STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365026	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexner Heritage House	1151 College Avenue Columbus, OH 43209

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 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 observation, medical record review and interviews, the facility failed to ensure Resident #29 and #71 was treated in a dignified manner. This affected two residents (#29 and #71) of three residents reviewed for dignity. The facility census was 72. Findings Include: 1. Review of the medical record for Resident #29 revealed an initial admission date of 06/02/25 with the diagnoses including but not limited to encounter for surgical aftercare following surgery on the digestive system, infarction of spleen, activated protein C resistance, extranodal marginal zone B-cell lymphoma of mucosa associated lymphoid tissue, asthma, chronic kidney disease, hypertension, edema, atrial fibrillation, gout, sarcoidosis, hyerplipidemia, benign prostatic hyperplasia with lower urinary tract symptoms, presence of urogenital implants and other diseases of spleen. Review of the resident admit/readmit screener dated 06/02/25 revealed the resident had no cognitive deficit. The assessment indicated the resident was admitted to the facility with an indwelling urinary catheter. Review of the resident's monthly physician orders for June 2025 identified orders dated 06/02/25 change Foley catheter size 15 FR with 10 milliliter (ml) balloon as needed for clogged or dislodged, Foley catheter care every shift, urinary drainage bag to have a cover over it every shift, monitor urinary output every shift, Foley catheter to straight drain, check every shift, change urinary drainage bag every two week and as needed, may use leg bag when out of bed, Foley leg strap to secure tubing and monitor skin at strap location every shift, empty indwelling catheter collection bag every eight hours. On 06/04/25 at 10:52 A.M., an observation of Resident #29 revealed the resident's indwelling urinary catheter catheter collection bag was visible from the hallway with clear yellow urine visible. Further review revealed no evidence the resident had a privacy bag for the indwelling urinary catheter collection bag in his room. On 06/04/25 at 10:54 A.M., an interview with Licensed Practical Nurse (LPN) #133 verified the resident's indwelling urinary catheter collection bag was not contained in a privacy bag and urine was visible from the hallway. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record Resident #71 revealed an initial admission date of 08/18/23 with the latest readmission date of 03/25/24 with the diagnoses including but not limited to acute transverse myelitis in demyelinating disease of central nervous system, atrial fibrillation, neuromuscular dysfunction of bladder, peripheral vascular disease, hypertension, chronic pain, disease of spinal cord, anemia, depression, dysphagia, insomnia and quadriplegia. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter. Review of the resident's monthly physician orders for June 2025 identified orders dated 08/19/23 change Foley catheter size 18 FR with 30 milliliter (ml) balloon every month and as needed, Foley catheter care every shift, urinary drainage bag to have a cover over it every shift, monitor urinary output every shift, Foley catheter to straight drain, check every shift for Foley catheter maintenance, change urinary drainage bag every two week and as needed, may use leg bag when out of bed, Foley leg strap to secure tubing, monitor skin at strap location every shift, 11/05/23 Foley catheter to be changed every 28 days, 12/16/24 flush/irrigate suprapubic catheter daily with 30 ml of sterile saline daily and as needed. On 06/04/25 at 9:43 A.M., an observation of Resident #71 revealed he was up in his power wheelchair with a blanket over his legs coming out of his room. Further observation revealed the resident's indwelling urinary catheter collection bag was resting on the padded footrest of the wheelchair with no privacy cover and light yellow urine was visible while the resident was mobilizing down the hallway. On 06/04/25 at 9:45 A.M., an interview with Licensed Practical Nurse (LPN) #127 verified the resident's indwelling urinary catheter collection bag was not contained in a privacy bag and urine was visible as the resident was mobilizing down the hallway. This deficiency represents non-compliance investigated under Complaint Number OH00165299.