STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365315	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital City Gardens Rehabilitation and Nursing Ce	920 Thurber Drive West Columbus, OH 43215

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, facility staff interviews, review of the fire investigation report, observation of facility video camera footage, review of the facility submitted Self-Reported Incident (SRI), and review of facility policy, the facility failed to ensure a resident was free from neglect when staff did not timely implement fire procedures when a mattress/bedding fire occurred in Resident #19's room. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, negative health outcomes and/or death when on 09/26/24 at 11:46 P.M. a fire occurred in Resident #19's room which ignited the resident's mattress/bedding on fire, activating the fire alarm and sprinkler system and facility staff did not attempt to immediately implement fire protocols to rescue, contain and/or extinguish the fire in Resident #19's room until 11:53 P.M. on 09/26/24. Resident #19 sustained burns to her legs, torso, and arm, was transferred to the hospital and admitted to the Surgical Care Intensive Care Unit (SICU) for treatment of extensive burns received on her legs, torso, and arm. Resident #19 was treated for acute respiratory failure with hypoxia and intubated with a moderate inhalation injury. This affected one (#19) resident who resided in Room B05 and placed an additional nine residents (Residents #11, #15, #16, #17, #18, #20, #21, #22, and #23), residing in the same smoke compartment as Resident #19 at potential risk for the likelihood of serious injury, impairment, negative health outcomes, and/or death, due to potential for the fire and smoke to spread throughout the hall. The facility census was 88. On 10/10/24 at 2:47 P.M., the Administrator, Director of Nursing (DON), Corporate Nurse (CN) #309, and Regional Director of Operations (RDO) #334 were notified Immediate Jeopardy began on 09/26/24 when facility staff did not timely and appropriately implement fire safety protocols and procedures, in accordance with facility policy, to rescue residents, contain the fire, extinguish the fire, and evacuate residents who resided in the compartment where the fire was located. On 09/26/24 at 11:46 P.M., the fire alarm was activated and the fire doors shut. On 09/26/24 at 11:53 P.M., facility staff were observed, via video camera footage, to enter Resident #19's room with a fire extinguisher and Resident #19 was brought out of her room at 11:56:10 P.M. and at 11:57 P.M., Emergency Medical Services (EMS) took over care of Resident #19. Emergency Medical Services (EMS) transported Resident #19 to the hospital where she was admitted to the SICU for 35% Total Burn Surface Area (TBSA) burn, and status post escharotomy (a surgical procedure that involves cutting through burnt skin to release the eschar and relieve pressure) of the right lower extremity. Resident #19 was treated for acute respiratory failure with hypoxia and intubated with a moderate inhalation injury. The affected ten residents' (#11, #15, #16, #17, #18, #19, #20, #21, #22, and #23) who resided in the smoke compartment were the fire was located. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

The Immediate Jeopardy was removed on 10/18/24 when the facility implemented the following corrective actions:

On 09/26/24 at 11:46 P.M., the fire alarm sounded which transmits an alarm to the fire department of the fire.

On 09/26/24 at approximately 11:46 P.M., the facility's incident investigation indicated Licensed Practical Nurse (LPN) #251 called 911 to report the incident of fire.

On 09/26/24 from 11:50 P.M. through 11:52 P.M., residents are seen via facility video camera footage to be directed out of their rooms and attempting to make their way off the hallway.

On 09/26/24 at 11:53 P.M., LPN #251 was observed via video footage to take a fire extinguisher into the resident's room B05, identified as Room B05. A subsequent interview with the nurse revealed she could see fire in the room, and she was able to extinguish the fire by utilizing the extinguisher, but was not able to rescue the resident due to the smoke and everything was wet (as a result of the activation of the sprinkler system). She stated that she could not see in the room, and she kept tripping on items. Video camera footage noted other staff were observed standing outside the door to Room B05. Two male residents are observed to be closing resident room doors concurrently to contain the fire.

On 09/26/24 at 11:55 P.M., Columbus Police Officers are visible on the hallway and enter Room B05. LPN #251 and State tested Nurse Aide (STNA) #248 were also in the room with Resident #19.

On 09/26/24 at 11:56:10 P.M., Resident #19 was observed on the video footage being brought out of Room B05 in the bed and was pushed down the hallway by LPNs #251 and #444, and STNA #248 with Police Officers following.

On 09/26/24 at 11:57 P.M., the care of Resident #19 was turned over to the emergency medical responders at this time.

On 09/27/24 at 12:02 A.M., the facility had completed a head count of residents, and all 90 residents were accounted for.

On 09/27/24 at 1:10 A.M., the Columbus Fire Department exited the facility, and a Fire Watch was initiated and completed by the Administrator and DON.

On 09/27/24 at 1:15 A.M., Respiratory Assessments were initiated by Unit Manager/ LPN #225, and LPN #203 on Residents #17, #20, #18, #15, #21, #23, #22, #16, and #11, who resided in the same smoke compartment where the fire was located, with no adverse reactions noted. The assessments were completed on 09/27/24 at 3:10 A.M.

On 09/27/24 at 1:00 A.M. through 3:00 A.M., cleaning of the fire debris in Room B05 and the adjacent hall area began by Maintenance Director #390 and Regional Environmental Services #805.

