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No. 0938-0391

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	03/06/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, resident interview, staff interview, and facility document review, the facility failed to allow residents to refuse treatment without the threat of being discharged from the facility. This affected one (Resident #201) of two residents reviewed for dignity/rights. The census was 89. Findings include: Review of Resident #201's medical record revealed an admitted [DATE]. Resident #201's diagnoses included osteomyelitis, fusion of spine, asthma, discitis, intraspinal abscess and granuloma, arthritis due to other bacteria, methicillin susceptible staphylococcus aureus, bacteremia, viral hepatitis C, other psychoactive substance abuse, subluxation of L4/L5 (lumbar) vertebra, anemia, depression, anxiety disorder, muscle weakness, difficulty walking, and need for assistance with personal care. Review of the minimum data set (MDS) assessment, dated 02/25/25, revealed she was cognitively intact. Review of Resident #201's Substance Use Disorder Program agreement revealed she signed the form to agree to substance use treatment in the facility on 02/13/25. She signed this document while she was in the hospital, prior to being admitted to the facility. Interview with Resident #201 on 03/03/25 at 2:39 P.M. and 03/06/25 at 12:11 P.M., confirmed she felt forced to go through the stepping stones program (substance abuse program) while in the facility; she confirmed she does not want to be a part of it. She stated she does not remember talking or hearing about the stepping stones program at this facility. She remembers talking to someone in the hospital about multiple facilities she could go to, but she chose to go to the one she was in right now. She stated the facility Administrator and Stepping Stones Counselor #303 both went to her room after she was admitted and told her she needed to sign a variety of consent form or she would be discharged from the facility. She stated she could not remember what the consent forms were, but she was confident she was told that she needed to sign the documents and participate in the stepping stones program, or she would be discharged from the facility. She stated she would not have admitted to this facility had she known she would have had to go through with the stepping stones program. She confirmed she did not want to go to counseling, did not want to drug test, and did not want to have visitors in a public place. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Corporate Director #301 and [NAME] President of Business Development (VPBD) #305 on 03/06/25 at 10:05 A.M., revealed each resident who has a history of substance abuse, the facility will be notified about a possible referral due to this facility having the stepping stone program. The residents will sign a contract prior to entering the facility for medical care. They are told about the stepping stones program prior to admitted to this facility, while they are at the hospital. The facility hospital liaison goes to the hospital, discusses the program and what is expected of them if they are admitted , and get them to sign the contract that they will participate in the stepping stone program. They continued to say the resident signed the contract to participate in the stepping stones program, so they have to participate when they are in the facility. When asked if a resident would be discharged if they did not participate, their answer was, each resident is different, but it would be discussed. Interview with Administrator on 03/06/25 at 12:00 P.M., revealed the resident will sign a contract at the hospital prior to being admitted to the facility, to participate in the stepping stones program. The hospital liaison will review the contract with the resident prior admitted to the facility, and then the resident will sign it. He confirmed if the resident comes into the facility, and they determine they don't want to do the stepping stones program, they will try to find another facility for the resident and perform a safe discharge. Interview with Stepping Stones Counselor #303 on 03/06/25 at 12:27 P.M., revealed the hospital will give referrals to the facility about those who have a positive drug test or a history of substance abuse. She confirmed if they don't sign the consent forms (transportation, medical care, etc) in the facility for treatment, they can not go forward with stepping stones, and they will be removed from that program. She stated she has no decision power as to whether the resident stays in the facility if they don't continue with the stepping stones program. Review of the undated facility agreement titled, Substance Use Disorder Program, revealed a Stepping Stone's counselor will conduct in-house counseling sessions on a frequency to be determined where attendance for those in the substance use disorder program is mandatory. Refusal to attend such sessions will result in immediate discharge planning due to refusals to participate as previously agreed prior to admission. The candidate for admission to the facility and Substance Use Disorder program will also agree, prior to admit, to the following protocol based on the team collaboration with the physicians