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to notify Resident #61's primary care physician of an unstageable deep tissue injury (DTI) (Persistent non-blanchable deep red, maroon or purple discoloration, intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue). This affected one resident (#61) of three residents reviewed for pressure ulcers. The facility census was 72. Findings Include: Review of the medical record for Resident #61 revealed an initial admission date of 09/28/24 with the diagnoses including but not limited to COPD, symbolic dysfunction, nicotine dependence, pressure induced deep tissue damage to left heel, dysphagia, hyperlipidemia, hypertension, retention of urine, history of traumatic brain injury, constipation and gout. Review of the progress note dated 11/02/24 at 7:31 P.M. revealed a CNA notified the nurse the resident had a dark painful mark on his left heel. The nurse observed what appeared to be an 8.0 centimeter (cm) unstageable pressure area with intact skin. Management and the resident power of attorney (POA) was notified of the area. Review of the weekly skin and wound evaluation dated 11/02/24 revealed the resident was found to have an unstageable pressure ulcer to his left heel that was not present on admission. The wound measured 4.2 centimeters (cm) by 2.8 cm with slough and/or eschar present. The assessment had no description of the wound. Review of the medical record revealed no treatment or intervention implemented for the unstageable DTI pressure ulcer to the resident's left heel. Further review revealed no documented evidence the resident's physician was made was aware of the unstageable DTI to the resident's left heel at the time of discovery. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was at risk for skin breakdown and had one unstageable pressure ulcer not present on admission. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care and applications of ointments/medications other than to feet. On 06/05/25 at 2:20 P.M., an observation of Licensed Practical Nurse (LPN) #146 provided the physician ordered treatment to the unstageable pressure injury to the resident's left heel. On 06/05/25 at 3:00 P.M., an interview with the Director of Nursing (DON) verified the resident's primary care physician was not notified of the unstageable DTI to the resident's left heel at the time of discovery on 11/02/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Notification and Reporting of Changes in Health Status, Illness, Injury and Death of a Resident, last revised 03/28/25 revealed the nursing home administrator or the administrator's designee shall immediately inform the resident, consult with resident's physician or other licensed health professional acting within the applicable scope of practice, or the medical director if the attending physician or other licensed health professional acting within the applicable scope of practice is not available, and notify the resident's sponsor or authorized representative, with the resident's permission and other proper authority in accordance with state and local laws and regulation when there is a significant change in the resident's physical, mental or psycho-social status such as a deterioration in health, mental or psycho-social status in either life-threatening conditions or clinical complications.

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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 closed medical record review, interview and facility policy review, the facility to ensure the required information was provided to the receiving provider and the transfer was documented in the resident's medical record. This affected one resident (#42) of three residents reviewed for transfers. The facility census was 72. Findings Include: Review of the closed medical record for Resident #42 revealed an initial admission date of 12/02/22 with the diagnoses including but not limited to dementia with behavioral disturbances, symbolic dysfunctions, abnormal posture, violent behavior, repeated falls, diabetes mellitus, hypertension, hyperlipidemia, osteoporosis, overactive bladder, obesity and depression. The resident was discharged to an acute care hospital on [DATE]. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the progress note dated 06/03/25 at 12:29 P.M. revealed the nurse assessed the resident and she was not responding to commands. The nurse obtained vital signs. The resident's son was at bedside and requested the resident be sent to the local emergency room (ER) for an evaluation. The nurse obtained the order. Further review of the medical record revealed no disposition of the resident's transfer from the facility or transferring information including physician responsible for the resident's care, resident representative information, advance directives, alls special instructions or precautions for ongoing care, comprehensive care plan goals, all other necessary information to ensure a safe and effective transition of are. On 06/05/25 at 3:00 P.M., an interview with the Director of Nursing (DON) verified the resident had no documented evidence the receiving facility received the required information to ensure a safe and effective transition of care and the transfer was not documented in the resident's medical record. Review of the facility policy titled, Admission/Transfer/Discharge Criteria Policy, last revised 02/25 revealed to ensure a safe transition of care, documentation of all discharge/transfer will include but not limited to the following, reason for discharge/transfer by the physician, physician responsible for the resident's care, resident representative information, advance directives, alls special instructions or precautions for ongoing care, comprehensive care plan goals and history of present illness and pertinent past medical/surgical history. This deficiency represents non-compliance investigated under Complaint Number OH00165908.

