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

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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 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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide assistance with completing activities of daily living, which included shaving. This affected one (Resident #55) of two residents reviewed for activities of daily living. The facility census was 44 residents.Findings include:Resident #55 was admitted to the facility on [DATE] and had diagnoses that included atrial fibrillation, diabetes mellitus, traumatic brain injury, lymphedema, and sleep apnea.Review of the Brief Interview for Mental Status (BIMS) Evaluation dated 04/10/26 revealed the resident was cognitively intact. Review of the functional assessment dated [DATE] revealed Resident #55 required substantial or maximal assistance with shower and bathe self.Review of Resident #55's baseline plan of care dated 04/08/26 revealed a goal to achieve and maintain maximum Activities of Daily Living (ADL) functional potential with interventions that included providing assistance to ensure safe completion of ADL tasks.Review of Resident #55's medical record revealed no documentation of shaving or shaving refusals.Observation of Resident #55 on 04/13/26 at 9:58 A.M. revealed long stubble to the face.Interview with Resident #55 on 04/13/26 at 9:58 A.M. revealed resident would like to shave but needs assistance. Resident #55 stated facility staff have not assisted him to shave since arrival to facility.Interview with Certified Nursing Assistant (CNA) #521 on 04/14/26 at 2:35 P.M. confirmed Resident #55 had long stubble to the face.Review of the job description, Certified Resident Care Associate,' dated October 2009 confirmed personal nursing care responsibilities included shaving male residents.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to address a resident's hearing aids going missing and put through laundry. This affected one (Resident #3) of one resident reviewed for hearing. The facility census was 44. Findings include:Review of the medical record for Resident #3 revealed an admission date of 12/17/2025. Diagnosis included stage 2 chronic kidney disease, neoplasm of the colon, and depression. Review of the plan of care dated 12/17/25 revealed Resident #3 demonstrates hearing loss. Interventions included to refer to speech therapy for evaluation of need for communication device as appropriate, use hearing aids as indicated, refer to physician to assess for wax buildup and monitor for changes in hearing, refer to audiologist for a hearing evaluation as needed, ensure resident is near the activity leader/speaker during activities and care-giver, use written communication as needed. communicate with resident in a clear, concise manner, increase volume to ensure resident receives the message. Review of Resident #3's Significant Change in Status dated 02/17/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #3 was noted to have adequate hearing with the use of hearing aids. Interview on 04/15/2026 at 12:30 P.M. with the Administrator revealed when there is a reported missing item, she is the person who is responsible for following up with these reports. Per the missing item log, there has been no reported concerns related to Resident #3 missing her hearing aids or them being damaged while going through the laundry. Interview on 04/16/2026 11:33 A.M. with Resident #3 revealed she had reported to one of the staff members that she could not locate her hearing aids and though they may have been sent to laundry. Resident #3 claimed that a laundry staff member did fine one hearing aid that had accidently been washed and returned it to her. It appeared stretched out and did not work. The second hearing aid could not be located. Resident #3 claimed that a staff member did come to her room yesterday to follow up on the damaged hearing aids and asked her if she would like to schedule an appointment to get new ones. Residents #3 claimed she did want to get new hearing aids but was worried about how the cost would be covered and voiced that with her cancer diagnosis, she was not sure if it was worth making bills to be paid by her family if she may not be able to use them very long. Interview on 04/16/2026 at 11:00 A.M. with Environmental Services Assistant (ESA) #626 revealed when a resident had a personal belonging that gets laundered and it was not supposed to, they will return the item to that resident if they can or place it on the shelf in the clean laundry room for safe keepings and then send out a message to all staff notifying them that an item was located with no name and for everyone to ask around. Claimed that if the items look to be damaged, they will tell their manager and that person will follow up from there. Most of the time, if the item was damaged or not, they will notify the manger if an item goes through the laundry and was not supposed to. [NAME] claimed that they try to search all personal clothing that comes through, but they are very busy and most of the time it's just a quick pat down. ECA #626 claimed that she could recall Resident #3's hearing aid was sent through the laundry about 6 weeks ago. She found the hearing aid and took it to the resident but only found one. Claimed she did not know if the hearing aid still worked or not. ESA #626 claimed she could not recall if she told her manager but normally, they tell the manager about everything that goes through laundry that was not clothing. Interview 04/16/2026 at 11:10 A.M. with Environmental Services Supervisor (ESS) #311 revealed they had no knowledge of Resident #3's hearing aid going through the laundry, being damaged, or that one was still missing. ESS #311 claimed that when they have an item go through laundry that is damaged, she will report it to the Administrator and then they will replace the missing item. They do not officially use a log or report form for incidences like this; they just keep the receipt for the item replaced. Interview on 04/16/2026 at 12:50 P.M. with Director of Social Services #410 revealed she had no knowledge of Resident #3 missing one of her hearing aids nor was she aware that the located hearing aid was damaged.