and certified nurse practitioners (CNP) involved in the Substance Abuse program: leave of absences (LOA) based on physician order, supervised visits with outside visitors in a common area, visitors alone in the resident's rooms based on discretion of the physician and interdisciplinary team (IDT), ancillary physician appointments outside the facility may require a responsible escort, random labs and urine drug screens on an as needed basis. The resident will be immediately discharged based on the IDT investigation for any violation of the Substance Use program in collaboration with the involved physicians and CNPs. Review of Facility Services Agreement between this facility and Stepping Stones Outpatient Services, LLC, dated 03/10/21, revealed the agreement identified Stepping Stones as provider throughout the language of the agreement. Under the section of Resident Choice, the agreement stated, the parties agree that nothing contained in this agreement shall prevent any resident from electing services from any health care provider of resident's or their legal representative's choosing and at no time shall any resident of the facility be obligated to use the services offered by provider.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on observations, medical record review, resident interview, staff interview, and facility policy review, the facility failed to ensure air temperatures remained in the appropriate range. This affected three (#81, #79, and #247) of seven resident rooms observed for air temperatures. Also, the facility failed to repair a sink to prevent continuous dripping noises. This affected one (#59) of seven residents rooms observed. The census was 89. Findings include: 1. Review of Resident #81's medical record revealed an admission dare on 12/15/24. Her diagnoses included cachexia, unspecified protein calorie malnutrition, hypotension, fatty liver, post traumatic stress disorder, borderline personality disorder, bipolar disorder, polyneuropathy, vitamin A deficiency, asthma, type II diabetes, malingerer, anxiety disorder, muscle weakness, cellulitis, pulmonary embolism, anemia, thrombocytopenia, and intellectual disability. Review of her minimum data set (MDS) assessment, dated 12/20/24, revealed she was cognitively intact. Observation on 03/03/25 at 4:03 P.M., revealed Resident #81 underneath three different blankets, lying in her bed. She expressed that it was very cold in her room. Observation of with Regional Maintenance Director #300 during this time, found that his air temperature tool deemed the room to be 77 degrees, but the air vent to her room was blowing cold air and there was cold air blowing in from her window, which is where her bed was located. Regional Maintenance Director #300 confirmed they would have the Heating Ventilation Air Conditoning (HVAC) vendor to the facility as soon as possible to assess the heating units for each room that had issues. Observation on 03/04/25 at 7:38 A.M., revealed Resident #81 was again under three blankets in bed, but she was covering her head with the blankets as well. The room was frigid to feel, and Resident #81 confirmed she was cold. Regional Maintenance Director (RMD) #300 entered Resident #81 room and confirmed with his air temperature tool that it was 66 degrees in her room. He confirmed the HVAC vendor would be in the facility that day to work on the units. Administrator offered for Resident #81 to move to a semi-private room for the time being, but she declined due to wanting to remain in her private room. Interview with Resident #81 on 03/03/35 at 4:03 P.M. and 03/04/25 at 7:40 A.M., confirmed her room is constantly that cold. She confirmed the maintenance staff told her that a valve needed to be replaced in her room unit, but she is unsure if that has been completed. She confirmed she was covering her head on 03/04/25 because she did not want icicles to form from her nose because it was so cold. Interview with RMD #300 on 03/04/25 at 7:45 A.M. and 03/05/25 at 9:00 A.M., confirmed that Resident #81 room temperature on 03/04/25 was 66 degrees. He confirmed that was too cold and they would be addressing the issue. On 03/05/25, he confirmed the HVAC vendor came to the facility and found that the HVAC lines needed to be bled so they got air pockets out. The system is working appropriately now. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #79's medical record revealed an admitted [DATE]. Her diagnoses included end stage renal disease, type I diabetes, hypertension, chronic pain syndrome, asthma, hypothyroidism, insomnia, polyneuropathy, other psychoactive substance abuse, anxiety disorder, major depressive disorder, scoliosis, history of falling, and anemia. Review of her MDS assessment, dated 01/24/25, revealed she was cognitively intact. Observations on 03/04/25 at 7:53 A.M., found that Resident #79 room was 68 degrees, after she had complained her room was cold. The temperature was confirmed by Regional Maintenance Director #300. Interview with Resident #79 on 03/04/25 at 7:53 A.M., confirmed her room was cold and had been that way for about a week. She stated she doesn't want to move, but would prefer to have her heat fixed soon. Interview with RMD #300 on 03/04/25 at 7:55 A.M. and 03/0/25 at 9:00 A.M., confirmed Resident #79 room temperature was 68, which was outside the acceptable range. He gave same reason as Resident #81 room for being cold; they had to bleed the HVAC lines to get the air pockets out. They would be monitoring the affected rooms three times daily until they have deemed the temperature issue has been resolved. 