On 09/27/24 at 3:00 A.M., all residents who lived in the smoke compartment where the fire occurred were temporarily moved to open rooms in the B and C halls.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/27/24 at 8:00 A.M., four sprinkler heads were replaced in Room B05 by Fire Safety Company #800 to maintain safety in the building and restore water to the facility. On 09/27/24 at 11:00 A.M., all 88 residents were interviewed for post incident safety, conducted by Admissions, Licensed Social Worker (LSW) #270 and Human Resource Director # 259 (Resident #19 was in the hospital and a male resident discharged Against Medical Advice on the morning of 09/27/24). On 09/27/24 at 12:00 P.M., the Fire Department inspected the facility and cleared the facility from Fire Watch. The facility was notified the residents could return to their original rooms as the facility was deemed safe by the fire department. On 09/27/24 at 12:00 P.M., the two fire extinguishers that were used and deployed during the fire were replaced by Maintenance Director #390 to ensure adequate tools for fire safety are available to the staff. On 09/27/24 at 1:00 P.M., all department managers were educated by the Regional Director of Clinical Services (RDCS) #810 on the Smoking Policy, Change in Condition Policy, Fire safety (RACE & PASS), and Abuse and Neglect Policy. Those receiving education were the Administrator, Admissions/Licensed Social Worker (LSW) # 270, Maintenance Director #390, Unit Manager LPN #225, Human Resources #259, Therapy Director #825, Business Office Manager #830, Activity Director #268, Dietary Manager #835, Medical Records/Central Supply #840, Assistant Director of Dietary #845, and Housekeeping Manager #850. On 09/27/24 at 1:21 P.M., an all-staff education was initiated by Department Managers and the DON for the facility's employees. The education was in person and by telephone/text covering Change in Condition Policy, Smoking Policy, Fire Safety (RACE & PASS) and Abuse and Neglect Policies. Staff were able to return/continue to work once training was completed. The education was completed on 09/27/24 at 7:52 P.M. On 09/27/24 beginning at 11:00 A.M. and completed by 3:06 P.M., all 88 resident rooms were searched by the Department Managers for smoking contraband. Non-permitted smoking articles were found in the rooms of Residents #33, #79, #82, #49, and #64, who were previously unsupervised smokers. This contraband was collected and further education provided to these residents by the Administrator and LSW #270. On 09/27/24 beginning at 10:45 A.M. and completed by 3:30 P.M., all 88 residents were assessed by Unit Manager LPN#225, Unit Manager LPN #579, and Registered Nurse (RN) #820 for a change in condition to assess for any changes in physical and mental condition, including distress from the incident. No residents were found to have a change in condition. On 09/27/24 at 4:00 P.M., a Fire Drill was conducted by Maintenance Director #390 without incident. On 09/27/24 at 4:13 P.M., the Fire Marshall was notified by the Administrator of the incident of fire via the Fire Marshall's electronic portal. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/27/24 beginning at 3:23 P.M. and completed by 4:45 P.M., a second Respiratory Assessment was initiated on Residents #17, #20, #18, # 15, #21, #23, #22, #16, and #11, who lived in the same smoke compartment where the fire occurred, by RN # 229, LPN # 251, LPN #444, and LPN #203 with no adverse reaction noted. On 09/27/24 at 6:15 P.M., a Quality Assurance and Performance Improvement (QAPI) meeting was held with the Administrator, RDCS #810, LSW # 270, Maintenance Director #390, Unit Manager LPN #225, Human Resources # 259, Therapy Director #825, Business Office Manager #830, Activity Director #268, Dietary Manager #835, Medical Records/Central Supply #840, Assistant Director of Dietary #845, Housekeeping Manager #850, and Medical Director #900. The following audits to be conducted: Resident Smoke Breaks- five times a week for four weeks, then one time a week for four weeks, completed by the DON. Room Sweeps for Smoking Materials- three times per week for four weeks and one time a week for four weeks, completed by the Departmental Managers. Fire Drills on Each Shift - weekly for eight weeks (7a-7p and 7p-7a), completed by Maintenance Director #390. Assess/Re-educate as needed - staff knowledge of Fire Safety RACE/PASS - weekly/per shift times eight weeks, completed by Maintenance Director #390. Although the Immediate Jeopardy was removed on 10/18/24, the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings Included: Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, depression, anxiety, and suicidal ideation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a Brief Interview of Mental Status score of 15 (out of 15) which indicated she was cognitively intact. Resident #19 required setup assistance with meals and oral intake. Resident #19 was dependent on staff with personal hygiene, dressing, and transfers. Resident #19 was dependent on staff with using her manual wheelchair. Review of the physician order dated 09/16/24 revealed Resident #19 had an order for five liters of oxygen per minute by nasal cannula, routine. Resident #19's oxygen was to be monitored every shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the plan of care dated 09/13/24 revealed Resident #19 had mood problems related to agitation with hallucinations, suicidal ideations, and delirium. Interventions included to administer medication, assist the resident in positive coping skills, behavioral health consult, educate the resident and family regarding expectations of treatment, monitor and document risk for harm to self, suicidal plan, past attempts at suicide, possession of suicidal note, trying to harm self, refusing to eat or drink, sense of hopeless or helplessness, and impaired judgement or safety awareness. Resident #19 was to be monitored for mood patterns, anxiety, sad mood, behavior monitoring protocol, monitor increased anger, and observe for signs and symptoms of mania and hypomania, and increased irritability. Review of Resident #19's medication administration record (MAR) for September 2024 revealed behaviors were assessed every shift and the resident was coded as not having any behaviors at the facility. Resident #19 had an order for Hydroxyzine (used to control anxiety and tension) 25 milligrams (mg), give 12.5 mg every eight hours as needed for 14 days dated 09/14/24. The MAR revealed the resident received the medication on 09/13/24 at 6:15 P.M., 09/18/24 at 4:04 P.M., 09/19/24 at 9:04 A.M, 09/21/24 at 8:39 A.M., 09/22/24 at 1:52 P.M., 09/23/24 at 10:09 A.M., 09/25/24 at 3:52 P.M., and on 09/26/24 at 10:23 P.M. All doses provided were documented as being effective. Review of the Smoking-Safety Screen dated 09/16/24 revealed Resident #19 had been evaluated for smoking and safety. Resident #19 stated she smoked in the morning one to two cigarettes per day. Resident #19 could light her own cigarette, needed a smoking apron, had dexterity problem, no visual deficit, and had cognitive loss. Resident #19 needed the facility to store the lighter and cigarettes for safety. The care plan was updated for smoking safety. The decision by the interdisciplinary team was Resident #19 was safe to smoke with supervision. Review of the plan of care dated 09/25/24 revealed Resident #19 was a smoker. The care plan was updated on 09/27/24 and indicated Resident #19 chooses not to follow smoking policy at times. Interventions included to instruct the resident about smoking risks and hazards, and about smoking cessation. Resident #19 was instructed about the facility policy on smoking, locations, times, and safety concerns. Monitor Resident #19's oral hygiene, observe clothing and skin for signs of cigarette burns, notify charge nurse immediately if it was suspected resident had violated facility smoking policy, resident required a smoking apron while smoking, and Resident #19 required supervision while smoking. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility document titled Incident Investigation-Room [Resident #19's room] Fire dated 09/26/24 through 09/27/24 revealed the following: staff interviews and statements revealed their actions during the active incident and during the evacuation appeared consistent with the video surveillance. Two residents interviewed (Resident #08 and Resident #17) stated Resident #19 was yelling, which was normal in the evening for Resident #19. One resident reported shortly before the fire alarm activated, the resident was heard shouting, I'll show them. The statement seems to stand alone without sufficient context to determine its meaning. Interviews and video surveillance reveal the fire alarm sounded at approximately 11:45 P.M. on 09/26/24. Video shows staff responding appropriately using both the RACE and PASS method of dealing with an active fire. Staff used fire extinguishers to extinguish the flames. At approximately 11:46 P.M., emergency 9-1-1 was called. The local police arrived at the facility at 11:54 P.M. and the Fire Department and EMS arrived at 11:58 P.M. The local police and staff had already evacuated Resident #19 from her room. Resident #19 was examined by medics and transported to the hospital. The report stated Emergency Department notes provided helpful information in determining the origin of the fire. The notes state that the resident intentionally started the fire to get staff's attention. Where the resident obtained an instrument, i.e., matches, a lighter, etc. to ignite the fire cannot be determined. As a supervised smoker, the resident would have had her smoking material and paraphernalia collected at the time of her previous smoking session. An examination of the room [Resident #19] and the bed the resident was in was not determinative as to the source of ignition. The Administrator and Maintenance Director #390 closely examined the room and debris looking for a burned cigarette and/or a source of ignition. No cigarettes or lighters or matches were discovered in the debris. However, it can be noted that the bed was the origin of the fire. In fact, there appeared to be two separate ignition points. One point of origin appears to be on the resident's right-hand side of the bed at about the midpoint of the bed; the other point of origin (which looked to be the original point of origin) appeared at the right-side foot of the bed. The report listed the facilities conclusion as: facility staff responded appropriately at the time of the incident, ensuring the fire was extinguished, the residents and others were safely evacuated. Facility staff provided care to the resident prior to the incident. The resident started the fire intentionally and with knowledge that her actions could result in significant harm. The facility will continue to monitor other residents' for both physical and psycho social well-being. The facility will cooperate with the fire department in their investigation of the incident. The report was completed by the Administrator. Review of the EMS report dated 09/27/24 revealed upon arrival to the facility, Resident #19 was alert and oriented and suffering from third degree burns to 15% of her lower left leg and lower right leg. Resident #19 had just been evacuated minutes before arrival. Resident #19 was quickly assessed and given 25 milligrams (mg) of Ketamine for pain and then transferred to the medic. Resident #19's condition was stable and transferred to Hospital #500's burn unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the hospital document titled Rehabilitation Psychology Follow-Up Note dated 09/30/24 at 5:49 P. M. by Hospital Psychologist (HP) #499 revealed the examination was done related to mental status exam and humanistic interventions. HP #499 stated Resident #19 was alert and oriented, to person, place, time, and generally to situation. Resident #19 was being hospitalized due to burns. Resident #19 had difficultly providing accurate personal history, speech was normal rate, volume, and prosody (a word to describe the rate, rhythm, and melody of speech), but with word finding issues and frequent verbal preservation. Resident #19's mood was anxious; affect appropriate, and congruent. Eye contact at time intense and at other times she was observed staring off into space. Resident #19 asked to walk and later then swim and did not appreciate that there would be any barriers to these activities. Though content relevant to conversation and questioning but with off-topic responses and evident confusion. Delayed in responding to questions rather than most recent prompt. Resident #19 denied perceptual abnormalities, staring into space occasionally but denied any hallucinations when asked. Denied suicidally but endorsed setting a fire to get the attention. Resident #19 discussed that she was calling for help and thought she would set a fire to get help. Resident #19 discussed thinking she was somewhere else. Resident #19 stated the nursing home and funeral home interchangeably and also noted that she thought her son was in the next room at the time. She denied that this was an attempt to die or inflict intentional injury. She reported using lighter to set the fire. Resident #19 was aware of her burns and the association with her actions and the fire that was set. Review of the hospital document titled Critical Care Attestation dated 10/01/24, by Critical Care Physician (CCP) #450 revealed Resident #19 had been admitted to hospital for 35% total Burn Surface Area (TBSA) burn, and status post escharotomy (a surgical procedure that involves cutting through burnt skin to release the eschar and relieve pressure) of the right lower extremity. Review of the hospital document titled [NAME] Flow Sheet (a tool useful in the management of burns for estimating TBSA) dated 10/01/24 revealed Resident #19 had the following burns: anterior trunk had 13% injury with 5% second degree burns, right lower arm had 3% injury with 2% second degree burns, right thigh had 9.5% injury with 2% second degree burns and 2% third degree burns with 4% total area, right leg was 7% third degree burn, left leg was 7% injury with 5% third degree burn, and right foot was 3.5% injury with 3. 5% third degree burns. Resident #19 had injuries to head, neck, posterior trunk, right and left buttocks, right upper arm, left upper arm, left lower arm, right and left hand and left thigh that had suffered injury. Interview on 10/02/24 at 10:05 A.M. with STNA #246 stated she did not know what happened to Resident #19 only that she had a fire in her room and was taken to the hospital with burns. STNA #246 stated she arrived at the facility to assist with evacuation at the facility due to the fire that night. STNA #246 stated she had recently received education on fire training on 09/27/24, including the use of a fire extinguisher, but stated she forgot what the fire acronyms RACE and PASS stood for. Interview on 10/02/24 at 10:15 A.M. with STNA #223 verified they had been educated about fire evacuation, and using the fire extinguisher but did not know the date of the education. STNA #223 stated she does not know what she learned. Interview on 10/02/24 at 10:20 A.M. with STNA #235 stated she was not sure about the fire, but that the next day she was educated on 09/27/24. The education included fire drills, using closest exit for evacuation, and to close all resident room doors in the area of the fire. STNA #235 stated she could recite what the acronym of RACE meant which was rescue, alarm, contain, and evacuate. STNA #235 stated she was not sure about PASS and its meaning. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At 11:50:43 P.M., STNA #214 was observed to open the door to Room B05, and black smoke was observed to come out of the room. The three staff were observed to flee from the room, STNA #230 and LPN #444 were observed to walk back up the hallway, and STNA #214 was observed to walk further down the hallway. At 11:50:44 P.M., STNA #230 and LPN #444 walked past the fire extinguisher hanging on the wall again which was now on their right side as they were coming back up the hallway. They did not attempt to pick up the extinguisher. At 11:50:46 P.M., STNA #230 and LPN #444 are observed to walk past Resident #17 who was observed in a wheelchair coming out of a resident room and into the hallway, neither staff member assisted Resident #17 in getting off the hallway where there was a room with black smoke coming out of the door, but the staff were seen to walk up the hallway off camera and leave Resident #17 attempting to move herself off the hallway on her own. At 11:50:55 P.M., Resident #17 was joined in the hallway by Resident #16 who was observed to walk out of a resident room which was just past the fire extinguisher hanging on the wall. Smoke was observed to continue to come into the hallway from Room B05 and no staff were observed on the hallway to assist residents, extinguish the fire, or contain the fire. The two residents are seen just congregating in the hallway. At 11:51:04 P.M., STNA # 214 was observed back at the end of the hallway and entered a room on the opposite side of the hallway from Room B05. Black smoke continues to come into the hallway form Room B05. No resident room doors have been shut and no other staff are observed on the hallway. At 11:51:20 P.M., STNA #230 and LPN #444 are observed to enter the hallway and direct Resident #16 and #17 off the hallway using hand gestures. At 11:51:24 P.M., STNA #230 and LPN #444 are observed on the hallway close to Room B05 but across the hall, the smoke in the hallway is thick and it is hard to see past the two staff. Neither of the staff grabbed the fire extinguisher off the wall as they walked down the hallway toward Room B05. No room doors were closed as the staff walked down the hallway. At 11:51:30 P.M., Resident #11 is visible sitting in a wheelchair in a room doorway two doors up the hallway on the same side of the hall as Room B05 across from STNA #230 and LPN #444 who are observed to be standing in the hallway, STNA #214 is visible at the end of the hallway, and smoke continues to fill the hallway. STNA #230 and LPN #444 are seen to turn and make their way back up the hallway past the fire extinguisher, without evacuating Resident #11 who was in the doorway. The staff did not attempt to shut any room doors or assist any residents to leave the hallway. At 11:51:34 P.M., STNA #214 was observed to stop at the doorway where Resident #11 is observed sitting in the wheelchair and raise his arm straight out toward the resident. Then the STNA is observed to continue to walk up the hallway, past the resident and past the fire extinguisher and exit the hallway. STNA #214 did not shut any resident room doors as he walked from one end of the hallway to the other end. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital City Gardens Rehabilitation and Nursing Ce	920 Thurber Drive West Columbus, OH 43215

