STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365410	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Village Nursing Care C	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on closed medical record review, hospital record review, toxicology report review, review of the facility admission policy, review of the facility assessment and interviews, the facility failed to ensure Resident #82 received adequate, timely and appropriate treatment and continuity of care following admission to the facility resulting in a situation of neglect. This resulted in Immediate Jeopardy and serious life-threatening harm/subsequent death beginning on [DATE] at 8:30 P.M. when Resident #82, who had been hospitalized prior to admission, arrived at the facility for placement and staff failed to obtain physician orders for medications/treatments or contact the physician/medical director regarding the resident's admission. From [DATE] through [DATE] the resident was not ordered and did not receive medications including blood pressure medication, blood thinning medication, or insulin. In addition, Resident #82 presented to the facility with a history of illegal drug use; however, the facility failed to adequately identify this history or implement comprehensive and individualized interventions to maintain the resident's safety (as it pertained to his history of drug abuse). On [DATE] at 1:39 A.M., Resident #82 activated his call light for complaints of shortness of breath. The resident's condition continued to deteriorate, and emergency medical services was called via nine-one-one (911). On [DATE] at 1:54 A.M., CPR (cardiopulmonary resuscitation) was initiated. Resident #82 was subsequently pronounced deceased by emergency medical service (EMS) staff on [DATE] at 2:19 A.M. After being pronounced deceased , the facility failed to provide timely and appropriate post-mortem care by allowing the resident's body to remain in the facility from 2:19 A.M. until 1:56 P.M. when his body was eventually transported to the morgue, as facility staff did not know how to proceed with the resident's deceased body. This affected one (#82) resident of three residents reviewed for death. The facility census was 81. On [DATE] at 2:48 P.M., the Administrator, Regional Registered Nurse (RRN) #481 and the Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at 8:30 P.M. when facility staff admitted Resident #82 to the facility, after he had left AMA from the hospital, and neglected to notify the physician of the resident's admission to the facility and lack of admission orders to provide continuity of care to the resident with known comorbidities. Despite a known history of drug abuse, the facility did not have appropriate supervision in place to provide a safe environment. The resident experienced a rapid condition change on [DATE], which required CPR; however, the resident expired at the facility. Following the resident's death, his body remained at the facility 11 hours and 37 minutes before being transported to the morgue for further assessment and determination of his final resting 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