47059 3. Review of Resident #247's medical record revealed admitted [DATE], with diagnoses that included iron deficiency anemia, peripheral vascular disease, end stage renal disease with dependence on renal dialysis, type 2 diabetes mellitus with neuropathy and retinopathy, psychoactive substance abuse, atrial fibrillation, seizures, and an acquired absence of left leg below the knee. Review of the admission MDS assessment dated [DATE] revealed Resident #247 was cognitively intact with brief interview for mental status (BIMS) score of 13/15. Interview on 03/03/25 at 09:48 A.M., with Resident #247 in his room, revealed Resident #247 feels the room is always cold. Resident #247 has been in the facility for a week and there has been no heat in the room the whole time. Resident #247 states he has asked several times for the heat to be fixed and the temperature in the room never gets warmer. Observation on 03/03/25 at 10:30 A.M., of Resident #247's room with RDM #300 revealed the air thermometer registered a temperature fluctuating between 69- and 70-degrees Fahrenheit. Interview on 03/03/25 10:33 A.M., with RDM #300 confirmed room temperature reading topped out at 70.7 degrees Fahrenheit. Regional director of maintenance #300 confirmed room temperature readings should be warmer at 71 - 81 degrees Fahrenheit. 49039 4. Review of the medical record for Resident #59 revealed an admitted [DATE], with diagnoses of major depressive disorder, post-traumatic stress disorder, panic disorder, schizophrenia, psychoactive substance abuse, anxiety, insomnia and unspecified mood disorder. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 10/27/23 revealed Resident #59 has diagnoses of anxiety with an intervention of maintaining a calm environment. Review of MDS assessment completed 01/17/25 revealed Resident #59 has a brief interview for mental status (BIMS) score of 15, indicating the resident is cognitively intact. Review of functional abilities section revealed the resident requires supervision or touching assistance with oral hygiene, toileting, and personal hygiene. Observation on 03/05/25 at 3:46 P.M., of Resident #59 revealed a significant buildup of scaling between the porcelain and the left handle of the sink faucet. This buildup prevented the sink from shutting off completely, causing a continuous flow of water to spill into the sink basin Interview on 03/05/24 at 3:44 P.M., with Resident #59 voiced concern regarding the constant leaking of the sink since admission to the facility, the resident voiced that staff members were notified of the issue and the noise was annoying. Observation on 03/06/25 at 10:31 A.M., of Resident #59's room revealed the sink was still leaking with the large amount of scaling and build up. Interview on 03/06/25 at 10:35 A.M., with Maintenance Director #178 confirmed presence of building up on the sink, he confirmed he was unaware of the issue and currently did not have a request out to fix the sink. Review of policy titled, Quality of Life - Homelike Environment dated May 2017, revealed residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: comfortable and safe temperatures (71-81 degrees). This deficiency represents non-compliance investigated under Complaint Numbers OH00162277, OH00162188, and OH00161970.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview and policy review, the facility failed to ensure all resident Pre-Admission Screening and Resident Review (PASARR) documents were accurate to resident current conditions and diagnoses. This affected three (#3, #15, and #59) of four residents reviewed for PASARR documents. The census was 89. Findings include: 1. Review of Resident #3's medical record revealed an admitted [DATE]. Her diagnoses included acute bronchitis, epileptic seizures, pulmonary embolism, post traumatic stress disorder, conversion disorder, phantom limb syndrome, bipolar disorder, unspecified protein calorie malnutrition, hypothyroidism, hypertension, other cervical disc degeneration, vitamin D deficiency, insomnia, atrial fibrillation, nonrheumatic mitral valve prolapse, muscle weakness, hypotension, repeated falls, pain, type II diabetes, depression, macular degeneration, hypermetropia, hyperlipidemia, anxiety disorder, acquired absence of right leg below knee, and epilepsy. Review of her Minimum Data Set (MDS) assessment, dated 12/09/24, revealed she was cognitively intact. Review of Resident #3 PASARR document, dated 11/03/22, revealed under Section E, the diagnoses listed were panic or other severe anxiety disorder. But review of her diagnoses list, she also had the following diagnoses that should have been indicated/updated on her PASARR document: bipolar disorder, major depressive disorder, and post traumatic stress disorder. 