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At 11:51:45 P.M., Resident #21 is seen ambulating at the end of the hallway and Resident #15 was observed to be standing in a room doorway. The resident at the end of the hallway walks past Room B05 staying close to the other side of the hallway and LPN #444 was observed to wave the resident toward the fire door and off the hallway. The resident is no longer seen on camera and is off the hallway where the fire was. At 11:52:38 P.M., Resident #15 who was standing in the doorway was observed to exit his room walking with a walker and a hat on his head, and he exits the hallway with the fire. At 11:52:40 P.M., Resident #11 who was sitting in a wheelchair in his doorway is observed to wheel out of his room and into the hallway. At 11:52:43 P.M., LPN #251 was observed coming on the hallway where the fire is located, and grabbed the wheelchair of Resident #11 and moved him off the hallway at 11:52:53 P.M. At 11:52:54 P.M., LPN #251 was observed on the hall walking toward Room B05 carrying a fire extinguisher. LPN #251 was observed to enter Room B05 at 11:53 :09 P.M., exit the room at 11:53:14 P.M., reenter the room at 11:53:15 P.M. and re-exit the room by herself at 11:53: 30 P.M. At 11:53:44 P.M., Resident #08 and Resident #21 are observed on the hallway shutting room doors, staff are observed standing outside Room B05, and smoke is observed filling the hallway. At 11:55:29 P.M., the Columbus Police Officers are visible on the hallway and enter Room B05. LPN #251 and STNA # 248 were also in the room with Resident #19. At 11:56:10 P.M., Resident #19 was brought out of Room B05 and down the hall by LPNs #251 and #444, and STNA #248 with Police Officers following. Interview and observation of the facility video camera footage with Regional Director of Operations (RDO) #334 on 10/09/24 at 2:00 P.M. confirmed the facility did not follow their policy and procedures regarding fire safety and they did not rescue the resident in the room where the fire occurred timely and the facility staff did not implement the fire procedures and take a fire extinguisher to the room and attempt to extinguish the fire. He confirmed multiple staff walked past a fire extinguisher hanging on the wall and did not attempt to pick up the extinguisher and the staff did not evacuate other residents on the hallway where the fire was located and/or shut the room doors to contain the fire. Review of the facility submitted SRI dated 10/10/24 revealed after a review of the facility's video surveillance on 10/09/24, related to a fire incident on 09/26/24 at approximately 11:46 P.M., the Administrator launched an investigation for Neglect due to staff response to the fire. The Summary of Incident and Investigation noted the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365315	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital City Gardens Rehabilitation and Nursing Ce	920 Thurber Drive West Columbus, OH 43215

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/26/2024 at approximately 11:45 P.M., the facility fire alarm was activated. Staff on the A/B hall observed the fire panel and noted the fire to be in Room B-5. A review of the facility's video surveillance showed facility staff viewing the fire panel and immediately proceeding to Room B-5. The video footage shows that the door to B-5 was closed, and smoke was coming from under the door. A facility STNA opened the door and noted the Resident's bed to be the source of the smoke/fire. The facility sprinkler system had activated. The door to Room B-5 was left open while staff retrieved a fire extinguisher and returned to the room and sprayed the contents of the fire extinguisher on the source of the fire. Simultane [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365315	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital City Gardens Rehabilitation and Nursing Ce	920 Thurber Drive West Columbus, OH 43215