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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, observations, and interviews, the facility failed to accurately assess pressure ulcers for Resident #9. This affected one resident (#9) of the three residents reviewed for pressure ulcers. The facility census was 44.Findings include:Review of the medical record for Resident #9 revealed an admission date of 12/21/24 with diagnoses of but not limited to functional quadriplegia, unspecified severe protein-calorie malnutrition, lymphedema, pressure ulcer of right hip, and non-pressure ulcer of other part of right foot limited to breakdown of skin. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Additionally, the MDS revealed Resident #9 was dependent on staff for showers, toileting hygiene, and lower body dressing. Resident #9 was at risk for pressure ulcers, but had non-surgical dressings being applied other than to feet. Resident #9 had no psychosis, no verbal or physical behaviors and no rejections of care.Review of Resident #9's wound notes dated 01/29/26 revealed the resident had a wound to the right ischial tuberosity (lower buttocks). The wound was documented as an abrasion measuring 4 centimeters (cm) in length by 2 cm by width, with no depth noted. The skin was red. Review of Resident #9's wound management detail report dated 02/11/26 revealed the wound to the right ischial tuberosity was an abrasion measuring 3.7 cm by 0.9 cm. The skin was pink, yellow, red, and the dressing was saturated with 50 percent (%) of wound slough in the middle and the outer edges had some epithelial (first layer of skin) tissue. Review of hospitalization notes dated 03/04/26 to 03/08/26 revealed Resident #9 arrived at the outside hospital with a stage two pressure injury. Review of Resident #9's wound management detail report dated 04/08/26 revealed the wound to the right ischial tuberosity was an abrasion measuring 1.8 cm in length by 0.4 cm in width. The skin color was pink and red.Review of Resident #9's wound management detail report dated 04/14/26 revealed the wound to the right ischial tuberosity was changed to pressure ulcer in gluteal fold right ischial tuberosity measuring at 4 cm in length by 2 cm in width. The drainage was serosanguineous (pale red to pink, thin, and watery), moderate amount with slough. The comments stated the wound was previously an abrasion but has changed to a pressure ulcer.Observation on 04/14/26 at 12:21 P.M. of Assistant Director of Health Services (ADHS) #210 complete wound dressing change for Resident #9 revealed Resident #9 was placed on her left side, and the old dressing to her right buttocks was removed. ADHS #210 cleaned the wound bed with normal saline and a gauze. The wound appearance was red, and about the size of the bottom of an eight-ounce cup and had an opening to the lower right side of the wound which was about the size of a dime with yellow exude covering it. ADHS #210 removed the exude from the open dime sized area and subcutaneous tissue was visible. During the dressing change, the Director of Health Services stated the wound was documented as an abrasion, but at this stage she is unable to tell what the wound is, then she stated the wound was a pressure injury. ADHS #210 stated the wound is an unstageable pressure injury as this is the first time he had noticed slough to it.Interview on 04/14/26 at 12:57 P.M. with ADHS #210 revealed he documented last week that the wound was pink and red and had epithelial tissue and was red and open in the middle. ADHS #210 viewed a picture of pressure injury stage two and stage three and stated the wound last week looked more like the picture of the pressure injury stage three. Additionally, ADHS #210 stated the wound had gotten worse since last week. Furthermore, ADHS #210 reviewed the discharge paperwork from Resident #9's hospital admission dated 03/04/26 to 03/08/26 and verified the hospital notes revealed right ischial tuberosity stage two pressure ulcer for Resident #9 on 03/04/26. Interview on 04/14/26 at 1:39 P.M. with the Director of Health Services revealed she only looked at resident wounds if ADHS #210 asked her to or he had questions. Director of Health Services stated she did not know the wound had been present and ongoing since 01/29/26. Director of Health Services