2. Review of Resident #15's medical record revealed an admitted [DATE]. Her diagnoses were acute pulmonary edema, type II diabetes, ulcerative colitis, respiratory failure, major depressive disorder, chronic obstructive pulmonary disease, lymphedema, atrial fibrillation, chronic kidney disease (stage III), anxiety disorder, repeated falls, muscle weakness, dorsalgia, bipolar disorder, anemia, insomnia, heart failure, hypertension, adult failure to thrive, mood disorder, and nicotine dependence. Review of her MDS assessment, dated 02/13/25, revealed she was cognitively intact. Review of Resident #15 PASARR document, dated 02/15/24, revealed under Section E, the diagnoses listed were mood disorder and depression. But review of her diagnoses list, she also had the following diagnoses that should have been indicated/updated on her PASARR document: bipolar disorder, anxiety disorder, and adult failure to thrive. Interview with Social Services #207 on 03/06/25 at 8:35 A.M. confirmed the PASARR documents for Residents #3 and #15 need to be updated to accurately reflect her diagnoses. 49039 3. Review of the medical record for Resident #59 revealed an admitted [DATE], with diagnoses of major depressive disorder, post-traumatic stress disorder, panic disorder, schizophrenia and psychoactive substance abuse. Updated diagnoses included anxiety, insomnia and unspecified mood disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of preadmission screening and resident review (PASARR) identification screen dated 04/10/23 revealed diagnoses present were schizophrenia, mood disorder, panic or other severe anxiety disorder and post-traumatic stress disorder. Review of physician orders dated 08/19/24 revealed Melatonin capsule three milligrams (mg) at bedtime for insomnia. Review of minimum data set (MDS) assessment completed 01/17/25 revealed Resident #59 has a brief interview for mental status (BIMS) score of 15, indicating the resident is cognitively intact. Review of additional active diagnoses included insomnia. Review of physician note dated 02/16/25 revealed diagnoses of depressive disorder with anxiety and insomnia, treated with escitalopram, buspirone and Melatonin with a follow up with psychiatry. Review of psychiatric note dated 02/18/25 revealed Resident #59 reports stable anxiety, however has a history of excessive worrying which occurs more days than not, for greater than 6 months with the following symptoms: restlessness, daytime fatigue, irritability and sleep disturbance. Interview on 03/06/25 at 8:35 A.M., with Admissions/Social Services #207 confirmed Resident #59 PASARR screening completed on 04/10/23 was inaccurate because it did not include the diagnosis of insomnia. Review of the undated policy titled, Resident Assessment - Coordination with PASARR Program, revealed the facility coordinates assessments with the PASARR program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The social services director shall be responsible for keeping track of each resident;s PASARR screening stats, and referring to the appropriate authority. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview and policy review, the facility failed to ensure all significant mental health changes were communicated to the state mental health agency. This affected three (#3, #15, and #59) of four residents reviewed for Pre-Admission Screening and Resident Review (PASARR) documents. The census was 89. Findings include: 1. Review of Resident #3's medical record revealed an admitted [DATE]. Her diagnoses included acute bronchitis, epileptic seizures, pulmonary embolism, post traumatic stress disorder, conversion disorder, phantom limb syndrome, bipolar disorder, unspecified protein calorie malnutrition, hypothyroidism, hypertension, other cervical disc degeneration, vitamin D deficiency, insomnia, atrial fibrillation, nonrheumatic mitral valve prolapse, muscle weakness, hypotension, repeated falls, pain, type II diabetes, depression, macular degeneration, hypermetropia, hyperlipidemia, anxiety disorder, acquired absence of right leg below knee, and epilepsy. Review of her Minimum Data Set (MDS) assessment, dated 12/09/24, revealed she was cognitively intact. Review of Resident #3 PASARR document, dated 11/03/22, revealed under Section E, the diagnoses listed were panic or other severe anxiety disorder. But review of her diagnoses list, she also had the following diagnoses that should have been indicated/updated on her PASARR document: bipolar disorder, major depressive disorder, and post traumatic stress disorder. Review of her progress notes revealed no evidence to support the state mental health agency was notified of the significant mental health changes as required. 2. Review of Resident #15's medical record revealed an admitted [DATE]. Her diagnoses were acute pulmonary edema, type II diabetes, ulcerative colitis, respiratory failure, major depressive disorder, chronic obstructive pulmonary disease, lymphedema, atrial fibrillation, chronic kidney disease (stage III), anxiety disorder, repeated falls, muscle weakness, dorsalgia, bipolar disorder, anemia, insomnia, heart failure, hypertension, adult failure to thrive, mood disorder, and nicotine dependence. Review of her MDS assessment, dated 02/13/25, revealed she was cognitively intact. Review of Resident #15 PASARR document, dated 02/15/24, revealed under Section E, the diagnoses listed were mood disorder and depression. But review of her diagnoses list, she also had the following diagnoses that should have been indicated/updated on her PASARR document: bipolar disorder, anxiety disorder, and adult failure to thrive. Review of her progress notes revealed no evidence to support the state mental health agency was notified of the significant mental health changes as required. Interview with Social Services #207 on 03/06/25 at 8:35 A.M., confirmed she had not notified the state mental health agency of the significant changes for either resident. 