| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365195 | A. Building<br>B. Wing | 04/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McNaughten Pointe Nursing and Rehab | 1425 Yorkland Road<br>Columbus, OH 43232 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538<br><br>Based on record review, review of resident council minutes, review of audio/video footage, observation and interview the facility failed to ensure a resident was afforded privacy and dignity during care. This affected one resident (#46) of four residents reviewed for dignity. The facility census was 126.<br><br>Findings include:<br><br>Review of Resident #46's medical record revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, dependence on a ventilator, dysphagia following cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction unspecified side.<br><br>Review of Resident #46's admission Minimum Data Set assessment dated [DATE] revealed the resident was rarely or never understood and was dependent on staff for all activities of daily living.<br><br>Review of audio/video footage taken from Resident #46's room via an audio/video monitoring camera that was placed in the resident's room with the video time stamp dated 03/17/25 at 2:36 P.M. revealed the resident to be lying in her bed and receiving care from two unidentified Certified Nursing Assistants (CNAs). Resident #46 was naked and exposed in front of a window with the window blind open at the time.<br><br>On 04/07/25 at 1:07 P.M. interview with Resident Representative #100 revealed concern with the resident not being provided privacy during care including not closing the window blind. Resident Representative #100 stated there were children that lived next door and she was afraid they could see into the resident's room through the open blind while she received care.<br><br>On 04/07/25 at 1:15 P.M. observation of the resident's room and window revealed the resident was lying in bed and the blind was open. The resident's room was on the ground floor and passersby could see into the resident's room if the blind was not closed.<br><br>In an interview on 04/07/25 at 3:23 P.M. the Director of Nursing reviewed the video and confirmed Resident #46 was unclothed and exposed in front of a window with the window blind open at the time. The DON was unable to identify the two CNAs caring for the resident.<br><br>(continued on next page) |



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

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of Resident Council minutes dated 03/10/25 revealed a request was voiced during the meeting that the CNAs be reminded to knock on doors before entering resident rooms to respect resident privacy.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00163801. |

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| McNaughten Pointe Nursing and Rehab | 1425 Yorkland Road<br>Columbus, OH 43232 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538<br><br>Based on interview, review of audio/video footage and review of Centers for Disease Control Guidelines for Enhanced Barrier Precautions, the facility failed to ensure infection control procedures were implemented to prevent the spread of infection. This affected one Resident (Resident #46) of four residents reviewed for infection control.<br><br>The facility census was 126.<br><br>Findings include:<br><br>Review of Resident #46's medical record revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, dependence on a ventilator, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction unspecified side.<br><br>Review of Resident #46's admission minimum data set (MDS) dated [DATE] revealed the resident to be rarely or never understood and to be dependent on staff for all activities of daily living. Further review of the MDS revealed Resident #46 had an enteral feeding tube and a tracheostomy.<br><br>Review of audio/video footage taken from Resident #46's room via an audio/video monitoring camera that was placed in the resident's room with the video time stamp dated 03/18/25 at 11:51 A.M. revealed Resident #46 was receiving care from an unidentified Certified Nursing Assistants (CNA). The unidentified CNA was wearing gloves and a mask but was not wearing a gown. Resident #46 was on enhanced barrier precautions (EBP). The unidentified CNA proceeded to perform incontinence care on Resident #46 by cleansing her from back (rectum) to front (her urethra) potentially contaminating her urethra with fecal bacteria. The unidentified CNA then repositioned Resident #46 without removing his potentially soiled gloves and performing hand hygiene.<br><br>In an interview on 04/07/25 at 3:23 P.M. the Director of Nursing (DON) viewed the video and confirmed the unidentified CNA was wearing gloves and a mask but was not wearing a gown. Resident #46 was on enhanced barrier precautions due to her feeding tube and tracheostomy. The unidentified CNA proceeded to perform incontinence care on Resident #46 by cleansing her from back to front potentially contaminating her urethra with fecal bacteria. The DON verified incontinence care should be from from front to back to prevent potential contamination from stool into the urinary tract. The unidentified CNA then repositioned Resident #46 without removing his potentially soiled gloves and performing hand hygiene. The DON stated they did not have an enhanced barrier precautions policy but followed the Center for Disease Control (CDC) guidelines.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the CDC's guidelines for Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, dated 06/21, revealed residents known to be colonized or infected with a multidrug-resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) should use EBP including a gown and gloves to interrupt the spread of novel or targeted MRDOs. Resident-to resident pathogen transmission in skilled nursing facilities occurs, in part, via healthcare personnel, who may transiently carry and spread MRDOs on their hands or clothing during resident care activities. Residents who have complex medical needs involving wounds and indwelling medical devices are at higher risk of both acquisition and colonization by MRDOs. Examples of indwelling medical devices include but are not limited to feeding tubes and tracheostomy/ventilator.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00163801. |