reviewed the hospital paperwork dated 03/04/26 and acknowledged the hospital had documented Resident #9 had a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injury stage two.Interview on 04/14/26 at 3:58 P.M. with Medical Director revealed he was not aware of a pressure injury in January 2026 for Resident #9. Medical Director stated he was not a wound expert and relied on ADHS #210's assessment and recommendations for wounds in the facility.Interview on 04/16/26 at 8:15 A.M. with Resident #9 revealed the wound to the right buttocks had been there for a long time and kept re-opening. Review of the facility policy, Pressure/Statis/Arterial/Diabetic Wound Guidelines, dated 04/09/25 revealed the purpose of the policy is to provide weekly documentation guidelines of wound measurements and condition. Documentation description of the wound should include length, width, depth, exudates, color, odor, wound margins, surrounding tissue, and tunneling and/or undermining if applicable. Additionally, the facility policy Pressure/Statis/Arterial/Diabetic Wound Guidelines dated 04/09/25 revealed re-assessment/measurement weekly or with significant change in wound noting current treatment, medical interventions provided, and comments as needed in progress notes and wound management or with follow up weekly in wound zoom.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to use a Hoyer lift (a mechanical device used to transfer individuals with limited mobility) during a resident transfer as per care plan resulting in a fall without injury. This affected one (Resident #15) of five residents reviewed for accidents. The facility census was 44 residents.Findings include:Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] and had diagnoses that included repeated falls, need for assistance with personal care, and muscle weakness (generalized).Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was cognitively intact, required substantial or maximal assistance for shower/bathe self, and was dependent for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer.Review of the care plan dated 03/25/26 revealed Resident #15 was dependent assist with Hoyer lift for transfers.Review of the late entry occurrence progress note entered 04/02/26 and dated 03/29/26 revealed Resident #15 had a fall on 03/29/26. Further review revealed Resident #15 was lowered to the floor and complained of pain rated 5/10 at that time after the fall.Review of Resident #15's fall care plan revealed an intervention to educate staff member to utilize Hoyer for all transfers related to therapy recommendation implemented 03/29/26.Review of the Interdisciplinary Team (IDT) note dated 04/09/26 revealed Resident #15 was being transferred by two staff members and, due to weakness and instability, had to be lowered to the floor. The post fall intervention was to educate the staff member to use the Hoyer lift for all transfers related to therapy recommendations.Interview with Resident #15 on 04/13/26 at 1:48 P.M. revealed the resident had a fall trying to go to the shower with staff.Interview with Registered Nurse (RN) #322 on 04/15/26 at 7:54 A.M. revealed the RN was told in shift change report that Resident #15 fell while transferring to the shower. Resident #15 was assisted to the floor by staff members performing the transfer after the resident's knees buckled.Interview with the Director of Health Services on 04/15/26 at 9:45 A.M. confirmed that two staff members transferred Resident #15 without using a Hoyer lift which resulted in a fall without injury. Further interview with the Director of Health Services revealed that the post fall intervention was to educate the staff member to use the Hoyer lift for all transfers related to therapy recommendations; however, the Director of Health Services confirmed formal education was not provided, and the staff member provided self-education on the importance of following the care plan. Interview with Occupational Therapist (OT) #632 on 04/15/26 at 12:23 P.M. confirmed Resident #15 required a Hoyer lift for transfer at the time of the fall.Review of the policy, ?Comprehensive Care Plan Guideline,' effective 05/22/18 and reviewed 12/10/25 revealed the comprehensive care plan serves to ensure appropriateness of services and communication that will meet the resident's needs.