49039 (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses of major depressive disorder, post-traumatic stress disorder, panic disorder, schizophrenia and psychoactive substance abuse. Updated diagnoses included anxiety, insomnia and unspecified mood disorder. Review of preadmission screening and resident review (PASRR) identification screen dated 04/10/23 revealed diagnoses present were schizophrenia, mood disorder, panic or other severe anxiety disorder and post-traumatic stress disorder. Review of physician orders dated 08/19/24 revealed Melatonin capsule three milligrams (mg) at bedtime for insomnia. Review of MDS assessment completed 01/17/25 revealed Resident #59 has a brief interview for mental status (BIMS) score of 15, indicating the resident is cognitively intact. Review of additional active diagnoses included insomnia. Review of physician note dated 02/16/25 revealed diagnoses of depressive disorder with anxiety and insomnia, treated with escitalopram, buspirone and Melatonin with a follow up with psychiatry. Review of psychiatric note dated 02/18/25 revealed Resident #59 reports stable anxiety, however has a history of excessive worrying which occurs more days than not, for greater than 6 months with the following symptoms: restlessness, daytime fatigue, irritability and sleep disturbance. Interview on 03/06/25 at 8:35 A.M. with Admissions/Social Services #207 confirmed Resident #59 PASARR screening completed on 04/10/23 was inaccurate because it did not include the diagnosis of insomnia. Additionally, this incorrect review had been sent to the Department of Aging and would need to be corrected. Review of the undated policy tiled, Resident Assessment - Coordination with PASARR Program, revealed the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Additionally any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, staff interview, and policy review, the facility failed to ensure weekly weights were obtained per physician orders. This affected two (#77 and #92) of five reviewed for nutritional monitoring. The facility census was 96. Findings include: 1. Review of the medical record for Resident #92 revealed an admitted [DATE], with diagnoses of acute and subacute infective endocarditis, bacteremia, viral hepatitis, presence of heart valve replacement, rheumatic tricuspid insufficiency, shortness of breath, psychoactive substance use, hypertension, pulmonary embolism without acute cor pulmonale and edema. Review of nutritional assessment review dated 11/15/24 revealed Resident #92's most recent weight measurement for Resident #92, taken on 11/12/24, showed a weight of 178 pounds. To help maintain a stable weight, interventions included fluid restriction, protein supplements three times daily, double protein with meals, a no-added-salt diet, and weekly weight monitoring. Review of the medical record for Resident #92 revealed the only weight taken by facility staff was on 11/12/24 with a result of 178 lbs. Review of the care plan dated 11/15/24 revealed Resident #92 has nutritional problem related to recent surgery, infective endocarditis, bacteremia, hepatitis, shortness of breath, psychoactive substance abuse, hypertension, and anxiety. As of 11/27/24, it is noted to continue monitoring weekly weights to establish a baseline. Interventions include following the prescribed fluid restriction, serving the ordered diet, recording meal intake at each meal, and having the dietitian assess and make any necessary diet adjustments. Additionally, the resident will be monitored for any significant weight loss. Review of physician orders dated 11/15/24 revealed an order for fluid restriction was placed, limiting intake to 1500 milliliters every 24 hours. Additionally, on 11/16/24, an order for a house shake was made for three times a day. On 11/17/24, an order for weekly weight checks for four weeks, followed by monthly weigh-ins. Review of care conference dated 11/18/24 revealed Resident #92 current diet includes no added salt, regular texture, and a fluid restriction of 1500 milliliters per day. They are also receiving a house shake three times a day. The resident has reported weight loss during their hospital stay, with a goal of maintaining their weight. Review of admission minimum data set (MDS) assessment completed 11/19/24 revealed Resident #92 had a brief interview for mental status of 15, indicating the resident was cognitively intact. Additionally the record revealed the resident has not experienced a 5% weight gain or loss in the past month, nor a 10% or greater weight change over the last six months. Review of section K Swallowing/Nutritional status revealed a weight of 178 pounds (lbs). (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 03/06/2025
