

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Mayfair Village Nursing Care C		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Bethel Rd Columbus, OH 43230	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008</p> <p>Based on observation, staff interview, and medical record review, the facility failed to provide resident dignity with use of an indwelling urinary catheter. This deficient practice affected two (#5 and #27) of four residents reviewed for indwelling urinary catheters. The facility census was 81.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), muscle weakness, high blood pressure, and obstructive uropathy. Resident #5 required assistance from staff for activities of daily living (ADL) tasks, and was assessed as cognitively intact.</p> <p>Review of the physician orders for Resident #5 revealed an order dated 04/11/22 for a suprapubic catheter to straight drain due to chronic tubulointerstitial nephritis, and an order dated 01/28/23 for a dignity bag to cover the catheter drainage bag.</p> <p>Observation on 09/03/24 at 10:45 A.M. revealed Resident #5 was resting in bed with the urinary catheter drainage bag hung from the bed frame. The urinary catheter collection bag was facing the doorway with urine visible from the door and hallway.</p> <p>2. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including acute parametritis and pelvic cellulitis, muscle weakness, anxiety, and obstructive uropathy. Resident #27 required assistance from staff for ADL tasks including incontinence care and transfers.</p> <p>Review of the physician orders for Resident #27 revealed an order dated 08/31/24 for an indwelling urinary catheter, and an order dated 09/02/24 for a dignity bag to cover the drainage bag at all times.</p> <p>Observation on 09/03/24 at 10:55 A.M. revealed Resident #27 was resting in bed with the indwelling urinary catheter drainage bag hanging from the bed frame. The collection bag was facing the doorway with urine visible from the door and hallway.</p> <p>Interview on 09/03/24 at 11:30 A.M. with Licensed Practical Nurse (LPN) #148 confirmed the urinary catheter drainage collection bags for Resident #5 and Resident #27 were uncovered and in view of the hallway and doorway.</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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00156817.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008</p> <p>Based on medical record review and staff interview, the facility failed to ensure professional standards were maintained when a medication ordered for one (#74) was administered to another (#33) resident. This deficient practice affected two (#33 and #74) of two residents reviewed for staff borrowing medications. The facility census was 81.</p> <p>Findings Included:</p> <p>1. Review of the medical record for Resident #74 revealed an admitted [DATE] with diagnoses including dementia, type two diabetes mellitus, bipolar disorder, and schizoaffective disorder. Resident #74 had impaired cognition and required assistance with activities of daily living (ADL) tasks and medication administration.</p> <p>Review of the physician orders for Resident #74 revealed a one-time order dated 08/07/24 for the antipsychotic medication Zyprexa 10 milligrams (mg) to be given via intramuscular (IM) injection. Further review of Resident #74 medication administration record (MAR) dated 08/07/24 revealed the order for Zyprexa 10 mg was refused by Resident #74 for administration.</p> <p>2. Review of the medical record for Resident #33 revealed an admitted [DATE], with a readmitted [DATE]. Diagnoses included epilepsy, high blood pressure, schizoaffective disorder, and traumatic brain injury. Resident #33 was assessed with impaired cognition, impaired decision making, and physical behaviors towards others.</p> <p>Review of the physician orders for Resident #33 revealed a one-time order dated 08/12/24 for Zyprexa 10 mg to be given via IM injection for increased agitation. Further review of Resident #33's MAR dated 08/12/24 revealed the order for Zyprexa 10 mg was administered at 6:02 P.M. and was effective.</p> <p>Review of a pharmacy delivery document for the delivery of Zyprexa 10 mg for Resident #33 dated 08/12/24 was not available for review.</p> <p>Interview on 09/04/24 at 12:35 P.M. with Registered Nurse Unit Manager (RN UM) #101 revealed the Zyprexa which was ordered for Resident #74, and was refused by Resident #74 on 08/07/24, was placed in a box for return to the pharmacy. RN UM #101 stated on 08/12/24, Resident #33 was having escalated behaviors, and an order was received for Resident #33 to receive Zyprexa 10 mg via IM injection. RN UM #101 stated Resident #74's discontinued Zyprexa 10 mg IM medication was still in the medication storage room and had not been returned to the pharmacy. RN UM #101 confirmed Resident #33 was administered Resident #74's ordered Zyprexa 10 mg IM medication on 08/12/24.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156951 and Complaint Number OH00156817.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569</p> <p>Based on medical record review, staff interview, and review of a facility policy, the facility failed to prevent the administration of an unnecessary antipsychotic medication. This deficient practice affected one (#33) out of two resident reviewed for antipsychotic medication use. The facility census was 81.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #33 revealed an admitted for 09/09/22 with a readmitted [DATE]. Diagnoses included epilepsy, high blood pressure, schizoaffective disorder, and traumatic brain injury. Resident #33 was assessed with impaired cognition, impaired decision making, and physical behaviors towards others.</p> <p>Review of the physician orders for Resident #33 revealed a one-time order dated 08/12/24 for the antipsychotic medication Zyprexa 10 milligrams (mg) to be given via intramuscular (IM) injection for increased agitation. Further review of Resident #33's medication administration record (MAR) dated 08/12/24 revealed the order for Zyprexa 10 mg was administered at 6:02 P.M. and was effective. Further review of the MAR revealed Zyprexa was administered on 08/12/24 due to increased agitation and behaviors.</p> <p>Review of the progress notes for Resident #33 dated 08/11/24 to 08/13/24 revealed there were no entries or progress notes depicting Resident #33's increased behaviors which reportedly occurred on 8/12/24, and required an order for Zyprexa 10 mg via IM injection for behavior management.</p> <p>Review of the Point of Care (POC) tasks documentation in Resident #33's medical record dated 08/12/24 revealed there were no entries or documentation completed for Resident #33's increased behaviors as reported on 08/12/24.</p> <p>Interview on 09/05/24 at 12:45 P.M. with the Director of Nursing (DON) confirmed there was no documentation or progress notes related to Resident #33's reported escalating behaviors towards others dated 08/12/24 when Resident #33 was administered Zyprexa 10 mg via IM route. The DON stated the expectations for the nurses are to document resident behaviors and the interventions the staff attempted to implement prior to the order for as needed (PRN) medication was received and administered.</p> <p>Review of the facility's policy titled, Nursing Documentation, dated 08/10/23, revealed the facility will ensure nursing documentation is consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156951 and Complaint Number OH00156817.</p>		