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	725000	A. Building B. Wing	04/16/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and review of insulin pen directions, the facility failed to ensure the medication error rate did not exceed five percent (%). The facility had two medication errors of 38 opportunities for an error rate of 5.41%. This affected one Resident (#11) of four residents observed for medication administration. The facility census was 44 residents.Findings include:Review of the medical record for Resident #11 revealed an admission date of 04/02/26 and diagnoses of but not limited to encounter for orthopedic aftercare following surgical amputation of right toe, osteomyelitis, sepsis due to methicillin susceptible staphylococcus aureus, cellulitis of right lower limb, type two diabetes mellitus with foot ulcer, constipation, hypertension, and hyperlipidemia.Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Resident #11 received insulin injections.Review of an order for Resident #11 dated 04/03/26 for Lantus Solostar U-100 insulin (insulin glargine) insulin pen; 100 unit per milliliter (mL) (three mL); amount 32 units; subcutaneous once a day.Review of an order for Resident #11 dated 04/03/26 for polyethylene glycol 3350 powder: 17 gram per dose once a day.Observation on 04/14/26 at 8:36 A.M. of Registered Nurse (RN) #625 administering Lantus 32 units to the left lower abdomen of Resident #11, revealed RN #625 did not prime the insulin pen. Additionally, RN #625 administered polyethylene glycol 3350 powder 17 gram per dose in five ounces of water. Interview on 04/14/26 at 8:43 A.M. with RN #625 verified she did not prime the Lantus pen prior to administration of the Lantus. RN #625 stated she did know the Lantus pen must be primed with two units of insulin pushed through the needle, then dial the prescribed dose of insulin. Additionally, RN #625 stated she gave the polyethylene glycol 3350 powder 17 gram per dose in five ounces of water instead of the full eight ounces, which is stated on the package.Review of the Lantus Solostar Pen instruction leaflet under step three states Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that the pen and needle work properly and removing air bubbles. Select a dose of two units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the needle cap and discard it. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way n. Check of insulin comes out of the needle tip. Check the dose window shows 0 following the safety test.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and insulin pen instructions, the facility failed to prevent a significant medication error when the nurse did not prime the insulin pen prior to administration. This affected one resident (#11) of four residents observed for medication administration. The facility census was 44 residents.Findings include:Review of the medical record for Resident #11 revealed an admission date of 04/02/26 and diagnoses of but not limited to encounter for orthopedic aftercare following surgical amputation of right toe, osteomyelitis, sepsis due to methicillin susceptible staphylococcus aureus, cellulitis of right lower limb, type two diabetes mellitus with foot ulcer, constipation, hypertension, and hyperlipidemia.Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Resident #11 received insulin injections.Review of an order for Resident #11 dated 04/03/26 for Lantus Solostar U-100 insulin (insulin glargine) insulin pen; 100 unit per milliliter (mL) (three mL); amount 32 units; subcutaneous once a day.Observation on 04/14/26 at 8:36 A.M. of Registered Nurse (RN) #625 administering Lantus 32 units to the left lower abdomen of Resident #11 revealed RN #625 did not prime the insulin prior to administration. Interview on 04/14/26 at 8:43 A.M. with RN #625 verified she did not prime the Lantus pen prior to administration of the Lantus. RN #625 stated she did know the Lantus pen must be primed with two units of insulin pushed through the needle, then dial the prescribed dose of insulin. Review of the Lantus Solostar Pen instruction leaflet under step three states Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that the pen and needle work properly and removing air bubbles. Select a dose of two units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the needle cap and discard it. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way n. Check of insulin comes out of the needle tip. Check the dose window shows 0 following the safety test.