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	04/22/2026

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 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. Based on observation and interviews, the facility failed to ensure a safe, comfortable, and homelike environment. This had the potential to affect all 91 residents in the facility.Findings include:Observation on 04/19/26 at 7:30 A.M. revealed the walls, paneling, and floorboards around the C hall nursing station appeared severely damaged and were in significant disrepair with exposed drywall and missing floorboards.Observations on 04/19/26 at 7:36 A.M. in the shower room of hall B revealed exposed hot water shutoff pipes visible through missing drywall/door covering, ripped/missing drywall covering on the wall immediately outside of the shower, no privacy curtain around the toilet, plumbing fixtures at the shower head were held together by disposable gloves, and soiled grout throughout the shower with approximately one foot of missing tile exposing bare wall at the bottom of the shower.Interview on 04/19/26 at 10:02 A.M. with Maintenance Director #417 revealed pipes for the hot water shutoff should be covered in the B hall shower room. Further interview at this time revealed Maintenance Director #417 was unaware of the gloves holding together the shower head. Maintenance Director #417 stated they believed the gloves were holding together the shower head due to a water leak from the fixture. Maintenance Director #417 verified the other listed findings stating they would not want their home to appear how the shower room does.Observation on 04/19/26 at 10:10 A.M. revealed there was no privacy curtain around the toilet in the shower room of C hall, disposable gloves were holding together the shower head in C hall shower room, and there was a lightbulb not securely installed or covered hanging from exposed electrical wiring directly above the shower. Concurrent Interview with Maintenance Director #417 revealed the Maintenance Director #417 stated nobody tells me about this type of thing. Maintenance Director #417 verified the other listed findings of disrepair in the shower room of C hall including the exposed lightbulb and wiring above the shower and the shower head that was being held together by disposable gloves.Interview on 04/19/26 at 10:16 A.M. with Maintenance Director #417 verified the walls around the nurse's station of C hall were in significant disrepair.Observation on 04/20/26 at 1:00 P.M. revealed loose railing at the bottom of the handicapped ramp entrance/exit at the front of the facility. The railing was easily movable with application of regular force. There was also observed crumbling/broken concrete below the railing on the upper-level railing closer to the front entrance doors of the facility, next to the steps up to the front door. Interview on 04/20/26 at 4:08 P.M. with the Regional [NAME] President of Maintenance #204 verified the railing along the handicapped ramp entrance/exit outside the front of the facility was loose and they were aware that residents hold on to this rail for assistance while using the ramp, however they were unaware that the rail was movable with regular force. Regional [NAME] President of Maintenance #204 revealed they were aware of the crumbling/broken concrete below the railing on the upper walkway closer to the main entrance doors. This deficiency represents non-compliance investigated under Complaint Numbers 2979015 and 2784905.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure the food was prepared and stored in a safe and sanitary manner. This had the potential to affect all but two residents who the facility identified did not receive food from the kitchen. The facility census was 91. Findings include:Observation on 04/19/26 at 7:07 A.M. of the kitchen revealed Dietary Aide #217 in the kitchen preparing breakfast trays with waist length braids and no hairnet on. Dietary [NAME] #215 verified the observation at the time of the observation.Observation on 04/19/26 at 7:09 A.M. of the ready refrigerator in the kitchen revealed one cup container of applesauce, one eight-ounce glass of orange juice, one clear container of pudding, and ten salads in brown bowls wihich were undated. Dietary Aide #217 verified the undated food items at the time of the observation.Observation on 04/19/26 at approximately 7:10 A.M. walk in refrigerator near the dry food storage revealed one bowl of chicken noodle soup, one bag of mozzarella cheese, one bag of salad, and one bag of cheddar cheese which were opened and undated. Dietary [NAME] #216 verified the findings at the time of the observation.Review of the facility policy Food Receiving and Storage dated July 2014 revealed all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of facility policy, the facility failed to follow enhanced barrier precautions, and failed to ensure intravenous (IV) bags were properly secured and not on lying on a soiled surface. This affected one (Resident #3) of 14 residents reviewed for enhanced barrier precautions and had the potential to affect 34 residents identified by the facility on enhanced barrier precautions. The facility census was 91.Findings include:Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with the primary diagnosis of abscess of liver, additional diagnoses include resistance to Vancomycin (antibiotic) and bacterial infections involving multiple species of bacteria such as enterococcus, proteus mirabilis, and pseudomonas.Further review of Resident #3's medical record revealed the resident had a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment.Review of Resident #3's physician orders revealed the resident had active orders for an intravenous (IV) antibiotic Ceftazime with a start date of 04/18/26, along with an order for enhanced barrier precautions with a start date of 03/24/26 related to indwelling medical devices, wounds, and/or infection with a multidrug resistant