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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/25 at 5:17 P.M., with Corporate Nurse #304 confirmed the facility has recognized an issue with staff not consistently obtaining weekly weights upon admission and as ordered. The facility has been actively working on finding a solution to this issue and tracking progress Interview on 03/06/25 at 11:46 A.M., with Dietician #302 confirmed Resident #92 has physician orders to have weekly weights since admission. The dietitian confirmed the resident has several risk factors for weight loss or gain, including diagnosis of hepatitis with a history of ascites, cardiac disorder with prescribed antibiotics, a prolonged hospital stay, and a fluid restriction. She also confirmed that facility staff did not complete the weekly weights as ordered. 37100 2. Review of Resident #77's medical record revealed an admitted [DATE]. His diagnoses included fracture of tibia or fibula, end stage renal disease, type II diabetes, edema, hyperlipidemia, congestive heart failure, dependence on renal dialysis, hypertension, insomnia, muscle weakness, and acquired absence of spleen. Review of his minimum data set (MDS) assessment, dated 02/04/25, revealed he was cognitively intact. Review of Resident #77's weights, dated 01/29/25 to 02/10/25, revealed the following weights and dates they were taken: 01/29/25 (200 pounds), 02/05/25 (186.7 pounds), 02/07/25 (180.2 pounds), 02/10/25 (180.2 pounds), and 02/10/25 (182.3 pounds). From 01/29/25 to 02/05/25, there was a decrease of 6.7 percent, and from 01/29/25 to 02/07/25, there was a decrease of 9.9 percent. Review of Resident #77's nutritional progress note, dated 02/06/25 and 02/14/25, revealed a trigger for 5 percent and 7.5 percent weight decrease respectively. It was documented that there may be some expected weight fluctuation, but the dietitian recommended that the weekly weights continue so they could establish a weight baseline. Also, there was a note that the initial weight could be erroneous, so they wanted to continue the weekly weights. Review of Resident #77's physician orders, dated 02/03/25, revealed the facility was to take Resident #77 weights on a weekly basis for a month. Review of Resident #77's nutritional care plan revealed an intervention added on 02/14/25 for the facility to continue weekly weights. Review of Resident #77's weights, dated 02/10/25 to 03/06/25, revealed no further weights were taken, which did not comply with the dietary recommendation and the physician/nutritional order as written to establish his baseline weight. Interview with Dietitian #302 on 03/06/25 at 11:43 A.M. confirmed weights weekly for first four weeks is standard and what she would have liked to have happened for Resident #77. She reviewed the weights for the first two weeks, and then put an order/recommendation that she wanted the weekly weights to continue to get two more weights. She confirmed she didn't count the 02/07/25 and 02/10/25 weights as weekly weights; only verifications. She confirmed there was no additional weight in the record. She confirmed she is not certain the initial weight of 200 was accurate or they got it from hospital records/from him personally, which is why she wanted to weekly weights to continue to establish an accurate baseline weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Weight Assessment and Intervention, dated September 2012, revealed the team will strive to prevent, monitor, and intervene for undesirable weight loss for residents. Weight assessment includes nursing staff will measure residents weights on admission, the next day, and weekly for two weeks thereafter. If no weights concerns are noted at this point, weights will be measured monthly thereafter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review, review of hospital records and staff interviews, the facility failed to ensure a resident's respiratory needs were being met. This affected the one resident (#196) of one resident reviewed for oxygen use. The facility census was 89 residents. Findings include: Review of Resident #196's medical record revealed an admission on 01/16/25, with diagnoses that included chronic obstructive pulmonary disease, unspecified asthma, pulmonary embolism and heart failure. Review of Resident #196's census revealed she was hospitalized from 02/09/25 until 02/28/25. Review of Resident #196's physician orders revealed she was ordered to have a Bilevel Positive Airway Pressure (BiPap) face mask, humidified, oxygen at 3 liters per minute at bedtime starting on 01/30/25 and ending on 02/27/25. On 03/04/25, Certified Nurse Practitioner #350 entered orders for Resident #196 to have BiPap to be worn at bedtime. Resident #196's record was silent for BiPap orders from 02/28/25 until 03/04/25. Review of Resident #196's hospital records dated 02/26/25 revealed she had physcian orders for a BiPap and she needed to wear it for a minimum of six hours at night on a daily basis, or she would risk death. Interview on 03/05/25 at 2:30 P.M., with the Director of Nursing, confirmed Resident #196's BiPap orders were omitted from her facility readmission orders on 02/28/25 and were not entered into her orders until 03/04/25. Interview on 03/06/25 at 8:54 A.M., with Certified Nurse Practitioner #350 confirmed when Resident #196 was readmitted to the facility on [DATE], she should have had BiPap orders entered into her physician orders, as she should never be without her BiPap daily.