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the residents received necessary and timely dental services. This affected one (Resident #5) of one records reviewed for dental services. The facility census was 44 residents.Findings include:Review of Resident #5's medical record revealed the resident was admitted [DATE] and had diagnoses that included acute and chronic respiratory failure, type 2 diabetes mellitus, dysphagia, need for personal assistance with care, and unspecified dementia. Review of Resident #5's Brief Interview for Mental Status (BIMs) dated 01/30/26 revealed the resident had severe cognitive impairment.Review of Resident #5's Minimum Data Set, dated [DATE] revealed the resident used a wheelchair for mobility. Resident #5 was dependent for self-care and mobility.Review Resident #5's care plan dated 02/06/26 revealed the resident was at risk for malnutrition related to no natural teeth (edentulous) with a full upper denture only.Review of the progress note dated 02/14/26 revealed Resident #5 lost several teeth while eating lunch. Further review of the progress note revealed the top left anterior area of Resident #5's mouth was examined and scant bleeding was noted. Further review of the progress note revealed the teeth resembled a bridge that had become detached.Review of the late entry progress note entered 02/17/26 and dated 02/16/26 revealed a dental appointment was scheduled on 02/16/26 for 03/09/26.Review of Resident #5's progress notes from 03/09/26 to 04/05/26 revealed no documentation of the dental appointment or any follow up of the dental appointment.Review of the progress note dated 04/05/26 and authored by Transportation Associate #320 revealed the granddaughter requested an update on Resident #5's dental appointment from March. Further review of the progress note revealed the dental office was contacted regarding the dental referrals, and Transportation Associate #320 was informed that the referrals would need to be contacted. Further review of the progress notes revealed this information was relayed to the Director of Health Services and the Assistant Director of Health Services #210 at that time.Phone interview with Resident #5's representative on 04/13/26 at 11:52 A.M. revealed the resident lost her dental bridge. Further interview revealed the resident representative did not receive any communication regarding the outcome of the dental appointment or follow up until speaking with the facility driver.Review of the progress note authored by Director of Social Services #410 and dated 04/13/26 at 11:56 A.M. revealed referrals to the dental offices were contacted.Interview with Speech Language Pathologist (SLP) #532 on 04/14/26 at 11:21 A.M. revealed Resident #5 was discharged from speech therapy on 02/11/26. Further interview revealed, at that time, Resident #8 had difficulty swallowing but no complaints of mouth pain. Resident #5 did not have dentures but possibly had a partial and many of her teeth were missing. Resident #5 consumed a pureed diet with honey thick liquids. Resident #5 had restorative dining after discharge from speech therapy. Interview with the Director of Social Services #410 04/14/26 at 3:56 P.M. revealed the dentist's office was unable to treat Resident #5 at the initial appointment and referrals were contacted. Interview 04/14/26 at 4:04 P.M. with Life Enrichment Director #212, who oversees Transportation Associates, revealed that Transportation Associate #320 was working with the Assistant Director of Health Services #210 to schedule the dental appointment for Resident #5.Interview with Assistant Director of Health Services #210 on 04/14/26 4:08 P.M. revealed the Assistant Director of Health Services was working on dental referrals for Resident #5 but was unable to provide additional information on scheduling the dental referrals. Interview with the Director of Health Services #210 on 04/14/26 4:08 P.M. revealed the referrals were sent for the dental appointment and would provide documentation the referrals were sent.Interview with dietician on 04/15/26 at 10:34 A.M. revealed the dietician was not aware Resident #5 had lost teeth and did not evaluate this as part of the nutritional assessment.Interview with Transportation Associate #320 on 04/15/26 at 10:35 A.M. revealed Resident #5 was transported to a dental appointment on 03/09/26. Further interview revealed the dentist attempted to examine Resident #5 but was unable so referrals (continued on next page)

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