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F 0686 Level of Harm - 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 observation, record review, review of wound notes, facility policy review and interview, the facility failed to assess, monitor, and implement a comprehensive and individualized prevention program to prevent the development of avoidable pressure ulcers and failed to ensure adequate interventions were in place to prevent new pressure injuries for Resident #61. Additionally, the facility failed to comprehensively assess, monitor and implement a treatment for Resident #80's unstageable (full-thickness skin and muscle loss, with slough or eschar obstructing the wound bed making it impossible to determine the true depth of the ulcer.) pressure ulcer on admission to the facility for more than two days. Actual harm occurred on 11/02/24 when Resident #61 who utilized a wheelchair and was dependent on staff for bed mobility developed an unstageable pressure ulcer to the left heel as a result of propelling himself in his wheelchair with no shoes on and/or no off-loading of the left heel while in bed. The facility failed to implement comprehensive and individualized interventions to prevent the development of the pressure ulcer and failed to properly assess, monitor, or implement skin interventions for the unstageable pressure injury until 11/07/24. This affected two residents (#61 and #80) of three residents reviewed for pressure ulcers. The facility census was 72. Findings Include: 1. Review of the medical record for Resident #61 revealed an initial admission date of 09/28/24 with diagnoses including chronic obstructive pulmonary disease, nicotine dependence, pressure induced deep tissue damage to left heel, dysphagia (difficulty swallowing), hypertension, retention of urine, history of traumatic brain injury, and constipation. Review of the resident's admit/readmit screener dated 09/28/24 revealed the resident was admitted to the facility with no skin issues. Review of the resident's Braden scale dated 09/28/24 revealed the resident was at risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 09/30/24 and last revised on 05/20/25 revealed the resident had a potential for development of pressure injuries and other skin impairment related to acute on chronic health conditions, impaired strength and endurance, generalized weakness, lack of coordination, debility, recent acute kidney infection, anemia, history of right radial fracture and right hip fracture/surgery, anticoagulant injections, potential edema to right lower extremity and had a pressure injury to his left heel. Interventions included administer treatments/preventative measures as ordered, monitor for side effects and effectiveness, notify physician with any concerns, assist/encourage resident to turn/reposition as needed, as ordered/tolerated, monitor areas of skin impairment for signs/symptoms of infections, notify physician as needed, assist with maintaining skin clean and dry daily, provide local care to areas of skin impairment as ordered, Dietician will evaluate nutritional status and make recommendations as needed, encourage good food and fluid intake as needed to promote nutritional status, encourage, assist as needed/ tolerated to float heels when in bed daily, monitor skin with daily cares for redness, blisters, dark discolorations, skin pep to heels as ordered, the resident has increased risk of bruising related to anticoagulant use. Monitor/Document/Report all new instances of bruising, weekly skin assessment as scheduled and wound physician/nurse will evaluate and treat as ordered. On 11/07/24, Prevalon boots as ordered were added. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident was at risk for skin breakdown and had no unhealed pressure ulcers. The assessment indicated the facility implemented a pressure-reducing device to the bed/chair and application of ointments/medication other than to feet. Review of the progress note dated 11/02/24 at 7:31 P.M. revealed a certified nursing assistant (CNA) notified the nurse the resident had a dark painful mark on his left heel. The nurse observed what appeared to be an 8. 