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, staff interviews, observation of facility video footage, review of the facility submitted Self-Reported Incident (SRI), and facility policy review, the facility failed to report an incident of potential neglect when the facility failed to timely implement fire protocol regarding rescuing residents, containing the fire and extinguishing and evacuating residents. This affected one Resident (#19) who had a fire in her room on 09/26/24 and had the potential to affect the other nine residents (Resident #11, #15, #16, #17, #18, #20, #21, #22, and #23) living in the same smoke compartment as Resident #19. The total facility census was 88. Findings included: Review of Resident #19's medical record revealed the resident was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, depression, anxiety, and suicidal ideation. Review of physician order dated 09/16/24 revealed Resident #19 had an order for oxygen at five liters per minute via nasal cannula, routine. Resident #19's oxygen was to be monitored every shift. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #19 had a Brief Interview of Mental Status (BIMS) score of 15 (out of 15) indicating the resident was cognitively intact. Resident #19 required setup assistance with meals and oral intake. Resident #19 was dependent on staff for personal hygiene, bathing, toileting, putting on and off shoes, dressing upper and lower body, and transfers. Resident #19 was dependent on staff for use of her manual wheelchair. Review of plan of care 09/25/24 revealed that Resident #19 was a smoker, and did not follow the smoking policy at times. Interventions included instruct the resident about smoking risks, hazards, and about smoking cessation. Resident #19 was instructed about the facility policy on smoking, locations, times, and safety concerns. Monitor Resident #19's oral hygiene, observe clothing and skin for signs of cigarette burns, and notify charge nurse immediately if it was suspected resident had violated facility smoking policy. Resident #19 required a smoking apron, and supervision while smoking. Review of the EMS report dated 09/27/24 revealed on arrival to the facility, Resident #19 was alert and oriented and suffering from third degree burns to 15% of her lower left leg and lower right leg. Resident #19 had just been evacuated minutes before arrival. Resident #19 was quickly assessed and given 25 milligrams (mg) of ketamine for pain and the transferred to the medic. Resident #19's condition was stable and transferred to Hospital #500's burn unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Capital City Gardens Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 920 Thurber Drive West Columbus, OH 43215	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/02/24 at 12:39 P.M. with State tested Nursing Assistant (STNA) #214 revealed the fire alarm went off, and he looked at fire panel to see Resident #19 room was on fire. STNA #214 stated he headed to Resident #19 room, and before arriving, Resident #17 came out of her room, and stated there was smoke coming out of the connecting bathroom door shared between her room and Resident #19's room. STNA #214 stated he touched the door to Resident #19's room and it was not hot and he opened and looked into the room. STNA #214 stated Resident #19's room had pure black smoke in the room and no fire was seen. STNA #214 stated he could not see or go into the room due to all the smoke in the room had irritated his throat and he could not breath. STNA #214 stated he did not go into Resident #19's room. STNA #214 stated he knew the resident was in the room, and thought he heard her. STNA #214 stated he then turned around and went into two other residents' rooms to assist them in evacuation. STNA #214 stated he had in-service training for fire that included RACE and PASS. Review of the additional camera footage provided to the survey agency on 10/08/24 from the facility revealed camera footage contained multiple camera's video feed and included the smoke compartment where Resident #19's room was located. The timeline of the following events was obtained from the provided camera's footage. The time was captured on Camera 7 footage and Camera 9 captured the hallway where Resident #19's room was located. The date of the footage is 09/26/24. At 11:50:29 P.M., State tested Nursing Assistant (STNA) # 214, #230 and Licensed Practical Nurse (LPN) #444 were observed walking onto the hallway. At 11:50:34 P.M., the three staff are observed to walk past a fire extinguisher which was on the wall to their left. None of the staff pick up the extinguisher. At 11:50:44 P.M., STNA #230 and LPN #444 walked past the fire extinguisher hanging on the wall again which was now on their right side as they were coming back up the hallway. They did not attempt to pick up the extinguisher. At 11:50:46 P.M., STNA #230 and LPN #444 are observed to walk past Resident #17 who was observed in a wheelchair coming out of a resident room and into the hallway, neither staff member assisted Resident #17 in getting off the hallway where there was a room with black smoke coming out of the door, but the staff were seen to walk up the hallway off camera and leave Resident #17 attempting to mover herself off the hallway on her own. At 11:50:55 P.M., Resident #17 was joined in the hallway by Resident #16 who was observed to walk out of a resident room which was just past fire extinguisher hanging on the wall. Smoke was observed to continue to come into the hallway from room B05 and no staff was observed on the hallway to assist residents, extinguish the fire, or contain the fire. The two residents are seen just congregating in the hallway. At 11:51:04 P.M., STNA # 214 was observed back at the end of the hallway and entered a room on the opposite side of the hallway from B05. Black smoke continues to come into the hallway form room B05. No resident room doors have been shut and no other staff are observed on the hallway. At 11:51:20 P.M., STNA #230 and LPN #444 are observed to enter the hallway and direct Resident #16 and #17 off the hallway off the hallway using hand gestures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Capital City Gardens Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 920 Thurber Drive West, Columbus, OH 43215	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:51:24 P.M., STNA #230 and LPN #444 are observed on the hallway close to room B05 but across the hall, smoke is thick is observed on the hallway and it is hard to see past the two staff. Neither staff grabbed the fire extinguisher off the wall as they walked down the hallway toward room B05. No room doors were closed as the staff walked down the hallway. At 11:51:30 P.M., Resident #11 is visible sitting in a wheelchair in a room doorway two doors up the hallway on the same side of the hall as B05 across from STNA #230 and LPN #444 who are observed to be standing in the hallway, STNA #214 is visible at the end of the hallway, and smoke continues to fill the hallway. STNA #230 and LPN #444 are seen to turn and make their way back up the hallway past the fire extinguisher, without evacuating Resident #11 who was in the doorway. The staff did not attempt to shut any room doors or assist any residents to leave the hallway. At 11:51:34 P.M., STNA #214 was observed to stop at the doorway where the Resident #11 is observed sitting in the wheelchair and raise his arm straight out toward the resident. Then the STNA is observed to continue to walk up the hallway, past the resident and past the fire extinguisher and exit the hallway. STNA #214 did not shut any resident room doors as he walked from one end of the hallway to the other end. At 11:51:45 P.M., Resident #21 is seen ambulating at the end of the hallway and Resident #15 was observed to be standing in a room doorway. The resident at the end of the hallway walks past room B05 staying close to the other side of the hallway and LPN #444 was observed to wave the resident toward the fire door and off the hallway. The resident is no longer seen on camera and is off the hallway where the fire was. At 11:52:38 P.M., Resident #15 who was standing in the doorway was observed to exit his room walking with a walker and a hat on his head, he exits the hallway with the fire. At 11:52:40 P.M., Resident #11 who was sitting in a wheelchair in his doorway is observed to wheel out of his room and into the hallway. At 11:52:43 P.M., LPN #251 was observed coming on the hallway where the fire is located, and grabbed the wheelchair of Resident #11 and moved him off the hallway at 11:52:53 P.M. At 11:52:54 P.M., LPN #251 was observed on the hall walking toward room B05 carrying a fire extinguisher. LPN #251 was observed to enter Room B05 at 11:53 :09 P.M., exit the room at 11:53 :14 P.M., reenter the room at 11:53:15 P.M. and re-exit the room by herself at 11:53: 30 P.M. At 11:53:44 P.M., Resident #8 and Resident #21 are observed on the hallway shutting room doors, staff are observed standing outside room B05, and smoke is observed filling the hallway. At 11:55:29 P.M., The Columbus Police Officers are visible on the hallway and enter room B05. LPN #251 and STNA # 248 were also in the room with Resident #19. At 11:56:10 P.M., Resident #19 was brought out of room B05 and down the hall by LPN #251 and #444, STNA #248 with Police Officers following. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Capital City Gardens Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 920 Thurber Drive West Columbus, OH 43215	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation of facility video camera footage with Regional Director of Operations (RDO) #334 on 10/09/24 at 2:00 P.M. confirmed the facility did not follow their policy and procedures regarding fire safety and they did not rescue the resident in the room where the fire occurred timely and the facility staff did not implement the fire procedures and take a fire extinguisher to the room and attempt to extinguish the fire. He confirmed multiple staff walked past a fire extinguisher hanging on the wall and did not attempt to pick up the extinguisher and the staff did not evacuate other resident on the hallway where the fire was located or shut the room doors to contain the fire. Interview with RDO #334 on 10/10/24 at approximately 10:15 A.M. confirmed the facility had not submitted a self-reported incident regarding the incident of fire on 09/26/24 and the facility's staff response to the fire on 09/26/24. Review of the facility submitted SRI dated 10/10/24 revealed after a review of the facility's video surveillance on 10/09/24, related to a fire incident on 09/26/24 at approximately 11:46 P.M., the Administrator launched an investigation for Neglect due to staff response to the fire. The Summary of Incident and Investigation noted the following: On 9/26/2024 at approximately 11:45 P.M., the facility fire alarm was activated. Staff on the A/B hall observed the fire panel and noted the fire to be in Room B-5. A review of the facility's video surveillance showed facility staff viewing the fire panel and immediately proceeding to Room B-5. The video footage shows that the door to B-5 was closed, and smoke was coming from under the door. A facility STNA opened the door and noted the Resident's bed to be the source of the smoke/fire. The facility sprinkler system had activated. The door to Room B-5 was left open while staff retrieved a fire extinguisher and returned to the room and sprayed the contents of the fire extinguisher on the source of the fire. Simultaneously, additional staff were observed on the surveillance video executing R (Rescue), A (Alarm -- already activated), C (Contain), and E (Evacuate). The Resident in B-5 was evacuated from the room and the building at 11:56 PM. Written statements from involved staff members confirms that all facility staff performed emergency procedures properly according to facility policy. The facility Administrator has been and continues to be in contact with the Columbus Division of Police, the Columbus Fire Department, and the [NAME] County Prosecutors Office to pursue criminal charges against the Resident. The facility Conclusion/Disposition Section of the SRI with a completion date of 10/17/24, indicated the evidence was inconclusive and Abuse, Neglect or Misappropriation is not suspected, and the SRI was Unsubstantiated. On 10/18/24, an Addendum was added to the SRI by the Administrator and indicated the following: Upon further review, the facility is substantiating a finding of neglect. Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 11/01/2019 revealed it was the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property, including injuries of unknown origin. The facility staff should immediately report all such allegations to the Administrator/designee and to the Ohio Department of health in accordance with the procedures in this policy. In cases where a crime was suspected, staff should also report the same to local law enforcement in accordance the facility's crime reporting policy. The failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Ohio Department of Health will be notified by using the online Enhanced Information Dissemination and Collection system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital City Gardens Rehabilitation and Nursing Ce	920 Thurber Drive West Columbus, OH 43215

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Master Complaint Number OH00158457, Complaint Number OH00158364, and Complaint Number OH00158347.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 44080 Based on medical record review, observations, facility staff interviews, resident interviews, family interviews, review of a fire drill report, review of emergency response reports, review of report of fire email communication, review of facility video camera footage, review of hospital records, review of the fire investigation report, and review of the facility policies for smoking and Oxygen Administration, the facility failed to ensure the residents environment remained as free from accident hazards as is possible when one resident (#19), who utilized oxygen therapy and who smoked cigarettes, possessed smoking materials, including cigarettes and a cigarette lighter, in her room. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, negative health outcomes and/or death when on 09/26/24 at 11:46 P.M. a fire occurred in Resident #19's room which ignited the resident's mattress/bedding on fire resulting in the resident sustaining severe burns to her legs, torso, and arm. Consequently, Resident #19 was transferred to the hospital and admitted to the Surgical Intensive Care Unit (SICU) for treatment of extensive burns received on her legs, torso, and arm. Resident #19 was treated for acute respiratory failure with hypoxia and intubated with a moderate inhalation injury. This affected one (#19) resident who resided in Room B05 and placed an additional nine residents (Residents #11, #15, #16, #17, #18, #20, #21, #22, and #23), residing in the same smoke compartment as Resident #19, at potential risk for the likelihood of serious injury, impairment, negative health outcomes, and/or death, due to the potential for the fire and smoke to spread throughout the hall. The facility identified a total of 50 residents currently residing in the facility who smoke (Residents #1, #2, #3, #5, #7, #8, #9, #10, #11, #12, #15, #16, #17, #20, #21, #22, #31, #32, #33, #34, #35, #37, #39, #40, #41, #42, #44, #45, #48, #49, #50, #52, #55, #57, #59, #61, #64, #67, #72, #74, #75, #77, #78, #79, #82, #86, #87, #88, #89, and #91). The total facility census was 88. On 10/03/24 at 3:18 P.M., the Administrator, Director of Nursing (DON), Corporate Nurse (CN) #309, and Regional Director of Operations (RDO) #334 were notified Immediate Jeopardy began on 09/26/24 at 11:46 P.M. when Resident #19, who utilized oxygen therapy and had a lighter and smoking materials in her possession, started a fire in her room igniting her mattress/bedding. Resident #19 was assessed on 09/16/24 to require supervision with smoking and the resident's lighter and cigarettes were to be stored by the facility. The facility's smoking policy and smoking plan indicated residents were not allowed to store their smoking materials in their room. On 09/26/24 at 11:46 P.M., the fire alarm was activated and the fire doors shut at 11:56:10 P.M. Resident #19 was eventually brought out of her room and at 11:57 P.M., Emergency Medical Services (EMS) took over care of Resident #19. EMS transported Resident #19 to the hospital where she was admitted to the SICU for 35% Total Burn Surface Area (TBSA) burn, and status post escharotomy (a surgical procedure that involves cutting through burnt skin to release the eschar and relieve pressure) of the right lower extremity. Resident #19 was treated for acute respiratory failure with hypoxia and intubated with a moderate inhalation injury. The Fire Department's Investigation Report dated 09/26/24 revealed smoked and unsmoked cigarettes, cigarette pack, and a lighter were found near the original location of the bed. The conclusion was an accidental fire caused by smoking materials in close proximity to high concentration oxygen. Observation on 10/15/24 at 1:45 P.M. revealed there was a pile of debris next to the facility sidewalk in the courtyard area and it was the debris from Resident #19's room on 09/26/24. The debris included a lighter with scorch marks on it. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

The Immediate Jeopardy was removed on 10/18/24 when the facility implemented the following corrective actions:

On 09/26/24 at 11:46 P.M., the fire alarm sounded which transmits an alarm to the fire department of the fire.