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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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50008 Based on medical record review, observations, staff interviews and review of policy, the facility failed to ensure communication between the facility and dialysis vendor regarding dialysis treatments was on going for continuity of care. This affected one (#24) of one resident reviewed for dialysis. Seven residents currently receive dialysis treatments. The facility census was 89 residents. Findings include: Review of Resident #24's medical record revealed an admission on 02/16/23, with diagnoses that included chronic kidney disease, end stage renal disease, chronic viral hepatitis C, hypertension and dependence on renal dialysis. Review of Resident #24's physician orders revealed a standing appointment for dialysis at an outside dialysis clinic three times weekly. Orders for nursing to complete a pre- and post-dialysis communication form on Mondays, Wednesdays and Fridays. Observation of Resident #24's hard chart on 03/04/25 at 3:24 P.M., revealed some post dialysis forms in the hard chart, but not in completion. Interview on 03/04/25 at 3:24 P.M., with Licensed Practical Nurse (LPN) #154, revealed when Resident #24 returns from dialysis, she does not always bring a communication sheet from the dialysis center with her. LPN #154 revealed when Resident #24 does not return with a communication form, she does not follow up with the dialysis center or inquire about the services performed at the dialysis center. Observation on 03/04/25 at 3:38 P.M., of a binder in the Director of Nursing's office revealed the remainder of the dialysis communication forms for Resident #24 were located in this binder. Interview on 03/04/25 at 3:38 P.M., with the Director of Nursing (DON) confirmed the communication with the dialysis center needed to be more defined. Interview on 03/06/25 at 12:40 P.M., with the DON revealed she expects the nurses to read the communications from the dialysis center. Review of an undated policy titled Hemodialysis revealed there should be ongoing communication between the dialysis center staff and the facility, including but not limited to weight changes, medication administration, and treatment complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 37100 Based on medical record review and staff interview, the facility failed to provide parameters for as needed pain medication. This affected one (#3) of five residents reviewed for unnecessary medications. The census was 89. Findings Include: Review of Resident #3's medical record revealed an admission on 03/05/19. Her diagnoses included acute bronchitis, epileptic seizures, pulmonary embolism, post traumatic stress disorder, conversion disorder, phantom limb syndrome, bipolar disorder, unspecified protein calorie malnutrition, hypothyroidism, hypertension, other cervical disc degeneration, vitamin D deficiency, insomnia, atrial fibrillation, nonrheumatic mitral valve prolapse, muscle weakness, hypotension, repeated falls, pain, type II diabetes, depression, macular degeneration, hypermetropia, hyperlipidemia, anxiety disorder, acquired absence of right leg below knee, and epilepsy. Review of her Minimum Data Set (MDS) assessment, dated 12/09/24, revealed she was cognitively intact. Review of Resident #3 physician orders, dated December 2024 to March 2025, revealed an order for acetaminophen 325 milligrams (mg), three tablets every six hours as needed for pain. Also, there was an order for Naproxen 500 mg every 12 hours as needed for pain. Finally, an order for oxycodone 5 mg every six hours for pain. None of the medications had parameters as to which pain medication should be given and what pain level each medication should be given at. Review of Resident #3 medication administration record (MAR), dated December 2024 to February 2025, revealed the following as needed pain medications were administered: in December 2024, acetaminophen was administered five times for pain levels between 3 and 8, Naproxen was administered five times all for pain level of 6, and oxycodone was administered a total of 55 times for pain levels between 0 to 8. For January 2025, acetaminophen was administered 18 times for pain levels between 5 and 8, Naproxen was administered twice for pain level 6 and oxycodone was administered a total of 57 times for pain levels between 0 and 9. Lastly, in February 2025, acetaminophen was administered eight times for pain levels between 3 and 10, Naproxen was administered once for pain level 5, and oxycodone was administered 48 times for pain levels between 4 and 10. Interview on 03/06/25 at 10:00 A.M., with Licensed Practical Nurse (LPN) #154, confirmed she has not typically seen parameters for resident as needed pain medications. She will ask the residents pain level and provide pain medications related to the pain level. She will administer the higher strength medication (examples include oxycodone, tramadol, etc) for pain levels 6 to 10, and the lower strength medication (acetaminophen, ibuprofen, etc) for pain levels 1 to 5. She will document the pain level and which medication she administered. Interview on 03/06/25 at 10:17 A.M., with