0 centimeter (cm) unstageable pressure area with intact skin. Management and the resident's power of attorney (POA) were notified of the area. Review of the weekly skin and wound evaluation dated 11/02/24 revealed the resident was found to have an unstageable pressure ulcer to his left heel that was not present on admission. The wound measured 4.2 centimeters (cm) by 2.8 cm with slough and/or eschar present. The assessment had no description of the wound. Review of the medical record revealed no treatment or intervention implemented for the unstageable pressure injury to the resident's left heel. Further review revealed no documented evidence the resident's physician was made aware of the unstageable DTI to the resident's left heel at the time of discovery. Review of the weekly wound physician note dated 11/06/24 revealed the unstageable wound to the resident left heel measured 4.2 cm by 6.2 cm with no exudate and described as an intact purple/maroon discoloration. The treatment to paint with betadine daily was implemented. Review of the late entry progress note dated 11/07/24 at 8:05 A.M. revealed the resident was noted to have a deep purple bruise to the left heel upon a skin assessment. The resident was unaware of how the bruise occurred. The note indicated wound physician was to follow. Intervention of Prevalon boots to both heels was implemented. The family as well as the physician were made aware of the area. Review of the residents' November 2024 Treatment Administration Record (TAR) revealed on 11/07/24 the treatment of paint left heel with betadine daily for wound care was initiated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the late entry interdisciplinary team (IDT) progress note dated 11/08/24 at 9:49 A.M. revealed the team met and discussed the area to the resident's left heel and the intervention of Prevalon boots in place when in bed was appropriate. Weekly wound physician assessments were completed on 11/13/24, 11/20/24, 11/27/24, 12/04/24, 12/11/24, 12/18/24, 12/25/24, 12/30/24, 01/08/25, 01/15/25, 01/22/25, 01/29/25, 02/05/25, 02/12/25, 02/19/25, 02/26/25, 03/05/25, 03/12/25, 03/19/25 and 03/26/25 which included measurements of the ulcer each week and status of the ulcer (i.e. improving and/or at goal). Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was at risk for skin breakdown and had one unstageable pressure ulcer not present on admission. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care and applications of ointments/medications other than to feet. Weekly wound physician assessments were completed on 04/02/25 and 04/09/25 with wound measurements included. Review of the weekly wound physician progress note dated 04/16/25 revealed the unstageable pressure ulcer to the resident's left heel measured 1.8 cm by 2.4 cm and described as 100% adherent thick devitalized necrotic tissue with a moderate amount of serous exudate. The facility determined the wound had improved (although there was the presence of 100% adherent thick devitalized necrotic tissue and a moderate amount of serous exudate which had not been present during the previous weeks assessments). The treatment was changed to cleanse the wound apply Mesalt and cover with gauze island with border dressing daily and as needed if saturated, soiled or dislodged at this time. Weekly wound physician assessments were completed on 04/23/25 (1.4 cm by 0.2 cm and described as 30% thick adherent devitalized necrotic tissue, 20% slough, 30% granulation tissue and 20% dermis, subcutaneous or tendon with a moderate amount of serous exudate) and 04/30/25 (1.3 cm by 2.3 by 0.2 cm and described as 20% thick adherent devitalized necrotic tissue, 20% slough, 40% granulation tissue and 20% dermis, subcutaneous or tendon with a moderate amount of serous exudate). Review of the weekly wound physician progress note dated 05/07/25 revealed the unstageable pressure ulcer to the resident's left heel measured 0.9 cm by 1.4 cm by 0.2 cm and described as 100% granulation tissue with a moderate amount of serous exudate. The facility determined the wound had improved. Weekly wound physician assessments were completed on 05/14/25, 05/21/25, 05/28/25 and 06/04/25 with measurements and the status of the ulcer documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's monthly physician orders for June 2025 revealed the following orders: an order dated 09/28/24 to assist resident to float heels as tolerated every shift for prevention, assist resident to turn and reposition every two hours as tolerated every shift for prevention and skin prep to bilateral heels every shift. On 11/07/24 Prevalon boots were ordered to be worn to bilateral feet when in bed. On 02/24/25 an order was initiated to complete skin and wound total body assessment weekly on Wednesday day shift. On 04/03/25 an order was received for active liquid protein 30 milliliters (ml) in eight ounces of water or juice for wound healing. On 04/16/25 an order was obtained to monitor left heel for signs/symptoms of infection every shift. On 05/17/25 an order was obtained for skin and wound picture due every day shift on Wednesday until healed and on 05/19/25 a treatment order was obtained to cleanse left heel with wound cleanser, pat dry, apply Mesalt and cover with island dressing daily and as needed for saturation or dislodgement. On 06/05/25 at 11:15 A.M., an interview with Licensed Practical Nurse (LPN) #146 revealed Resident #61 was admitted to the skilled unit (on 09/28/24) and developed the pressure injury (to the left heel) while on the skilled unit. The LPN revealed the resident was then transferred