organism (MDRO).Observation on 04/19/26 at 10:56 A.M. revealed an IV bag labeled Ceftazime was on the floor beneath Resident #3's bed while the IV bag was still connected to Resident #3's peripheral IV located in their Right arm. Further observation at this time revealed signage labeled Enhanced Barrier Precautions along with infection control instructions for visitors and staff was posted outside of Resident #3's room. Personal Protective Equipment (PPE) including disposable gloves and gowns were observed to be available outside of Resident #3's room for use when entering the room.Interview on 04/19/26 at 10:56 A.M. with Certified Nursing Assistant (CNA) #621 verified that the IV bag of Ceftazime was lying directly on the floor beneath Resident #3's bed while the bag was still connected to the resident's IV line. Further interview with CNA #621 at this time also verified the IV bag should not be on the floor when connected to a resident.Observation on 04/19/26 at 1:30 P.M. revealed CNA #621 was providing incontinence care to Resident #3. CNA # 621 was observed to no be wearing a gown. Observation at this time revealed the enhanced barriers precaution posted on Resident #3's door included instructions for staff to wear disposable gloves and a gown while providing high-contact resident care such as transferring the resident or toileting/incontinence care assistance.Interview on 04/19/26 at approximately 1:35 P.M. with CNA #621 verified they were not wearing a gown while providing incontinence care to Resident #3. The CNA revealed they went into Resident #3's room to transfer the resident from their wheelchair to their bed, and during this time realized the resident had been incontinent of bladder and needed incontinence care including changing the resident's briefs. CNA #621 verified they were aware that Resident #3 was on enhanced barrier precautions.Review of the facility policy titled Enhanced Barrier Precautions (EBP) Policy and Procedure (effective 04/01/24) revealed enhanced barrier precautions are an infection control intervention designed to reduce transmission of resistant organisms that employes targeted gown and glove use during high contact resident care activities. Further review of the policy revealed examples of resident care activities that would require gown and glove use included transferring and changing briefs or assisting with toileting.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility policy, the facility failed to ensure antipsychotic medications were used for an indicated diagnosis. This affected one, Resident (#73) out of five residents reviewed for unnecessary medications. The facility census was 91.Findings include:Review of the medical record for Resident #73 revealed the resident was admitted to the facility on [DATE] with diagnoses that included intervertebral disc disorder with radiculopathy in the lumbar region, chronic obstructive pulmonary disease, Type Two Diabetes Mellitus, alcoholic cirrhosis of the liver with ascites, generalized muscle weakness, and need for assistance with personal care. Additional review of Resident #73's medical record revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment.Review of medication orders in Resident #73's medical record revealed an order for Lurasidone (antipsychotic) 20 milligram (mg) tablets, one tablet taken once a day for antipsychotic, with a start date of 11/12/25. Review of Resident #73's psychiatric note dated 03/24/26 revealed the following statement: Gradual dose reduction (GDR) of Lurasidone was discussed; however, the patient declines. Will continue to reassess due to lack of a CMS- supported indication. Plan to increase Trazodone (antidepressant) and monitor response, tolerability, and potential side effects. Further review of the same psychiatric note revealed the following statement: The patient is currently on Lurasidone 20mg without an appropriate diagnosis according to CMS guidelines. His symptoms will be closely monitored, and a gradual dose reduction (GDR) will be attempted when he is clinically stable.Interview on 04/22/26 at approximately 3:45 P.M. with Regional Registered Nurse (RN) #212 verified Resident #73 had an active order for Lurasidone 20mg daily, was still receiving this medication, and the use of this medication for Resident #73 was not indicated or recognized as appropriate per Centers for Medicare and Medicaid Services (CMS) guidelines, but the medication was clinically indicated. RN#212 stated another provider involved in Resident #73's care that was not a psychiatric specialist had documented Resident #73 as having a mood disorder, and Regional RN #212 stated they believed this was an acceptable indication for use of the antipsychotic Lurasidone.Review of the Food and Drug Association (FDA) document Highlights of Prescribing Information (revised 03/2018) for lLrasidone revealed indications for usage of Lurasidone include the following: treatment of adult and adolescent patients with schizophrenia, monotherapy treatment of adult and pediatric patients with major depressive disorder associated with bipolar I disorder, and adjunctive treatment with Lithium (antimanic) or Valproate (antiseizure) in adult patients with major depressive episode associated with bipolar I disorder.Review of the facility policy titled Antipsychotic Medication Use (revised December 2016) revealed residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and review of the facility policy, the facility failed to investigate an allegation of verbal abuse. This affected one, Resident (#2) out of five residents reviewed for freedom from abuse, neglect, and misappropriation. The facility census was 91.Findings include:Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included frostbite with tissue necrosis of unspecified sites, vascular [NAME]-Danlos syndrome, chronic viral hepatitis, and major depressive disorder. Further review of Resident #2's medical record revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment.Review of the document, Care Conference dated 04/07/26 contained in Resident #2's medical record revealed no mention of staff making disrespectful comments regarding Resident #2's feet, and no mention of smell as an issue related to the resident's feet.Interview on 04/19/26 at 11:36 A.M. with Resident #2 revealed they felt facility staff had not been speaking to them in a respectful manner, and specifically that staff comments regarding the condition of her necrotic feet were hurtful. Further interview at this time with Resident #2 revealed there was an incident approximately two weeks prior to the day of the interview where Certified Nursing Assistant #519 told the resident that she stinks while assisting her with a shower, and that her (necrotic) feet smell.Interview on 04/19/26 at 1:55 P.M. with Resident #2's mother revealed after speaking with Resident #2, she raised her concerns about the facility staff's alleged disrespectful comments towards Resident #2 regarding the smell of her feet with the facility Administrator during a recent care conference that was held on 04/07/26. Interview on 04/19/26 at approximately 2:20 P.M. with Resident #2 revealed they would consider the comments made by nursing aides regarding her feet were hurtful and that she would consider these types of statements to be verbal abuse.Interview on 04/19/26 at 3:28 P.M. with the facility Administrator revealed they did recall having a care conference with Resident #2's mother on 04/07/26 and that amongst other concerns, the staff noticing the smell of Resident #2's feet was brought to his attention during the care conference. The Administrator stated he did not investigate the issue, as he did not recognize the situation to be an allegation of verbal abuse. The Admionistrator revealed he did offer a room change for the resident as he could understand how one might feel humiliated if they were told their feet stink or smell in the context of active necrosis due to a medical condition. The Administrator confiimed he did not investigate this concern as an allegation of verbal abuse. Interview on 04/20/26 at 9:00 A.M. with Resident #73 revealed their room was directly across the hall from Resident #2's room, and that they had heard staff speaking disrespectfully to Resident #2 on several occasions regarding the resident's personal hygiene and condition of their feet. Resident #73 revealed they had heard staff telling Resident #2 that she stinks. Resident #73 stated Her feet are rotting; she can't control that. She is a young lady and deserves respect. It's not right. Review of the facility policy titled Abuse Investigation and Reporting (revised July 2017) revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Further review of this policy revealed findings of abuse investigations will also be reported.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure a follow up appointment was scheduled in a timely manner for Resident #49. This affected one resident out of seven reviewed for wound care. The facility census was 91. Findings include:Review of the medical record revealed Resident #49 had an admission date of 10/23/25 with diagnoses of, but not limited to, arthritis due to other bacteria, right hip, muscle wasting and atrophy, muscle weakness, need for assistance with personal care, lumbar spina bifida with hydrocephalus, neuromuscular dysfunction of bladder, paraplegia, neurogenic bowel, heart failure, attention-deficit hyperactivity disorder, acute kidney failure, major depressive disorder, gastritis, anemia, gastro-esophageal reflux disease, narcolepsy, and depression. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #49 dated 01/29/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. The quarterly MDS dated [DATE] revealed no psychosis, no verbal or physical behavior, and no rejection of care. The quarterly MDS dated [DATE] revealed Resident #49 was independent in all care, had an ostomy and an indwelling catheter. The MDS had Resident #49 coded to have one stage four pressure ulcer which was present on admission. Review of a progress note dated 02/04/26 revealed Resident #49 had three new wounds to his left lateral foot, left posterior lower calf, and a fluid filled blister to the bottom of his left foot. Review of a wound note dated 02/24/26 revealed Resident #49 had ankle-brachial index (ABI) which was normal. Referral made to outside dermatology office for further evaluation, waiting for them to call for an appointment. Instructed staff to call again if they do not receive a call back from dermatology department. Review of a progress note dated 02/17/26 revealed an order was received for the facility to schedule a dermatology appointment for Resident #49. Review of a progress note dated 02/25/26 revealed the facility called an outside dermatology office and was told the dermatology office was a week behind on referrals and is currently unable to schedule an appointment until they get to Resident #49's referral and will call the facility back. Interview on 04/22/26 at 10:21 A.M. with Licensed Practical Nurse (LPN) unit manager #425 revealed the wound Nurse Practitioner (NP) had requested a referral for dermatology for Resident #49. LPN unit manager #425 stated she had faxed the referral to an outside dermatology office and called the outside dermatology office. LPN unit manager #425 stated someone at the dermatology office told her the office was about a week behind in scheduling and could not schedule an appointment now. LPN unit manager #425 stated the outside dermatology office stated they would call back to the facility. LPN unit manager #425 stated she called the dermatology office back in about a month to follow up and they still could not schedule. There was no progress note regarding a follow up call to the outside dermatology office, and the LPN unit manager #425 verified Resident #49 still did not have an appointment at the dermatology office.