On 09/26/24 at approximately 11:46 P.M., the facility's incident investigation indicated Licensed Practical Nurse (LPN) #251 called 911 to report the incident of fire.

On 09/26/24 from 11:50 P.M. through 11:52 P.M., residents are seen via facility video camera footage to be directed out of their rooms and attempting to make their way off the hallway.

On 09/26/24 at 11:53 P.M., LPN #251 was observed via video footage to take a fire extinguisher into the resident's room, identified as Room B05. A subsequent interview with the nurse revealed she could see fire in the room, and she was able to extinguish the fire by utilizing the extinguisher, but was not able to rescue the resident due to the smoke and everything was wet (as a result of the activation of the sprinkler system). She stated she could not see in the room, and she kept tripping on items. Video camera footage noted other staff were observed standing outside the door to Room B05. Two male residents are observed to be closing resident room doors concurrently to contain the fire.

On 09/26/24 at 11:55 P.M. per the video, Columbus Police Officers are visible on the hallway and enter Room B05. LPN #251 and State tested Nurse Aide (STNA) #248 were also in the room with Resident #19.

On 09/26/24 at 11:56:10 P.M., Resident #19 was observed on the video footage being brought out of Room B05 in the bed and was pushed down the hallway by LPNs #251 and #444, and STNA #248 with Police Officers following.

On 09/26/24 at 11:56:14 P.M., the Columbus Fire Department is seen on video footage arriving at the facility in response to the 911 call and enter the facility and walk toward Room B05.

On 09/26/24 at 11:57 P.M., the care of Resident #19 was turned over to the emergency medical responders at this time.

On 09/27/24 at 12:02 A.M., the facility had completed a head count of residents, and all 90 residents were accounted for.

On 09/27/24 at 1:10 A.M., the Columbus Fire Department exited the facility, and a Fire Watch was initiated and completed by the Administrator and DON.

On 09/27/24 at 1:15 A.M., Respiratory Assessments were initiated by Unit Manager/LPN #225, and LPN #203 on Residents #17, #20, #18, #15, #21, #23, #22, #16, and #11, who resided in the same smoke compartment where the fire was located, with no adverse reactions noted. The assessments were completed on 09/27/24 at 3:10 A.M.

On 09/27/24 at 1:00 A.M. through 3:00 A.M., cleaning of the fire debris in Room B05 and the adjacent hall area began by Maintenance Director #390 and Regional Environmental Services #805.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Capital City Gardens Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 920 Thurber Drive West Columbus, OH 43215	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/27/24 at 3:00 A.M., all residents who lived in the smoke compartment where the fire occurred were temporarily moved to open rooms in the B and C halls. On 09/27/24 at 8:00 A.M., four sprinkler heads were replaced in Room B05 by Fire Safety Company #800 to maintain safety in the building and restore water to the facility. On 09/27/24 at 11:00 A.M., all 88 residents were interviewed for post incident safety, conducted by Admissions, Licensed Social Worker (LSW) #270 and Human Resource Director #259 (Resident #19 was in the hospital and a male resident discharged Against Medical Advice on the morning of 09/27/24). On 09/27/24 at 11:41 A.M., the facility smoking policy was reviewed and revised by [NAME] President of Clinical services #340 to make all smoking supervised and all smokers have to submit smoking articles to staff. The smoking process was updated to divide all smokers into two groups (A & B), residents are given two cigarettes for smoke break, and the staff smoking supervisor has the only lighter and lights all cigarettes during smoke breaks. On 09/27/24 at 12:00 P.M., the Fire Department inspected the facility and cleared the facility from Fire Watch. The facility was notified the residents could return to their original rooms as the facility was deemed safe by the fire department. On 09/27/24 at 12:00 P.M., the two fire extinguishers that were used and deployed during the fire were replaced by Maintenance Director #390 to ensure adequate tools for fire safety are available to the staff. On 09/27/24 at 1:00 P.M., all department managers were educated by the Regional Director of Clinical Services (RDCS) #810 on the Smoking Policy, Change in Condition Policy, and Fire Safety (RACE & PASS) Policy. Those receiving education were the Administrator, Admissions/Licensed Social Worker (LSW) #270, Maintenance Director #390, Unit Manager LPN #225, Human Resources #259, Therapy Director #825, Business Office Manager #830, Activity Director #268, Dietary Manager #835, Medical Records/Central Supply #840, Assistant Director of Dietary #845, and Housekeeping Manager #850. On 09/27/24 at 1:21 P.M., an all-staff education was initiated by Department Managers and the DON for the facility's employees. The education was in person and by telephone/text covering facility policies related to Change in Condition, Smoking, and Fire Safety (RACE & PASS). Staff were able to return/continue to work once training was completed. The education was completed on 09/27/24 at 7:52 P.M. On 09/27/24 at 1:30 P.M., the Administrator held a meeting with the 50 residents (Residents # 1,# 2, #3, #5, #7, #8, #9, #10, #11, #12, #15, #16, #17, #20, #21, #22, #31, #32, #33, #34, #35, #37, #39, #40, #41, #42, #44, #45, #48, #49, #50, #52, #55, #57, #59, #61, #64, #67, #72, #74, #75, #77, #78, #79, #82, #86, #87, #88, #89, and #91) who smoke to review and sign the revised Smoking Policy and smoking process, including smoke break times and groups A & B. All 50 Residents were educated, agreed, and signed the new smoking policy. On 09/27/24 beginning at 11:59 A.M. and completed by 1:44 P.M., smoking assessments began on all residents that currently smoke by Unit Manager LPN #579 and Unit Manager LPN #225 to ensure up to date assessments are in place for all smokers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital City Gardens Rehabilitation and Nursing Ce	920 Thurber Drive West Columbus, OH 43215