to the long-term care unit located on the first floor with the pressure injury on 10/24/24: however, in report she was told the resident preferred to position his foot with the area of the wound on the bed which resulted in the pressure injury. On 06/05/25 at 2:20 P.M., an observation of LPN #146 provided the physician ordered treatment to the unstageable pressure injury to the resident's left heel. Observation of the wound revealed the wound was the size of a nickel with a pink wound bed and beige edges. The LPN provided the treatment as ordered. On 06/05/25 at 9:25 A.M., an interview with the Director of Nursing (DON) revealed the facility determined the DTI to the resident's left heel was caused by the resident using his feet to propel himself in his wheelchair. Further interview revealed the DON was unsure why the pressure injury was not found until it was an unstageable DTI when the facility nurses had been documenting they were applying skin prep to his bilateral heels every shift (from admission [DATE] through 11/02/24). On 06/05/25 at 3:00 P.M., an interview with the DON verified the unstageable DTI to Resident #61's left heel was first identified on 11/02/24 and a comprehensive assessment, monitoring or treatment was not completed until 11/06/24 when the facility contracted wound physician assessed the wound and implemented offloading interventions and treatment. 2. Review of the closed medical record for Resident #80 revealed an initial admission date of 05/10/25 with diagnoses including metabolic encephalopathy, palliative care, congestive heart failure (CHF), atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease or end stage renal disease, anemia, dysphagia, open wound right lower leg, anxiety disorder, gastrostomy status, tracheostomy status, acute respiratory failure with hypoxia, constipation, diabetes mellitus, end state renal disease, acquired absence of left foot, and insomnia. Review of the hospital Discharge summary dated [DATE] revealed the resident had an unstageable pressure ulcer to his sacrum and right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the admit/readmit screener dated 05/10/25 revealed the resident was admitted to the facility from a specialty select hospital and was dependent on staff for all activities of daily living (ADL). The assessment indicated the resident had no skin issues on admission. Review of the Braden scale dated 05/10/25 revealed the resident was at very high risk for skin breakdown. Review of the plan of care dated 05/12/25 revealed the resident was at risk for skin breakdown and development of pressure injury. Interventions included assist with maintaining skin clean and dry daily, dietician will evaluate nutritional status and make recommendations as needed, encourage good food and fluids intake as needed to promote nutritional status, encourage, assist as needed/tolerated to float heels when in bed daily, monitor skin with daily cares for redness, blisters, dark discoloration, skin prep to heels as ordered, weekly skin assessment as scheduled and wound physician/nurse will evaluate and treat as needed. Review of the resident's physician orders identified orders dated 05/12/25 to cleanse coccyx wound with wound cleanser, pat dry, apply Opti foam border dressing daily, cleanse mid pretibial right cellulitis with wound cleanser, pat dry, cover with non-adherent dressing and wrap with gauze daily, cleanse sacrum with wound cleanser, pat dry, apply Mesalt to wound bed, cover with gauze island dressing daily, assist resident to float heels as tolerated every shift for prevention, alternating air mattress every shift, no fitted sheets, one flat sheet and draw sheet only on air mattress, assist resident to turn and reposition every two hours as tolerated and HydraGuard Moisture Barrier apply topically to peri area and bilateral buttocks every shift and after each incontinence episode. Review of the progress note dated 05/16/25 at 2:10 P.M. revealed the hospice nurse provided skin care to the buttocks and right lower extremity. Review of the skin and wound evaluation dated 05/16/25 which was in progress revealed the resident had an unstageable pressure ulcer to the right heel that was present on admission to the facility. The wound measured 2.7 centimeters (cm) by 1.0 cm. The assessment had no description of the wound. Review of the medical record revealed no documented evidence the resident's unstageable pressure ulcers were comprehensively assessed. Review of the resident's May 2025 Treatment Administration Record (TAR) revealed the resident had no documented treatment to wounds until 05/12/25, two days after the resident's admission to the facility. On 06/05/25 at 3:00 P.M., an interview with the DON verified the unstageable pressure ulcer to the resident's sacrum and right heel were not comprehensively assessed and a treatment was not implemented until 