 ml every two hours as needed for moderate to severe pain. Please clarify this order with prescriber and update accordingly. On 12/04/2025 this was addressed by the physician and was deferred to hospice. Further review revealed no documented evidence it was addressed. On 02/12/2026 at 3:02 P.M. interview with Regional Director #451 verified no follow up by hospice on the pharmacy recommendation after the physician referral by the physician.

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	366462	A. Building B. Wing	02/17/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. 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. 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. 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. 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. 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. Interview with Housekeeping and Laundry Manager #339 on 02/11/26 at 12:15 P.M. confirmed she (continued on next page)

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	366462	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal Winchester Care Center	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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walked into Resident #126 room with a gown but no gloves or other PPE on. When asked why she donned the gown but not gloves, she said, the rules are always changing and I wasn't sure. I probably should have, but I didn't know. She confirmed she walked across the hallway after walking out of Resident #126 room with her gown on, and doffed the gown at the nurse's station where she placed the gown in the regular trash can. Review of facility Standard and Transmission Based Precautions policy, dated 02/04/26, revealed contact transmission is the most frequent mode of transmission of healthcare associated infections. Contact precautions include hand hygiene, personal protective equipment, gloves, and gown. Droplet transmission involves droplets generated by the resident during coughing, sneezing, and talking or during the performance of certain procedures such as suctioning or aerosol generating procedures. Droplet precautions include gloves, gown, mask, and eye protection. 3. Review of the medical record for Resident #73 revealed an admission date of 02/10/26 and diagnoses that included pulmonary embolism, COVID-19, cardiomegaly, acute respiratory failure, acute diastolic (congestive) heart failure, sepsis due to methicillin sensitive staph aureus, staphylococcal arthritis right shoulder, and edema unspecified. Observation of medication administration by Licensed Practical Nurse (LPN) #326 on 02/11/26 at 8:20 A.M. for Resident #73 revealed LPN #326 performed hand hygiene and donned personal protective equipment prior to entering Resident #73's room. LPN #326 touched Resident #73's bilateral lower extremities with weeping edema and soiled bed linens with gloved hands. LPN #326 touched a blood pressure cuff on Resident #73's left arm. LPN #326 administered Resident #73's medications. LPN #326 removed personal protective equipment and performed hand hygiene. Interview with LPN #326 on 02/11/26 at 09:00 A.M. verified soiled gloves were not removed and hand hygiene was not performed before touching the blood pressure cuff and administering the medications. Interview with Unit Manager #130 on 02/17/26 at 9:30 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 linens. 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, before and after handling clean or soiled dressings or linens, and before handling medications. 4. Review of the medical record for Resident #91 revealed the resident was admitted [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. 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene. Observation of wound care by Licensed Practical Nurse (LPN) #326 on 02/11/26 at 11:52 A.M. for 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. 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. 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. 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. 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. 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. Observation on 02/12/26 at 8:42 A.M. revealed Laboratory Technician #452 entered Resident #66's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. This deficiency represents non compliance investigated under Complaint Number #2713145.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed maintain a safe environment free of hazardous chemicals for one (Resident #97) of 17 residents on the 300 hall way. The census was 112. Findings include:Review of Resident #97's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to hypertension, hyperlipidemia and atrial fibrillation. Review of the comprehensive minimum data set (MDS) assessment dated [DATE] revealed Resident #97 was cognitively impaired, used a walker and wheelchair for mobility, and had no behaviors. The facility identified Resident #97 as being cognitively impaired, independent with ambulation and mobility, and residing on the 300 hallway.Observation on 02/11/2026 at 11:03 A.M. of the 300 hallway revealed residents up and about the hallways and a container of microdot minute wipes (clean and disinfectant wipes) on top of both medication carts stored on the 300 hallway.Review of the microdot minute wipe container revealed a label that read keep out of reach of children. Hazards to humans and domestic animals.Interview on 02/11/2026 at 11:27 A.M. with Licensed Practical Nurse (LPN) #284 confirmed the microdot minute wipes were on top of the medication cart, not secured.