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/27/24 beginning at 11:00 A.M. and completed by 3:06 P.M., all 88 resident rooms were searched by the Department Managers for smoking contraband. Non-permitted smoking articles were found in the rooms of Residents #33, #79, #82, #49, and #64, who were previously unsupervised smokers. This contraband was collected and further education provided to these residents by the Administrator and LSW #270. On 09/27/24 beginning at 10:45 A.M. and completed by 3:30 P.M., all 88 residents were assessed by Unit Manager LPN #225, Unit Manager LPN #579, and Registered Nurse (RN) #820 for a change in condition to assess for any changes in physical and mental condition, including distress from the incident. No residents were found to have a change in condition. On 09/27/24 at 4:00 P.M., a Fire Drill was conducted by Maintenance Director #390 without incident. On 09/27/24 at 4:13 P.M., the Fire Marshall was notified by the Administrator of the incident of fire via the Fire Marshall's electronic portal. On 09/27/24 beginning at 3:23 P.M. and completed by 4:45 P.M., a second Respiratory Assessment was initiated on Residents #17, #20, #18, #15, #21, #23, #22, #16, and #11, who lived in the same smoke compartment where the fire occurred, by RN #229, LPN # 251, LPN #444, and LPN #203 with no adverse reaction noted. On 09/27/24 at 6:06 P.M., the care plans of residents who were previously unsupervised smokers were revised to now being supervised smokers by Minimum Data Set (MDS) LPN #855. On 09/27/24 at 6:15 P.M., a Quality Assurance and Performance Improvement (QAPI) meeting was held with the Administrator, RDCS #810, LSW #270, Maintenance Director #390, Unit Manager LPN #225, Human Resources #259, Therapy Director #825, Business Office Manager #830, Activity Director #268, Dietary Manager #835, Medical Records/Central Supply #840, Assistant Director of Dietary #845, Housekeeping Manager #850, and Medical Director #900. The following audits to be conducted: Resident Smoke Breaks - five times a week for four weeks, then one time a week for four weeks, completed by the DON. Room Sweeps for Smoking Materials - three times per week for four weeks and one time a week for four weeks, completed by the Departmental Managers. Fire Drills on Each Shift - weekly for eight weeks (7a-7p and 7p-7a), completed by Maintenance Director #390. Assess/Re-educate as needed - staff knowledge of Fire Safety RACE/PASS - weekly/per shift times eight weeks, completed by Maintenance Director #390. Although the Immediate Jeopardy was removed on 10/18/24, the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, depression, anxiety, and suicidal ideation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a Brief Interview of Mental Status score of 15 (out of 15) which indicated she was cognitively intact. Resident #19 required setup assistance with meals and oral intake. Resident #19 was dependent on staff with personal hygiene, dressing, and transfers. Resident #19 was dependent on staff with using her manual wheelchair. Review of the physician order dated 09/16/24 revealed Resident #19 had an order for five liters of oxygen per minute by nasal cannula, routine. Resident #19's oxygen was to be monitored every shift. Review of the plan of care dated 09/13/24 revealed Resident #19 had mood problems related to agitation with hallucinations, suicidal ideations, and delirium. Interventions included to administer medication, assist the resident in positive coping skills, behavioral health consult, educate the resident and family regarding expectations of treatment, monitor and document risk for harm to self, suicidal plan, past attempts at suicide, possession of suicidal note, trying to harm self, refusing to eat or drink, sense of hopeless or helplessness, and impaired judgement or safety awareness. Resident #19 was to be monitored for mood patterns, anxiety, sad mood, behavior monitoring protocol, monitor increased anger, and observe for signs and symptoms of mania and hypomania, and increased irritability. Review of Resident #19's medication administration record (MAR) for September 2024 revealed behaviors were assessed every shift and the resident was coded as not having any behaviors at the facility. Resident #19 had an order for Hydroxyzine (used to control anxiety and tension) 25 milligrams (mg), give 12.5 mg every eight hours as needed for 14 days dated 09/14/24. The MAR revealed the resident received the medication on 09/13/24 at 6:15 P.M., 09/18/24 at 4:04 P.M., 09/19/24 at 9:04 A.M., 09/21/24 at 8:39 A.M., 09/22/24 at 1:52 P.M., 09/23/24 at 10:09 A.M., 09/25/24 at 3:52 P.M., and on 09/26/24 at 10:23 P.M. All doses provided were documented as being effective. Review of the Smoking-Safety Screen dated 09/16/24 revealed Resident #19 had been evaluated for smoking and safety. Resident #19 stated she smoked in the morning one to two cigarettes per day. Resident #19 could light her own cigarette, needed a smoking apron, had dexterity problem, no visual deficit, and had cognitive loss. Resident #19 needed the facility to store the lighter and cigarettes for safety. The care plan was updated for smoking safety. The decision by the interdisciplinary team was Resident #19 was safe to smoke with supervision. Review of the plan of care dated 09/25/24 revealed Resident #19 was a smoker. The care plan was updated on 09/27/24 and indicated Resident #19 chooses not to follow smoking policy at times. Interventions included to instruct the resident about smoking risks and hazards, and about smoking cessation. Resident #19 was instructed about the facility policy on smoking, locations, times, and safety concerns. Monitor Resident #19's oral hygiene, observe clothing and skin for signs of cigarette burns, notify charge nurse immediately if it was suspected resident had violated facility smoking policy, resident required a smoking apron while smoking, and Resident #19 required supervision while smoking. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility document titled Incident Investigation-Room [Resident #19's room] Fire dated 09/26/24 through 09/27/24 revealed the following: staff interviews and statements revealed their actions during the active incident and during the evacuation appeared consistent with the video surveillance. Two residents interviewed (Resident #08 and Resident #17) stated Resident #19 was yelling, which was normal in the evening for Resident #19. One resident reported shortly before the fire alarm activated, the resident was heard shouting, I'll show them. The statement seems to stand alone without sufficient context to determine its meaning. Interviews and video surveillance reveal the fire alarm sounded at approximately 11:45 P.M. on 09/26/24. Video shows staff responding appropriately using both the RACE and PASS method of dealing with an active fire. Staff used fire extinguishers to extinguish the flames. At approximately 11:46 P.M., emergency 9-1-1 was called. The local police arrived at the facility at 11:54 P.M. and the Fire Department and EMS arrived at 11:58 P.M. The local police and staff had already evacuated Resident #19 from her room. Resident #19 was examined by medics and transported to the hospital. The report stated Emergency Department notes provided helpful information in determining the origin of the fire. The notes state that the resident intentionally started the fire to get staff's attention. Where the resident obtained an instrument, i.e., matches, a lighter, etc. to ignite the fire cannot be determined. As a supervised smoker, the resident would have had her smoking material and paraphernalia collected at the time of her previous smoking session. An examination of the room [Resident #19] and the bed the resident was in was not determinative as to the source of ignition. The Administrator and Maintenance Director #390 closely examined the room and debris looking for a burned cigarette and/or a source of ignition. No cigarettes or lighters or matches were discovered in the debris. However, it can be noted that the bed was the origin of the fire. In fact, there appeared to be two separate ignition points. One point of origin appears to be on the resident's right-hand side of the bed at about the midpoint of the bed; the other point of origin (which looked to be the original point of origin) appeared at the right-side foot of the bed. The report listed the facilities conclusion as: facility staff responded appropriately at the time of the incident, ensuring the fire was extinguished, the residents and others were safely evacuated. Facility staff provided care to the resident prior to the incident. The resident started the fire intentionally and with knowledge that her actions could result in significant harm. The facility will continue to monitor other residents' for both physical and psycho social well-being. The facility will cooperate with the fire department in their investigation of the incident. The report was completed by the Administrator. Review of the witness statement from Resident #17 dated 09/27/24 revealed she was in her room on the evening of 09/26/24. Resident #17 stated it was a little before midnight. Resident #17 was waiting for the midnight movie to come on her television when she started to hear Resident #19 in her room next door, yelling Help, Help. Resident #17 thought nothing of this as Resident #19 generally does yell out in the evenings. Resident #19 started to rattle the side rail of her bed, as well. Resident #17 heard Resident #19 say I'll show them. Resident #17 stated when she moved around in her room, she saw smoke coming out from under her bathroom door. Resident #17 then stated she heard the fire alarm go off. Resident #17 went to the hall to yell for help. Review of the witness statement from Resident #08 dated 09/27/24 revealed he was lying in his bed and heard yelling. Resident #08 stated someone was banging on the wall. Resident #08 stated the fire alarm then went off and he saw smoke. Resident #08 ran to get the fire extinguisher and handed it to the nurse. Resident #08 stated the sprinkler system was going off in the room. Resident #08 could not see anything due to the smoke. Resident #08 saw staff coming, and the local police showed up. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the witness statement from STNA #248 dated 09/27/24 revealed there was an alarm on 09/26/24 at 11:45 P.M. RN #229 came to C station to ask him to hurry, and they needed help to get Resident #19 out of her room. STNA #248 stated he immediately went down to Resident #19's room and saw smoke and heard Resident #19 screaming. STNA #248 entered the room and was unable to see anything. STNA #248 managed to get hold of the bed, pushed everything out of his way, and pulled Resident #19 out of the room. The bed was then pushed out of the building. Resident #19 was taken to the hospital. Review of the witness statement by LPN #251 dated 09/27/24 revealed the fire alarm sounded, then looked at the fire panel to see the location of fire. LPN #251 ran to the room of Resident #19 where the fire was located. Resident #08 handed her the fire extinguisher. Resident #19's room was full of smoke, and the water sprinklers were on. LPN #251 stated she could not see anything, but the fire was on the foot of Resident #19's bed. LPN #251 stated she used the fire extinguisher and yelled for help to get the woman out of the room. LPN #251 stated she called 9-1-1 to report the fire in Resident #19's room. Review of the Fire Department's Investigation Report dated 09/26/24 revealed smoked and unsmoked cigarettes, cigarette pack, and a lighter were found near the original location of the bed. The conclusion was an accidental fire caused by smoking materials in close proximity to high concentration oxygen. Review of the EMS report dated 09/27/24 revealed upon arrival to the facility, Resident #19 was alert and oriented and suffering from third degree burns to 15% of her lower left leg and lower right leg. Resident #19 had just been evacuated minutes before arrival. Resident #19 was quickly assessed and given 25 milligrams (mg) of Ketamine for pain and then transferred to the medic. Resident #19's condition was stable and transferred to Hospital #500's burn unit. Review of the hospital document titled Rehabilitation Psychology Follow-Up Note dated 09/30/24 at 5:49 P. M. by Hospital Psychologist (HP) #499 revealed the examination was done related to mental status exam and humanistic interventions. HP #499 stated Resident #19 was alert and oriented, to person, place, time, and generally to situation. Resident #19 was being hospitalized due to burns. Resident #19 had difficultly providing accurate personal history, speech was normal rate, volume, and prosody (a word to describe the rate, rhythm, and melody of speech), but with word finding issues and frequent verbal preservation. Resident #19's mood was anxious; affect appropriate, and congruent. Eye contact at time intense and at other times she was observed staring off into space. Resident #19 asked to walk and later then swim and did not appreciate that there would be any barriers to these activities. Though content relevant to conversation and questioning but with off-topic responses and evident confusion. Delayed in responding to questions rather than most recent prompt. Resident #19 denied perceptual abnormalities, staring into space occasionally but denied any hallucinations when asked. Denied suicidally but endorsed setting a fire to get the attention. Resident #19 discussed that she was calling for help and thought she would set a fire to get help. Resident #19 discussed thinking she was somewhere else. Resident #19 stated the nursing home and funeral home interchangeably and also noted that she thought her son was in the next room at the time. She denied that this was an attempt to die or inflict intentional injury. She reported using lighter to set the fire. Resident #19 was aware of her burns and the association with her actions and the fire that was set. Review of the hospital document titled Critical Care Attestation dated 10/01/24, by Critical Care Physician (CCP) #450 revealed Resident #19 had been admitted to hospital for 35% TBSA burn, and status post escharotomy of the right lower extremity. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the hospital document titled [NAME] Flow Sheet (a tool useful in the management of burns for estimating TBSA) dated 10/01/24 revealed Resident #19 had the following burns: anterior trunk had 13% injury with 5% second degree burns, right lower arm had 3% injury with 2% second degree burns, right thigh had 9.5% injury with 2% second degree burns and 2% third degree burns with 4% total area, right leg was 7% third degree burn, left leg was 7% injury with 5% third degree burn, and right foot was 3.5% injury with 3. 5% third degree burns. Resident #19 had injuries to head, neck, posterior trunk, right and left buttocks, right upper arm, left upper arm, left lower arm, right and left hand and left thigh that had suffered injury. Interview on 10/02/24 at 10:01 A.M. with STNA #240 revealed Resident #19 was not sure what happened to her. STNA #240 stated Resident #19 had set her bed on fire. STNA #240 stated Resident #19 must have had her lighter in her room but was not sure. Sometimes residents at the facility keep their smoking paraphernalia. Interview on 10/02/24 at 10:05 A.M. with STNA #246 stated she did not know what happened to Resident #19 only that she had a fire in her room and was taken to the hospital with burns. STNA #246 stated she arrived at the facility to assist with evacuation of residents at the facility due to the fire that night. STNA #246 stated she had recently received education on fire training on 09/27/24, including the use of a fire extinguisher, but stated she forgot what the fire acronyms RACE and PASS stood for. Interview on 10/02/24 at 10:15 A.M. with STNA #223 stated sometimes the smoking products do not get returned by the residents. STNA #223 stated she does not know what she learned in the fire training. Interview on 10/02/24 at 10:20 A.M. with STNA #235 stated she was not sure about the fire, but that the next day she was educated on 09/27/24. The education included fire drills, using closest exit for evacuation, and to close all resident room doors in the area of the fire. Interviews on 10/02/24 at 10:28 A.M. with the Administrator stated Resident #19 was alert and oriented, supervised smoker, and lit the mattress on fire. At 10:50 A.M., the Administrator showed a picture of Resident #19's burned hospital bed. The hospital bed had a burned area at the foot of the bed on the right lower side of the bed on the top surface of the mattress that was black, charred, and debris was peeled away and attached to bed. The right-side middle area of the bed at the handrail was burned in large circle that was about 12 inches in diameter. The Administrator stated he reviewed the facility's video footage for dates 09/26/24 and 09/27/24 that showed staff was in providing routine care to Resident #19. Interviews on 10/02/24 at 11:55 A.M. with Resident #03, at 12:00 P.M. with Resident #12, at 3:00 P.M. with Resident #89, at 3:38 P.M. with Resident #22 and at 5:00 P.M. with Resident #08 confirmed before the facility had the fire incident on 09/26/24, the facility staff was not monitoring the residents closely in taking cigarettes and lighters away from residents. The five residents all confirmed they were allowed to keep smoking materials with them and not hand them in to the facility. Resident #22 stated Resident #19 was known to keep her materials including a lighter in her room. Resident #08 stated Resident #19 had family in to visit her on 09/26/24 and he heard them fighting about something. Resident #08 stated Resident #19 was yelling and upset. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/02/24 at 12:39 P.M. with STNA #214 stated the fire alarm went off, and then looked at the fire panel to identify Resident #19's room was on fire. STNA #214 headed to Resident #19's room, and before arriving, Resident #17 came out of her room, and stated there was smoke coming out of her door from the connecting bathroom to Resident #19's room. STNA #214 touched the door, and it was not hot then opened the door and looked into the room. STNA #214 stated Resident #19's room had pure black smoke in the room and no fire was seen. STNA #214 stated he could not see or go into the room due to all the smoke in the room as it irritated his throat, and he could not breathe. STNA #214 verified he did not go into Resident #19's room. STNA #214 stated the staff was supposed to collect all the smoking products, but sometimes residents keep their smoking products on them. Observation on 10/02/24 at 3:00 P.M. of the facility's video footage provided by the Administrator, DON, and CN #309 who reviewed the facility video dated 09/26/24 through 09/27/24 revealed a fire alarm started on 09/26/24 at 11:45 P.M. The video showed flashing fire alarms, and in the nurse's station at the beginning of the hall, the call light for Resident #19's room was not lit up. Resident #08 was seen assisting residents at the facility with closing doors, checking rooms, evacuating residents, and grabbing a fire extinguisher to hand to staff. At the end of the video Resident #19 was seen coming down the hall in her hospital bed with staff. The bed was burnt but not on fire. The Administrator stated there was no additional video footage of inside the fire doors to be able to see Resident #19's room after the fire doors closed at 11:45 P.M. Review of the facility interview dated 10/03/24 with the Administrator, Regional Director of Operations (RDO) #334, and the daughter of Resident #19 stated they had interviewed the daughter who provided additional information for the incident on 09/26/24. The daughter denied she had spoken to her mother (Resident #19). The daughter stated she visited her mother (Resident #19) the day of the fire. The daughter stated she left a lighter with Resident #19. The daughter stated she had no idea if her mother had started the fire, but it was possible. Interview on 10/03/24 at 9:21 A.M. with Resident #17 stated before the fire alarm went off at the facility, she had heard Resident #19 in her room constantly yelling for the staff and putting her call light on to get staff. Resident #17 stated she turned around in her room to see smoke pouring out from her bathroom door which was connected to Resident #19's room that shared the same bathroom. Resident #17 stated she came out into the hallway to see staff looking in the glass window of the double fire doors that closed. Resident #17 stated it was like slow motion, and staff were not fast enough. Resident #17 stated the staff never took our cigarette products away and the residents were pissed they could no longer keep their smoking products on them. Interview on 10/03/24 at 10:09 A.M. with the Administrator stated the facility had performed respiratory assessments, head to toe assessments, and residents who smoked signed another smoking agreement. Residents who were smokers at the facility had room sweeps with their permission, one resident denied permission Resident #08, and later then let facility staff sweep the room. The Administrator stated our system worked flawlessly, and our fire system had no problems. Interview on 10/03/24 at 10:10 A.M. with the DON stated they had no issues identified after the fire. The DON stated they changed their smoking set up on 09/27/24 and started two smoking gro [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Capital City Gardens Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 920 Thurber Drive West Columbus, OH 43215	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record reviews, staff interviews, review of facility camera footage, observation, review of a job description, review of the facility Self-Reported Incident (SRI), and facility policy review, the facility failed to be administered in a manner that enabled the facility to utilize available resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This included failure to prevent neglect of residents by staff during a fire that occurred on 09/26/24, failure to ensure residents utilizing oxygen therapy were not able to possess lighters and smoking materials unsupervised, failure to timely and appropriately implement emergency procedures, when a fire occurred in Resident #19's room and ignited the resident's mattress/bedding on fire which ultimately activated the sprinkler system, including: rescuing residents in and near the fire, containing the fire from potentially spreading, alerting emergency personnel timely, and attempting to extinguish the fire. The incident was also not documented on the facility's incident log as an incident with resultant injuries. Additionally, when the Administrator submitted the SRI dated 10/10/24, after a review of the facility's video surveillance on 10/09/24, related to a fire incident on 09/26/24, the Administrator launched an investigation for neglect due to staff response to the fire, and the conclusion was unsubstantiated on 10/17/24 indicating the evidence was inconclusive and facility staff performed emergency procedures properly according to facility policy. On 10/18/24, an Addendum was added to the SRI by the Administrator and indicated upon further review, the facility is substantiating a finding of neglect. This affected one (#19) resident who resided in Room B05 and placed an additional nine residents (#11, #15, #16, #17, #18, #20, #21, #22, and #23), residing in the same smoke compartment as Resident #19 at potential risk due to the potential for the fire and smoke to spread throughout the hall. The facility identified a total of 50 residents currently residing in the facility who smoke (Residents #1, #2, #3, #5, #7, #8, #9, #10, #11, #12, #15, #16, #17, #20, #21, #22, #31, #32, #33, #34, #35, #37, #39, #40, #41, #42, #44, #45, #48, #49, #50, #52, #55, #57, #59, #61, #64, #67, #72, #74, #75, #77, #78, #79, #82, #86, #87, #88, #89, and #91). The facility census was 88. Findings include: Review of the facility document titled Job Description and Performance Standards dated 04/22/24 revealed the Administrator had started a position as Administrator at the facility. The purpose of this position was to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet residents' needs in compliance with federal, state, and local requirements. Interview with the Administrator on 10/03/24 at 10:30 A.M. revealed they did not identify any issues related to the smoking incident when Resident #19 had a fire to her bed on 09/26/24. The Administrator stated the resident has the right to light herself on fire if she chose to and the resident has the right to have cigarettes and lighter on self if she chooses to. (continued on next page)