05/12/25 two days after the resident's admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Wound Skin Program, implemented on 03/30/12 and last revised 05/28/25 revealed all residents would be evaluated for specific level of risk for decreased skin integrity on admission and readmission using the Braden Scale. Re-assessment would be done quarterly or whenever the resident shows evidence of significant clinical change or development of an ulcer. The skin team would assess, measure and document all pressure ulcers. A signed physician's order regarding wound treatment must be kept on the resident's chart. The order must be specific and if applicable the order should also have a stop date. The wound nurse/designee would be responsible for the initial assessment of any wound using the Skin and Wound Evaluation form. The physician/nurse practitioner (NP), family, wound care nurse would be notified of new areas. Initial documentation would include specific description of the wound and pertinent history, co-morbidities, nutrition, continence and other contributing factor information. This deficiency represents non-compliance investigated under Complaint Number OH00165908 and Complaint Number OH00165299.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365026	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexner Heritage House	1151 College Avenue Columbus, OH 43209

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 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, medical record review, interview and facility policy review, the facility failed to residents with indwelling medical devices utilized enhanced barrier precautions (EBP) as required. This affected one resident (#39) of three residents reviewed for incontinence. The facility census was 72. Findings Include: Review of the medical record for Resident #39 revealed an initial admission date of 07/26/22 with the latest readmission of 02/10/23 with the diagnoses including but not limited to dementia with behavioral disturbances, dysphagia, chronic pulmonary edema, adult failure to thrive, hepatic failure, gastrostomy status, pressure ulcer of sacral region stage IV, disorders of lung, hypertension, depression, hyperlipidemia and osteoarthritis. Review of the plan of care dated 10/07/22 revealed the resident was prone to alterations in bowel and bladder function related to weakness, decreased mobility, non-ambulatory status, dementia, history of urinary tract infection, incontinence of bowel and bladder and increased risk for constipation related to reduced mobility. Interventions included administer laxatives and stool softeners as ordered, assist with toileting cares, hygiene and clothing management as needed daily, encourage good food and fluid intake as needed to promote bowel and kidney function, evaluate bowel sounds, abdomen for distention and firmness as needed, maintain call light within reach, encourage use for assistance answering promptly daily, monitor number of bowel movements and voids every shift, continent and incontinent daily, monitor urine for color, clarity, foul odor, and changes in level of consciousness and notify physician/nurse practitioner of significant changes in condition. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. On 06/05/25 at 1:35 P.M., an observation of Certified Nursing Assistants (CNA) #193 and #223 provide incontinence care to Resident #39 revealed the staff washed their hands, donned gloves and removed a disposable wipe from the package and cleansed the resident from front to back using a clean disposable wipe with each wipe. The resident was assisted onto her right side and CNA #193 cleansed the resident's rectal area of liquid stool from front to back using a clean disposable wipe with each wipe. The CNA then placed a clean incontinence brief and cloth pad under the resident. The resident was observed to have a indwelling medical device gastric tube to her left mid quadrant of her abdomen. The CNA was not observed wearing a gown during the incontinence procedure. On 06/05/25 at 1:48 P.M., an interview with CNA #193 and #223 verified EBP were not maintained during incontinence care by not utilizing a disposable gown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Review of the facility policy titled, Isolation Precautions Policy, last revised 03/2025 revealed EBP refer to an infection control intervention designed to reduce the transmission of multidrug resistant organisms (MDRO) that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of personal protection equipment (PPE) to donning of gown and gloves during high contact care activities that could expose healthcare worker hands/clothing to MDRO. The follow are considered high contact activities changing briefs or assisting with toileting. EBP are indicated for residents with any of the following indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomies.