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	11/21/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on interview, observation, record review and policy review, the facility failed to implement infection control procedures during a dressing change and while storing soiled laundry. This affected one (Resident #92) of three residents reviewed for wounds and had the potential to affect all residents residing in the facility. The facility census was 93. Findings include: 1. Review of the medical record for Resident #92, revealed an admitted [DATE]. Diagnoses included but were not limited to type 2 diabetes mellitus with diabetic neuropathy, human immunodeficiency virus disease, pneumonia due to other gram-negative bacteria and methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of resident is rarely/never understood. The resident was assessed to require total dependence on all aspects of assisted with daily living care. Review of the active plan of care dated 09/25/24 for Resident #92 revealed enhanced barrier precautions related to indwelling medical device with interventions to wear gown and gloves for high contact resident care. Review of the active physician order dated 09/21/24 for Resident #92 revealed enhanced barrier precautions related to indwelling medical device and/or wound and /or infection during high contact resident care activities. Further review revealed a physician order dated 11/11/24 for this resident revealed a wound order for the chest area: cleanse with normal saline, pat dry, apply collagen, cover with border dressing. Observation on 11/14/24 at 1:02 P.M. of Licensed Practical Nurse (LPN) #399 revealed a wound dressing change was completed to the left chest area of Resident #92. LPN #399 did not don a gown prior to providing wound care to Resident #92 despite requiring the use of enhanced barrier precautions. Observation also revealed LPN #399 did not wash her hands after a glove change when removing the soiled dressing and donned a new pair of gloves to complete wound care. (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: 365315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/14/24 at 1:11 P.M. with LPN #399 verified no hand washing was completed between the removal of soiled gloves (worn when removing the soiled dressing) and the donning of new gloves. The LPN also verified a gown was not worn during the dressing change despite the resident having orders for enhanced barrier precautions. Review the facility policy titled Wound Care revised October 2010 revealed put on exam gloves, loosen tape and remove dressing. Pull glove over dressing and discard into appropriate receptacle and to wash and dry hands thoroughly. Review of the facility policy titled Enhanced Barrier Precautions dated 04/01/24 revealed examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include wound care. 2. Observation on 11/14/24 at 10:15 A.M. revealed a stairwell leading to the basement with a small landing. Further observation revealed the facility's laundry room was located in the basement. Interview on 11/14/24 at 10:30 A.M. with Laundry Staff (LS) #357 revealed since the facility's elevator has been out of order, the laundry staff have had to take the laundry up and down the stairs. LS #357 stated the staff will throw the soiled laundry down the stairs to the landing and then the laundry staff will remove the laundry from the landing and place it in the cart at the bottom of the stairs which is then taken to the laundry room for processing. Observation on 11/18/24 at 1:11 P.M. revealed a large pile of bagged and unbagged soiled laundry on the landing of the stairwell leading to the basement of the facility. There were several unbagged clothing articles, towels and a visibly soiled washcloth lying on the steps. There was an empty wheeled cart located at the bottom of the stairwell. Interview on 11/18/24 at 1:16 P.M. with LS #252 confirmed the unbagged soiled laundry laying on the landing and the visibly soiled washcloth laying on the step. LS #252 donned gloves and removed the laundry from the landing and the stairs and placed it in the cart at the bottom of the stairwell. Observation on 11/19/24 at 2:20 P.M. revealed a moderate sized pile of bagged, soiled laundry located on the landing of the stairwell, leading to the facility basement. Interview on 11/19/24 at 2:25 P.M. with Regional Registered Nurse (RRN) #550 confirmed the bagged soiled laundry located on the stairwell landing. RRN #550 stated the expectations of the staff were to ensure soiled laundry was bagged and handled using infection control procedures which included not having the soiled laundry be thrown down the stairwell and stored on the landing of the stairwell until the laundry staff could remove and take it to the laundry room. This deficiency represents non-compliance investigated under Complaint Number OH00159824.