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were made to other dentists. Resident #5 did not receive discharge paperwork from the dentist's office. Transportation Associate #320 revealed the dental referrals were supposed to call to schedule the dental appointment. Transportation Associate #320 revealed normally the Transportation Associate would relay information to the nurse upon resident return regarding follow up, but no information was provided to nursing staff for Resident #5 since the referrals were supposed to call to arrange the appointment. Interview with the Director of Health Services on 04/15/26 at 11:26 A.M. revealed the dental referrals may have been contacted on 03/14/26 but revealed that this was not documented in the medical record.Review 04/15/26 at 11:30 A.M. of a calendar for March 2026 revealed 03/14/26 was a Saturday.Interview with the Director of Health Services on 04/16/26 at 8:26 A.M. revealed, if a resident returns from an appointment without discharge paperwork, nursing staff should call the office and follow up the day of the appointment. Further interview with the Director of Health Services confirmed the dental follow up documented in the medical record was not timely and revealed the dental appointment follow up was timely because the referrals were contacted sooner than what the documentation reflects.E-mail sent by Executive Director on 04/15/26 at 6:36 P.M., after exiting the facility, requested to update information regarding the dental services for Resident #5. Further review of the e-mail revealed the facility wished to submit phone logs demonstrating outbound calls to the family representative the week of 03/09/26. Review of the phone log on 04/18/26 at 08:48 A.M. revealed three outbound calls on 03/10/26, one outbound call on 03/12/26, and one outbound call on 03/27/26. Further review of the call log is silent for indication of what was communicated during the outbound calls.

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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 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 observation and staff interview, the facility failed to ensure staff followed infection control protocols during incontinence care. This affected one (Resident #5) of one resident observed for incontinence care. The facility census was 44.Review of Resident #5's medical record revealed the resident was admitted [DATE] and had diagnoses that included acute and chronic respiratory failure, type 2 diabetes mellitus, urinary tract infection, need for personal assistance with care, and unspecified dementia.Review of Resident #5's Brief Interview for Mental Status (BIMs) dated 01/30/26 revealed the resident had severe cognitive impairment.Review of Resident #5's Minimum Data Set, dated [DATE] revealed the resident used a wheelchair for mobility and was dependent for toileting hygiene. Resident #5 was always incontinent of bowel and bladder and had not had a trial of a toileting program.Review Resident #5's care plan dated 02/06/26 revealed the resident experienced episodes of incontinence related to immobility and impaired cognition.Observation on 04/14/26 at 11:34 A.M. of incontinence care for Resident #5 provided by Certified Nursing Assistant (CNA) #521 and the Director of Health Services. The Director of Health Services and CNA #521 performed hand hygiene and put on gloves. The Director of Health Services explained the procedure to Resident #5. The Director of Health Services elevated Resident #521's bed. The Director of Health Services removed Resident #5's blankets. CNA #521 removed #5's brief. CNA #5 cleaned Resident #5's perineal area with soap and water. CNA #521 dried Resident #5's peri area with a towel. The Director of Health Services assisted Resident #5 to roll to the left. CNA #521 cleaned the rectal area with soap and water. CNA #521 dried the rectal area with a towel. CNA #521 removed Resident #5's soiled brief. CNA #521 placed a new brief. The Director of Health Services applied barrier cream to Resident #5's buttocks. The Director of Health Services removed gloves, performed hand hygiene, and put on new gloves. CNA #521 repositioned Resident #5 and secured the incontinence brief. CNA #521 attached Resident #5's call light to the pillow. CNA #521 and the Director of Health Services placed pants on Resident #5. CNA #521 and the Director of Health Services pulled Resident #5 up to the head of the bed. CNA #521 and the Director of Health Services repositioned Resident #5 onto her left side. CNA #521 placed a pillow under Resident #5's back. The Director of Health Services floated Resident #5's heels. CNA #521 repositioned Resident #5's covers. CNA #521 lowered Resident #5's bed using the remote. CNA #521 and the Director of Health Services removed gloves and performed hand hygiene.Interview with CNA #521 on 04/14/2026 11:46 A.M. confirmed gloves were not removed and hand hygiene was not performed after completing incontinence care for Resident #5 and prior to touching other items in the resident's room.