

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 08/20/2024
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on medical record review, review of hospital records, resident representative interview, staff interview, and review of facility policy, the facility failed to ensure appropriate care and services were provided to residents following accidents with injury. This affected one (Resident #99) of three residents reviewed for accidents. The facility census was 79 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #99 revealed an admitted [DATE] with diagnoses including diffuse large B-Cell lymphoma, muscle weakness, viral hepatitis B, and atrial fibrillation.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #99 dated 07/06/24 revealed the resident had mildly impaired cognition and required partial/moderate assistance with turning from side to side.</p> <p>Review of the nurse progress note for Resident #99 dated 08/03/24 revealed the resident was being changed and assisted with bed mobility and hit her head on the side rail. There was no swelling or redness was noted. The facility did not notify the physician of the incident, nor did they initiate neurological checks or follow up assessments. On 08/04/24 Resident #99 was transferred to the hospital because the resident's representative was concerned the resident was not acting like herself. Resident #99 was admitted to the hospital with a diagnosis of sepsis.</p> <p>Review of the hospital computed tomography (CT) results for Resident #99 dated 08/04/24 revealed the resident had a mid-left parietal scalp hematoma without skull fracture present.</p> <p>Telephone interview on 08/20/24 at 9:25 A.M. with Resident #99's representative confirmed facility staff reported the resident's head hit the bed frame while care was being provided by staff. Resident #99's representative confirmed staff did not initiate neurological check following the incident, the physician was not notified of the incident, and no follow up care was provided to the resident after the incident initially occurred.</p> <p>Interview on 08 /20/24 at 12:00 P.M. with Licensed Practical Nurse (LPN) #215 confirmed Resident #99 hit her head on the bed frame while staff were providing care. LPN #215 confirmed the facility staff did not complete an incident report, did not initiate neurological checks, did not notify the physician of the incident, and did not conduct follow-up assessments of the resident following the incident.</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>Review of the facility policy titled Accident and Incident Policy revised 08/18/23 revealed the facility would report, investigate, and review any accident or incidents that might involve or allegedly involve a resident. The accident/incident report would contain the date and time the accident or incident took place, the nature of the injury, the circumstance surrounding the accident or incident, where the accident or incident took place, the names of witnesses and their accounts of the accident or incident, the residents account of the incident, the time the residents attending physician was notified, the date/time the residents family/representative was notified, the disposition of the resident, any interventions or corrective action taken, follow-up information, other pertinent data as necessary or required, and the signature and title of the person completing the report. In the event of head trauma, the nurse would initiate neurological checks as per protocol and would document on the neurological flow sheet. Abnormal findings would be reported to the practitioner.</p> <p>This deficiency represents noncompliance identified during the investigation of Complaint Number OH00156601.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure staff used appropriate hand hygiene and personal protective equipment (PPE) to prevent the spread of Coronavirus (COVID-19). This had the potential to affect 16 residents (#5, #7, #10, #23, #25, #26, #32, #36, #37, #41, #46, #50, #59, #60, #62 and #77) who resided in the hall where staff delivered meal trays without implementation of appropriate COVID-19 protocols. The facility identified two residents (#3 and #52) as having active COVID-19 infection. The facility census was 79 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including severe persistent asthma, shortness of breath, and COVID-19.</p> <p>Review of the nurse progress note for Resident #52 dated 08/12/24 revealed the resident tested positive for infection with COVID-19 after exposure from an infected family member was reported. The facility implemented contact and droplet precautions.</p> <p>Review of the physician's orders for Resident #52 revealed an order dated 08/13/24 for contact/droplet precautions for COVID-19.</p> <p>Review of the medical record for Resident #3 revealed the resident was admitted to the facility on [DATE] and had diagnoses including hypertension, hyperlipidemia, and COVID-19.</p> <p>Review of the nurse progress note for Resident #3 dated 08/14/24 revealed the resident tested positive for COVID-19 on 08/14/24 after exhibiting symptoms consistent with COVID-19 infection. The facility implemented contact and droplet precautions.</p> <p>Review of the physician's orders for Resident #3 revealed an order dated 08/14/24 for contact/droplet precautions for COVID-19.</p> <p>Observation on 08/19/24 at 12:40 P.M. revealed State tested Nursing Assistant (STNA) #103 was delivering the lunch meal trays to residents in their rooms. STNA #103 Resident #52's room carrying the lunch meal tray while wearing a surgical mask and no additional PPE. STNA #103 set up the resident's meal tray and exited the room without changing masks or performing hand hygiene. STNA #103 then entered the room of Residents #26 and #23 to deliver the lunch meal trays. STNA #103 exited the room without changing masks or performing hand hygiene. STNA #103 then entered the room of Resident #3 wearing the same surgical mask and no additional PPE. STNA #103 set up the resident's meal tray and exited the room without changing masks or performing hand hygiene. STNA #103 then entered the room of Resident #5 and Resident #46 to deliver the lunch meal trays.</p> <p>Interview on 08/19/24 at 12:50 P.M. with STNA #103 on 08/19/24 confirmed they wore only a surgical mask with no additional PPE while in the rooms of Resident #3 and Resident #52 and did not change the mask prior to entering other residents' rooms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 08/19/24 at 12:55 P.M. with Licensed Practical Nurse (LPN) #210 confirmed Resident #52 and Resident #3 had active COVID-19 infections and were in contact and droplet isolation. LPN #210 confirmed all staff should don an N-95 respirator mask, a gown, gloves, and a face shield when entering the room of a resident with COVID-19 infection and should perform hand hygiene upon exiting a resident's room.</p> <p>Review of the facility policy titled COVID-19 revised 10/26/23 revealed staff should don N-95 masks, eye protection, gown, and gloves when providing care for residents in transmission-based precautions for confirmed or suspected COVID-19 infection.</p> <p>This deficiency represents noncompliance investigated under Complaint OH00156711 and Complaint Number OH00156601 and Complaint Number OH00156578.</p>		