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, staff and resident interviews, review of plumbing invoices, and review of facility policy, the facility failed to maintain a safe, functional, and sanity environment in the shower room for the B hallway. This deficient practice had the potential to affect all residents residing in the facility. The facility census was 93. Findings Include: Review of the plumbing company invoice #143340436 dated 11/12/24 revealed plumbing company arrived at the customers property for a shower drain back up. After attempting to cable the shower drain, the blockage was removed and restored flow to the drain. Review of the plumbing company invoice #143544314 dated 11/13/24 revealed the facility was experiencing emergency flooding in the B hallway over the course of three days. The plumbing company attempted to clear the main line using high pressure jetter and a camera to evaluate the line. Observation on 11/14/24 at 10:10 A.M. revealed the shower room located on the B hallway there were multiple ceramic tiles laying on the floor revealing the wet wall material. There was a hole approximately three inches in diameter into the wall behind the toilet at the base of the wall. In the shower stall/area, there was a brown substance with dried particles of building material and dirt in a circle pattern radiating from the drain in the center of the shower stall/area. The shower room for B hallway had been removed from service for resident use. Interview on 11/14/24 at 10:55 A.M. with Resident #35 revealed there had been water in the hallway and in the room coming from the B hallway shower room on Monday 11/11/24 into Tuesday 11/12/24, the water was brown in color and had a horrible smell. Resident #35 stated the administration had offered to relocate Resident #35 and spouse Resident #34, neither Resident #34 or Resident #35 wanted to be separated so they remained in their room. Resident #35 stated the shower room has not been usable since the flooding occurred. Observation on 11/18/24 at 7:50 A.M. revealed the shower room located on the B hallway had been placed back into service for resident use. The shower stall/area had been cleaned with the previous brown substance and dried building material and dirt having been removed and the shower area appeared to have been recently used for showering. There continued to be a three-inch diameter hole at the base of the wall behind the toilet and the wall tiles continued to be laying on the floor with the wall material exposed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility timeline email of the emergency flooding received on 11/18/24 at 9:11 A.M. authored by the Regional Director of Plant Operations (RDPO) #512 revealed on 11/12/24 at 9:20 A.M. there was reported severe flooding of the bathroom at the facility which included most of the hallway and leaking into several resident rooms (rooms and hallway was not identified). The plumbing company was contacted, arrived at the facility and had stated the blockage was removed and flow was restored at 10:30 A.M. RDPO #512 stated at approximately 6:30 P.M. on 11/12/24 the facility notified of the emergency flooding in the B hall shower room extending into the hallway and nurse's station area. The local water valve located in the B hallway shower was turned off which ceased the drain backup in the shower. At approximately 8:30 P.M. the drain in the B hallway shower began backing up again into the shower room and the hallway. At this time the decision was made to shut the main water valves off which completely ceased all drainage backups. The plumbing company was contacted and advised the facility they would be returning to the facility on [DATE] to address the drainage backup. The facility then made available emergency water sources and personal hygiene wipes for use to the staff and the residents. All the main water lines for the sprinkler system were still active for any potential emergencies that could occur. On 11/13/24 the plumbing company returned to the facility with the results of troubleshooting and use of cameras revealed the main blockage was located in the line around the B hallway shower room. This blockage was determined to be the same blockage which was identified and supposedly removed on 11/12/24. Once the blockage was fully pushed through the line to the main drain line, water was slowly restored resulting in several shut off valves were blown off due to the water pressure. The plumbing company repaired all shut off valves and water was restored to the facility. The blockage was fully pushed through the main line to the street line and was determined to be several wash cloths and other pieces of fabric debris which caused the blockage in the facility. Interview on 11/18/24 at 10:30 A.M. with Certified Nursing Assistant (CNA) #335 revealed CNA #335 was not working during the water problems on 11/11/24 and 11/12/24. When CNA #335 returned to work on 11/14/24 B hallway shower room was not usable and the residents had to use the C hallway shower room for showers but the shower room was now back in use. Interview on 11/18/24 at 10:45 A.M. with CNA #236 revealed the facility has had problems with the plumbing for a long time. CNA #236 stated there are residents which will get mad at the facility and have been known to flush non-flushable items down the toilets causing plumbing issues and water leaks. CNA #236 stated, while the facility had the plumbing company fixing the most recent plumbing problem, the water had to be turned off and the facility had passed out wipes, large bottles of water and smaller bottles of water to the staff and the residents to use during the period the water was turned off. Interview on 11/14/24 at 3:15 P.M. with the Administrator confirmed the facility had experienced a plumbing failure on 11/11/24 and 11/12/24 causing water damage to the B hallway shower room. The Administrator stated the plumbing company had been contacted and subsequently came to the facility on [DATE] to investigate and fix the plumbing failure. The plumbing company had to return on 11/13/24 for continued drainage and flooding issues which were located and repaired. The Administrator stated the plumbing company had located a clog in the pipe which had been identified as wash cloths. Review of the facility's policy titled, Maintenance Service dated 12/09 revealed, Maintenance is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at al times. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents non-compliance investigated under Complaint Number OH00159812.