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	365315	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the complaint and partial extended survey, observations, record review, staff interviews, and policy review, resulted in concerns related to the operation of the facility including but not limited to abuse and neglect, fire safety, and implementing their smoking policy and plan. The facility failed to provide evidence that administrative staff had effective systems in place to timely identify abuse and quality of care concerns. 1. Resident #19's smoking and safety screen dated 09/16/24 revealed Resident #19 needed the facility to store lighter and cigarettes. On 09/26/24 at 11:45 P.M., a fire was started on Resident #19's bed. Resident #19 was sent to the hospital and sustained 35 percent (%) burns on her body. Resident #19 was admitted to the Surgical Care Intensive Care Unit (SICU) for treatment of extensive burns received on her torso, extremities and face. The patient was noted to be in excruciating pain. Resident #19 was treated for acute respiratory failure with hypoxia and was intubated with a moderate inhalation injury. 1a. The facility did not timely report an allegation of injury of unknown origin and/or potential neglect involving Resident #19's fire in her room resulting in burns to her body to the State Survey Agency. Interview on 10/09/24 at 2:00 P.M. with Regional Director of Operations (RDO) #334 confirmed the facility did not report an allegation of injury of unknown origin and/or neglect involving Resident #19 to the State Survey Agency. 1b. The facility did not complete a thorough investigation of the fire in Resident #19's bed. The facility did not identify the source of the fire and determine the timeline of events that occurred after the fire started. The facility did not identify there was a delay in staff's response to the fire until 10/08/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled Incident Investigation-Room [Resident #19's room] Fire dated 09/26/24 through 09/27/24 revealed the following: staff interviews and statements revealed their actions during the active incident and during the evacuation appeared consistent with the video surveillance. Two residents interviewed (Resident #08 and Resident #17) stated Resident #19 was yelling, which was normal in the evening for Resident #19. One resident reported shortly before the fire alarm activated, the resident was heard shouting, I'll show them. The statement seems to stand alone without sufficient context to determine its meaning. Interviews and video surveillance reveal the fire alarm sounded at approximately 11:45 P.M. on 09/26/24. Video shows staff responding appropriately using both the RACE (Rescue, Alert/Alarm, Contain, Extinguish) and PASS (Pull, Aim, Squeeze, Sweep) method of dealing with an active fire. Staff used fire extinguishers to extinguish the flames. At approximately 11:46 P.M., emergency 9-1-1 was called. The local police arrived at the facility at 11:54 P.M. and the Fire Department and EMS arrived at 11:58 P.M. The local police and staff had already evacuated Resident #19 from her room. Resident #19 was examined by medics and transported to the hospital. The report stated Emergency Department notes provided helpful information in determining the origin of the fire. The notes state that the resident intentionally started the fire to get staff's attention. Where the resident obtained an instrument, i.e., matches, a lighter, etc. to ignite the fire cannot be determined. As a supervised smoker, the resident would have had her smoking material and paraphernalia collected at the time of her previous smoking session. An examination of room [Resident #19] and the bed the resident was in was not determinative as to the source of ignition. The Administrator and Maintenance Director #390 closely examined the room and debris looking for a burned cigarette and/or a source of ignition. No cigarettes or lighters or matches were discovered in the debris. However, it can be noted that the bed was the origin of the fire. In fact, there appeared to be two separate ignition points. One point of origin appears to be on the resident's right-hand side of the bed at about the midpoint of the bed; the other point of origin (which looked to be the original point of origin) appeared at the right-side foot of the bed. The report listed the facilities conclusion as: facility staff responded appropriately at the time of the incident, ensuring the fire was extinguished, the residents and others were safely evacuated. Facility staff provided care to the resident prior to the incident. The resident started the fire intentionally and with knowledge that her actions could result in significant harm. The facility will continue to monitor other residents' for both physical and psycho social well-being. The facility will cooperate with the fire department in their investigation of the incident. The report was completed by the Administrator. The facility did not review all available camera footage in the hallway of Resident #19's room when completing their investigation, the facility only reviewed the camera footage down the long hallway and the footage did not show Resident #19's room after the fire doors closed. This camera footage was shown to the State Survey Agency on 10/02/24 at 3:00 P.M. The Administrator stated there was no additional video footage of inside the fire doors to be able to see Resident #19's room after the fire doors closed at 11:45 P.M. on 10/02/24 at 3:00 P.M. The State Survey Agency requested a copy of the camera footage of the fire and on 10/08/24, the facility provided camera footage that included all hallways of the facility including the hallway where Resident #19's door was located. The camera footage of Resident #19's room after the fire doors closed showed there was a delay in the staff's response to rescue Resident #19 and the other residents in the hallway of the fire. Regional Director of Operations #334 explained the Administrator was unaware the facility had this video footage of Resident #19's hallway on 10/08/24 at 11:00 A.M. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/03/24 at 10:09 A.M. with the Administrator and DON revealed the facility in response to the fire performed respiratory assessments and head to toes assessments on other facility residents. The smoking policy was updated and the residents who smoked were divided into two groups, group A and B. The residents who smoke at the facility were educated on the policy update and signed a new smoking agreement. Residents' room sweeps were completed. The DON stated they had no issues identified after the fire. They changed their smoking set up to group A and B which started on 09/27/24. The smokers were educated on the changes, the policy, they signed the new policy and agreed to not keep their smoking materials with them or in their room. The Administrator stated their system worked flawlessly, and their fire system had no problems. Observation and interview on 10/15/24 at 1:45 P.M. with Maintenance Director #390 and Corporate Nurse #309 revealed there was a pile of debris next to the facility sidewalk in the courtyard area where the smokers [NAME] was located. The debris contained insulation, broken ceiling tiles, a resident air mattress that had burn marks on it, a resident call light cord, a phone charging cord, several pop bottles, some burnt fabric, melted and disfigured room blinds and a lighter with scorch marks on it. Maintenance Director #390 stated the fire department put the debris outside on the night of the fire 09/26/24. Maintenance Director #390 verified it was the debris from Resident #19's room, and when the lighter was pointed out, Maintenance Director #390 and Corporate Nurse #309 both verified, they saw the lighter with the burned marks from the fire in the items removed form Resident #19's room. 1c. The facility did not implement their smoking plan and smoking policy prior to 09/27/24. Review of the facility document titled Smoking Plan dated 04/04/23 revealed during the hours the receptionist was in the facility, the following will occur: your cigarettes will be kept with the receptionist. The paraphernalia will need to be turned back into the receptionist, and you will need to get it from the receptionist when you are wanting to go out. Any resident found with their smoking paraphernalia (including cigarettes or lighters) will lose all rights to go out independently as you pose a risk to the safety of all other residents in the facility. Smoking was to occur under the sheltered smoking. Review of the facility's undated policy titled Smoking Policy-Residents' revealed all residents will have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. All residents will be required to follow supervised smoking. Residents may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision. The facility maintains the right to confiscate smoking articles found in violation of our smoking policies. The policy was updated on 09/27/24 to include Smoking was only permitted in designated resident smoking areas, which are located outside of the building. Oxygen use was prohibited in smoking areas. All residents shall have the direct supervision of a staff member, family member, visitor or volunteer, or worker at all time while smoking. All residents are required to follow supervised smoking. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews on 10/02/24 at 11:55 A.M. with Resident #3, at 12:00 P.M. with Resident #12, at 3:00 P.M. with Resident #89, at 3:38 P.M. with Resident #22 and at 5:00 P.M. with Resident #8 confirmed before the facility had the fire incident on 09/26/24, the facility staff was not monitoring the residents closely in taking cigarettes and lighters away from residents. The five residents confirmed they were allowed to keep smoking materials with them and not hand them in to the facility. Resident #22 stated Resident #19 was known to keep her materials including a lighter in her room. Resident #8 stated Resident #19 had family in to visit her on 09/26/24 and he heard them fighting about something. Resident #8 stated Resident #19 was yelling and upset. Interview on 10/02/24 at 12:39 P.M. with State tested Nursing Assistant (STNA) #214 stated the residents at the facility do keep smoking products on them sometimes. Review of the Fire Department's Investigation Report dated 09/26/24 revealed smoked and unsmoked cigarettes, cigarette pack, and a lighter were found near the original location of the bed. The conclusion was an accidental fire caused by smoking materials in close proximity to high concentration oxygen. 1d. Review of the facility's fall and incident log dated from 09/26/24 through 10/02/24 revealed Resident #19 was not documented as an incident with injury on the log. Interview on 10/02/24 at 10:28 A.M. with the Administrator verified Resident #19 was not listed on the facility's fall and incident log provided to the survey team. The Administrator stated he was not sure why her incident was not listed on the fall and incident log. 1e. Review of the facility document titled Emergency Preparedness dated 07/17/24 revealed only forty-five employees were educated. The education included managing oxygen in nursing homes, oxygen therapy, oxygen safety, RACE (Rescue, Alarm, Contain, Extinguish), and PASS(Pull (pull the pin to discharge the extinguisher), Aim (Point the nozzle at the base of the fire), Squeeze (Squeeze the handle to release the extinguishing agent), and Sweep (Sweep the nozzle from side to side at the base of the first until it's out). [NAME] President of Clinical Services #310 verified there was only 45 employees at the Emergency Preparedness and Safety Management training on 10/15/24 at 3:16 P.M. Interview on 10/02/24 at 10:01 A.M. with State tested Nursing Assistant (STNA) #240 stated she was recently educated on fire safety but could not remember the training. Interview on 10/02/24 at 10:05 A.M. with STNA #246 stated she had education on fire on 09/27/24. STNA #246 stated she forgot what the fire acronyms RACE and PASS stood for. Interview on 10/02/24 at 10:20 A.M. with STNA #235 stated she was educated on fire safety on 09/27/24. The education included fire drills, closest exit for evacuation, all doors to close for the fire. STNA #235 stated she could recite what the acronym of RACE meant. STNA #235 stated she was not sure about PASS and the meaning for it. Interview on 10/09/24 at 2:54 P.M. with STNA #214 verified he did not follow RACE during the fire incident involving Resident #19. STNA #214 verified he never rescued the resident or closed the door to contain the fire. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/09/24 at 3:27 P.M. with STNA #230 verified she did not go into Resident #19's room when the fire started to rescue Resident #19. STNA #230 stated she knew Resident #19 was in her room. STNA #230 verified she did not use the fire extinguisher and did not close Resident #19's door to her room. STNA #230 stated she knew what RACE meant but forgot what PASS meant. STNA #230 stated she was educated after the fire. STNA #230 stated she did follow RACE and did rescue other residents, but not Resident #19. Observation on 10/09/24 at 11:30 A.M. with RDO #334 of Video #9 (the camera footage of Resident #19's hallway after the fire started) revealed the facility staff had passed the fire extinguisher and were not shutting the resident's doors to contain the fire, and rescuing Resident #19 who was laying in her bed, while the fire was burning. Resident #19 was not rescued timely by staff at the facility. Interview on 10/09/24 at 2:00 P.M. with RDO #334 confirmed the facility did not follow their policy and procedures regarding fire safety, they did not rescue the resident in the room where the fire occurred timely, and the facility staff did not implement the fire procedures and take a fire extinguisher to the room and attempt to extinguish the fire. He confirmed multiple staff walked past a fire extinguisher hanging on the wall, did not attempt to pick up the extinguisher and the staff did not evacuate other residents on the hallway or shut the room doors to contain the fire. Interview on 10/15/24 at 4:30 P.M. with Corporate Nurse (CN) #309 stated Maintenance Director #390 was auditing staff for fire training and reviewing the acronyms for RACE and PASS with several employees who still do not remember the meaning. CN #309 verified the facility had 112 employees on the staff identifier list. This deficiency represents non-compliance investigated under Master Complaint Number OH00158457, Complaint Number OH00158364, and Complaint Number OH00158347.