

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 12/12/2024
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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on record review, review of facility investigations, staff interviews, and facility policy and procedure, the facility failed to ensure allegations of abuse and misappropriation had thorough investigations and documentation of the investigation. This affected three residents (#86, #94, and #95) out of four residents reviewed for allegations of abuse and misappropriation. The facility census was 89.</p> <p>Findings include</p> <p>1. Review of the medical record for Resident #94 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included surgical aftercare, endocarditis, bacteremia, shortness of breath, anxiety, and edema.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 was cognitively intact with a BIMS of 15 and was independent with mobility.</p> <p>Review of the online Self-Reported Incident (SRI) #254189 dated 11/18/24 revealed Resident #94 reported, during a care conference with social services staff, that he had to wake up Certified Nursing Aide (CNA) #55 for assistance. The resident also reported when he woke the CNA up, the CNA pushed Resident #94 away. The social service staff reported the allegation to the Administrator and an investigation was initiated. The summary stated the facility conducted a further interview with Resident #94, interviews with like residents, and interviews with staff. The facility also revealed they completed a head-to-toe assessment on the resident, reviewed Resident 94's care plan, removed the CNA from the schedule and reviewed CNA #55's employee file.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SRI investigation file revealed only a face sheet and care plan for Resident #94 were included. Upon request of further documentation the facility provided staff education, standardized questionnaire interviews with like residents and identical typed statements from staff. Review of the six identical staff statements revealed the statements were dated 11/19/24 and stated, I am unaware of any incident or allegation of abuse by a staff member toward Resident #94 or of any Resident at Capital City Gardens. None of the statements recalled events of the shift in question or interactions with Resident #94 or CNA #55 during the shift in question. Review of CNA #55's statement revealed he/she denied the allegation. The SRI investigation further revealed the facility had no interviews or statements from Resident #94, who reported the abuse allegation. The investigation revealed social service staff spoke with the resident during the care conference, and then the facility completed an initial interview/statement with the resident, and they also completed a follow-up interview/statement with the resident that was the same as the initial statement. Further review of the facility investigation revealed the facility had no actual statement written or signed as true by Resident #94.</p> <p>Interview on 12/11/24 at 1:07 P.M. with the Administrator revealed Resident #94's statement was incorporated in the allegation with details in the SRI summary. A follow up interview at 1:30 P.M. confirmed facility had no written statements or signed statements of Resident #94's direct account of the allegation. The Administrator also did not agree that the investigation was incomplete, but acknowledged the investigation summary was a summary of the evidence, but not actual evidence itself.</p> <p>2. Review of the medical record for Resident #86 revealed an admitted [DATE]. Diagnoses included hemiparesis, cerebral infarction, diabetes, dysphagia, anemia, heart failure and schizoaffective disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 was cognitively intact with a BIMS of 14 and was dependent with transfers and activities of daily living.</p> <p>Review of Resident #86's progress notes dated 11/26/24 revealed the resident reported another resident entered her room and groped her breast. The police were notified and a report was made.</p> <p>Review of the Self-Reported Incident (SRI) #254518 dated 11/26/24 revealed Resident #86 reported a male resident (Resident #46) entered her room and touched her inappropriately and the resident was also asked to reveal her breasts. An unnamed staff reported the allegation to the Administrator and an investigation was initiated. The summary revealed police were notified and interviews with like residents and staff were also completed. Resident #86 was interviewed by social service staff and revealed she had no recollection of the allegation and she denied interactions with Resident #46.</p> <p>Review of the SRI investigation file revealed along with the summary of the investigation, only a face sheet and care plan for Resident #86 was included. Upon request of further documentation, the facility provided facility education, standardized questionnaire interviews with like residents and identical typed statements from staff. Review of the six staff statements revealed the facility had identical statements dated 11/27/24 that stated, I am unaware of any incident or allegation involving inappropriate behavior or touching between Resident #46 and #86 or of any allegation involving appropriate behavior or touching between any resident. None of the staff statements recalled events of the shift in questions or interactions with Resident #46 or Resident #86 during the shift in question. Review of the signed statement from Resident #46 revealed he denied any knowledge of the issue or wrongdoing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the additional information provided for the SRI investigation revealed the facility had no interviews or statements from Resident #86 with specific details of her allegation. The facility had only provided a three-question questionnaire with yes or no answers from Resident #86. The questions were Do you feel safe? and the resident answered yes; Has another resident ever entered your room without being invited, if yes did you report it and what happened? the resident answered no; and If someone enters your room or touches you without consent, do you know how to report it? and the resident answered that they would call the police.</p> <p>Interview on 12/11/24 at 1:07 P.M. with the Administrator revealed Resident #86's statement was incorporated in the allegation with details in the SRI summary. A follow up interview at 1:30 P.M. confirmed the facility had no written statements or signed statements of Resident #86's direct account of the allegation. He also stated they facility came to the conclusion that Resident #46 was involved due to the initial report from Resident #86, but when the resident was re-interviewed, she denied anything happened. The Administrator also did not agree that the investigation was incomplete, but acknowledged the investigation summary was a summary of the evidence, but not actual evidence itself.</p> <p>3. Review of the medical record for Resident #95 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included cervical displacement, cutaneous abscess, endocarditis, opioid use, bacteremia, chronic hepatitis, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was cognitively intact with a BIMS of 15 and was independent with transfers and mobility.</p> <p>Review of the Self-Reported Incident (SRI) #253938 dated 11/11/24 revealed Resident #95 reported she was missing a half-carat diamond earring, but there was no specific allegation that it was stolen or as misappropriated. The resident had endorsed she wrapped the earring in a napkin and may have thrown it away, but an investigation was initiated. The summary revealed interviews were conducted with like residents and staff.</p> <p>Review of the SRI investigation file revealed standardized questionnaire interviews with like residents. The facility provided no evidence of interviews or statements from Resident #95, who reported the allegation, and also failed to provide any evidence of staff statements.</p> <p>Interview on 12/11/24 at 1:07 P.M. with Administrator revealed Resident #95's statement was incorporated in the allegation with details in the SRI summary. A follow up interview at 1:30 P.M. confirmed the facility had no written or signed statements of Resident #95's direct account of the allegation, nor any staff statements related to the investigation of missing items. The Administrator also did not agree that the investigation was incomplete, but acknowledged the investigation summary was a summary of the evidence, but not actual evidence itself.</p> <p>Interview on 12/12/24 at 8:18 A.M. with Regional Clinical Nurse #100 revealed the facility corporate office used universal statements. She acknowledged facility investigations should be complete and thorough and verified the investigation files were not complete and documents had to be located from various sources at the facility, and several items remained unaccounted for including staff statements and resident statements.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/27/17, revealed it was the facility's policy to investigate all alleged violations involving Abuse, Neglect, and Misappropriation. It stated the facility staff shall immediately report all such allegations to administration/designee. The policy revealed the allegation shall be investigated and the investigation shall include interviews with the accused and all witnesses. A statement shall be obtained from the resident(s) involved, the accused, and each witness. The policy further stated the evidence of the investigation should be documented.</p>		