Director of Nursing (DON) confirmed the doctor does not order parameters for as needed pain medications. The doctor allows the residents to make the decision on which pain medication they want to take. Nurses will ask if resident is in pain, and if the resident has multiple pain medications, they will ask the resident which medication they want. DON confirmed Resident #3 does not have any parameters for her as needed pain medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on observation, medical record review, staff interviews, and policy review, the facility failed to secure and store medications appropriately. This affected one (#72) of 24 residents observed during the annual survey. The facility census was 89. Findings include: Review of Resident #72's medical record revealed an admitted [DATE], with diagnoses that included cerebral infarction, dysphagia, major depressive disorder, psychoactive substance abuse, disorientation, anxiety disorder and pain. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #72 was cognitively intact, mild depression, with no signs of psychosis noted. Review of records for Resident #72 revealed no assessment or screening for self - medication documented and there was no physician's order to administer self-medications. Observations on 03/04/25 at 9:12 A.M. noted a medicine cup with several tablets and capsules on the over bed table for Resident #72. Interview on 03/04/25 at 9:12 A.M. with Resident #72 revealed Resident #72 had been sleeping. Resident #72 then stated those pills might be his morning medications he would need to ask his nurse. Interview on 03/04/25 at 9:15 A.M. with Licensed Practical Nurse (LPN) #154 confirmed the medication cup with morning medications for Resident #72 were left on the overbed table. Resident #72 was still eating breakfast when the medications were brought in and Resident #72 prefers to take medications after breakfast. LPN #154 stated she didn't realize he hadn't taken the medication yet. Interview on 03/06/25 at 8:40 A.M., with the Director of Nursing (DON) confirmed the expectations are the nurse will follow the professional standards of medication administration including watching the patient take the medication at the time the medication is brought into the room. Review of the policy titled, Administering Medications, dated December 2012 confirmed the expectations and process to prepare, administer, and document the administration of medications according to standard professional practice guidelines. This deficiency represents non-compliance investigated under Complaint Numbers OH00162277.

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	365315	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on resident record review, observations, staff interviews, and review of policy, the facility did not have proper personal protective equipment in the laundry room to manage infectious material. Also, the facility did not follow proper isolation procedures for Resident #89. This had the potential to affect 87 residents of 89 residents in the facility. The facility identified two residents (#13 and #43) who did not have the facility launder their items. The facility census was 89. Findings include: 1. Observation of the facility laundry room, on 03/04/25 at 8:32 A.M., revealed there was no personal protective equipment in the laundry room. Interview on 03/04/25 at 8:36 A.M., with Housekeeping Supervisor #340 confirmed there was no personal protective equipment in the laundry room for handling infectious materials. Interview with Laundry Aide #330 on 03/04/25 at 9:44 A.M., confirmed there was no personal protective equipment in the laundry room for handling infectious materials. Interview with Corporate Nurse #304 on 03/06/24 at 10:00 A.M., revealed on 03/04/25, there were two residents (#12 and #32) who were on transmission-based precautions due to infections. Review of the policy titled Infection Control, dated August 2014 revealed that gloves will be worn for contact with any potentially hazardous materials. 2. Review of Resident #89's medical record revealed an admitted [DATE], with diagnoses that included end stage renal disease and dependence on renal dialysis. Review of Resident #89's physician orders revealed that he had a hemodialysis catheter in his right upper chest wall. Resident #89 was on Enhanced Barrier Precautions related to this indwelling medical device, effective on 02/26/25. Observations on 03/05/25 at 4:46 P.M. and on 03/06/25 at 9:00 A.M., revealed Resident #89 did not have a sign on his door or outside of his room indicating that he was on Enhanced Barrier Precautions. Interview on 03/06/25 at 9:14 A.M., with the Director of Nursing confirmed Resident #89 was on Enhanced Barrier Precautions and did not have a sign on his door or outside of his room notifying staff of the precautions. Review of the policy titled Enhanced Barrier Precautions dated 04/01/24, revealed when implementing Enhanced Barrier Precautions, it is critical to ensure that staff has an awareness of the facility's expectations about hand hygiene and gown/glove use. To accomplish this, the facility posts signage on the door or outside of the resident room indicating that Enhanced Barrier Precautions are to be used.