STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 725000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Wyandot Trail	1495 Granville Pike Lancaster, OH 43130

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observations and interview with staff, the facility failed to ensure that the facility's electronic charting system was secure during medication administration. This affected 12 residents residing in the 300 hall (Resident #24, #26, #34, #20, #23, #41, #9, #40, #17, #44, #19, and #27) of 12 residents reviewed for privacy. The facility census was 44. Findings include:On 04/13/2026 at 9:47 A.M., during morning medication pass in 300 hall, Registered Nurse (RN) #228 was observed walking away from the medication cart. The laptop located on the medication cart remained open, and the facility's electronic charting system was visible and accessible to anyone in the immediate area. At 9:50 A.M., RN #625 approached the medication cart and began administering medications to residents in 300 hall. At 9:52 A.M., RN #625 entered a resident's room while the laptop screen remained open, and the facility's charting system was visible. This observation was corroborated by Housekeeper #627, who was present in the hallway at the time of the observation.At 9:55 A.M., RN #625 returned to the medication cart to prepare medication for another resident. Before leaving the cart, RN #625 minimized the charting system window, but the laptop remained open and was not secured. During this time, Resident #2 was observed ambulating through the hall near the unattended medication cart. At 9:58 A.M., RN #625 returned to the cart, and the laptop was still open and accessible.An interview conducted with RN #625 on 04/13/2026 at 9:58 A.M. confirmed that the laptop remained open during the observed period, allowing access to the facility's charting system. RN #625 stated that the expected practice is to minimize the charting system window and fold the laptop screen down when stepping away from the medication cart. RN #625 confirmed that this practice was not followed during the observed timeframe.An interview conducted with the Administrator and Director of Nursing (DON) on 04/14/2026 at 8:40 A.M. revealed that the facility did not have a formal written policy addressing laptop security when staff walked away from the medication cart. Both the Administrator and DON confirmed that the expectation is for nursing staff to minimize the charting system window and close the laptop screen sufficiently to prevent visibility to individuals passing by.This deficiency represents non-compliance investigated under Complaint Number 2615959.

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