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 03/21/2025
NAME OF PROVIDER OR SUPPLIER Mayfair Village Nursing Care C		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Bethel Rd Columbus, OH 43230	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 2:19 A.M., Resident #82 expired at the facility. On [DATE] at 1:56 P.M., Resident #82's body was transferred to the morgue. On [DATE], in-person and/or by phone education was provided to the facility's 32 nurses which included 12 Registered Nurses (RN) and 20 Licensed Practical Nurses (LPN) by the DON and Staff Development Coordinator (SDC) #81 on the facility's admission policies, notification of the physician on admission, and physician orders, including medications. One-on-one education was provided to RN #15 and RN #35 as they were responsible for Resident #82's care during admission. On [DATE], the initial Self-Reported Incident (SRI) was submitted by the Administrator based on the allegation of neglect. The admitting nurse for Resident #82, RN #35, was suspended on [DATE] at 7:30 P.M. pending the outcome of the investigation. On [DATE], a whole house audit of 23 residents admitted within the last 30 days was conducted by the DON, RRN #481 and the Administrator to ensure physician orders were consistent with hospital discharge orders and physicians were notified of admission. The 23 residents reviewed were Resident #6, #12, #24, #25, #28, #29, #33, #43, #66, #82, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97 and #98 and no discrepancies were identified. Weekly, all new admissions and re-admissions will be audited by the DON or designee for four weeks to ensure physician notification and physician orders are included. On [DATE], in person and/or by phone education was provided by the DON and/or SDC #81 to all 32 licensed nurses to communicate with facility leadership regarding changes that may occur to a resident's admission to the facility or with the hospital discharge plan, to seek further instruction and guidance; that residents with a history of drug abuse have a care plan with appropriate interventions in place; administration of an opioid reversal agent in suspected opioid overdose; the policy for postmortem care and pronouncement of death to include timely notification for release of a deceased resident and notification of the police and/or coroner as necessary. On [DATE], a whole house audit for residents with a drug abuse history diagnosis was completed by RRN #418/designee to ensure interventions were in place and care plans reflected updated interventions as needed. Staff can access the care plan and Kardex (information regarding the resident's care) through the electronic medical record. Three residents were identified (Residents #38, #44 and #74) and had appropriate care plans. Weekly audits of care plans will be completed by the DON/designee for four weeks to ensure care plans for all residents with a history of drug abuse are appropriate. On [DATE], audits of residents who have expired in the facility from [DATE] through [DATE] were reviewed by the DON/designee to ensure they were provided with timely and appropriate postmortem care with notifications of the coroner and police as appropriate. Weekly audits for four weeks will be completed by the DON or designee to ensure compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:15 P.M., an Ad Hoc (not scheduled) Quality Assurance and Performance Improvement Plan meeting was held with the DON, Administrator and RRN #481 in person and Certified Nurse Practitioner #493 by phone to discuss the removal plan and root cause analysis (RCA). The RCA was identified as the admission process was not followed per protocol. On [DATE] at 9:21 P.M., the Medical Director was notified of and approved the QAPI plan. All audits will be conducted weekly for four weeks and results will be discussed at the monthly QAPI meeting. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #82's hospital documentation (state agency requested as part of the onsite investigation) revealed the resident was admitted to the hospital on [DATE] after he had arrived at the emergency room via ambulance transport due to shortness of breath. Further review of the medical record revealed a history and physical dated [DATE] that revealed the resident experienced acute hypoxic (decreased oxygen levels) and hypercapnia (the body can't remove excess carbon dioxide from the blood so there is a buildup and the body can't maintain proper ventilation) respiratory failure, crack lung (an acute lung injury related to smoking crack cocaine and can cause lung injury, cough, difficulty breathing and even death) versus aspiration pneumonia (a substance from the stomach or mouth enters the lung and causes pneumonia) versus pulmonary edema (a condition caused by too much fluid in the lungs) exacerbation of chronic obstructive pulmonary disease, elevated troponin (a cardiac enzyme that becomes elevated when there is damage to heart muscle), suspect myocardial infarction (heart attack), acute metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic condition), hyperglycemia (blood glucose was 342 milligrams per deciliter of blood ((mg/dL)) on admission. A healthy adult blood glucose level ranges between ,d+[DATE] mg/dL), polysubstance abuse (positive for cocaine and fentanyl on admission), lung nodule in the left lower lobe (of the lung), and right renal cystic lesion. The patient required hospitalization due to acute respiratory failure in the setting of recent crack cocaine use requiring intubation and mechanical ventilation. Further review of the requested hospital record revealed a cardiology progress note dated [DATE] indicating the resident developed paroxysmal atrial fibrillation with a rapid ventricular response, multifocal atrial tachycardia and supraventricular tachycardia (all heart rhythms where the heart doesn't have a normal signaling process telling the heart when to beat and the signaling is disorganized and parts of your heart beat out of sync and may cause blood clots or compromised blood flow throughout the body). The resident also had newly diagnosed cardiomyopathy (disease that affects the heart muscle and may cause the heart muscle to become weakened, thickened, or rigid, making it difficult for the heart to pump blood effectively) with the heart ejecting only ,d+[DATE]% of blood from the left ventricle. The resident was given Lasix intravenously and amiodarone (antiarrhythmic) intravenously (to treat heart failure and abnormal heart rate). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mayfair Village Nursing Care C		STREET ADDRESS, CITY, STATE, ZIP CODE: 3000 Bethel Rd Columbus, OH 43230	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the requested hospital records revealed Resident #82 was prescribed no medications prior to admission to the hospital. During Resident #82's stay at the hospital, he was prescribed medications including amiodarone 200 mg (milligrams) daily, Eliquis (blood thinner) 5 mg twice a day, Lipitor (cholesterol medication) 40 mg nightly, Plavix (antiplatelet medication that prevents platelets from clumping together into blood clots) 75 mg daily, folic acid (form of Vitamin B) 1 mg daily, Lasix (diuretic) 20 mg twice daily, insulin lispro (fast acting insulin) injection 1 to 6 units subcutaneous three times a day before meals, Lopressor (a beta-blocker that treats angina, high blood pressure and heart failure) 12.5 mg twice a day, NicoDerm CQ 21 mg/24 hours transdermal daily, MiraLAX (laxative) 17 grams twice daily, Seroquel (antipsychotic) 25 mg twice daily, and Xopenex (bronchodilator) 1.25 mg/0.5 ml nebulizer solution every 6 hours when needed. Review of the hospital discharge summary dated [DATE] revealed Resident #82 was going to leave the hospital against medical advice (AMA) because his dog had a tumor on his face. The physician presented at the bedside and discussed this would be against medical advice, discussed the risks including worsening heart failure, cardiovascular accident (CVA), ACS (acute coronary syndrome), hypoxia, ischemia (restriction in blood flow) and death. Resident #82 expressed understanding. He signed out AMA on [DATE]. Review of Resident #82's facility closed medical record revealed he was admitted on [DATE]. Diagnoses included metabolic encephalopathy, respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), pulmonary edema, substance abuse, prediabetes and cardiomyopathy. Further review revealed no documentation of any admission orders or communication with the medical director for Resident #82 during the resident's stay at the facility. The resident discharged from the facility on [DATE]. Review of the admission baseline care plan dated [DATE] revealed the resident was at risk for elopement and negative health outcomes related to continued substance use while at the facility. Interventions included encourage to participate in activities of interest and medications per orders. Review of the progress notes dated [DATE] at 10:04 P.M. revealed Resident #82 showed no signs and symptoms of distress, is able to make needs and wants known, no concerns noted. Resident is on continued monitoring. Review of the progress notes dated [DATE] at 10:49 P.M. revealed Resident #82 was resting in bed, respirations are even and unlabored, lung sounds are clear bilaterally, denies pain and is able to make his needs known. Resident #82 is on continued monitoring. Review of the admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident's cognition was not assessed. He was independent with eating, required setup or clean-up assistance for oral hygiene, toileting, shower/bathing and dressing. He was always continent of urine and always incontinent of bowel. cognition was not assessed. He was independent with eating, required setup or clean-up assistance for oral hygiene, toileting, shower/bathing and dressing. He was always continent of urine and always incontinent of bowel. Review of the progress notes, dated [DATE] at 1:39 A.M and authored by RN #15, revealed at 1:15 A.M. Resident #82 told this nurse that he was going to get snacks from the vending machine, and the nurse offered (to) help, but he refused. Resident #82 came back to his room; the nurse assisted him in bed. (continued on next page)

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	365410	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Village Nursing Care C	3000 Bethel Rd Columbus, OH 43230

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the progress notes revealed at 1:39 A.M., he turned on his call light, this nurse went to the patient's room, and he told the nurse that he was having shortness of breath but denied chest pain. Resident #82 was on oxygen with the head of the bed elevated, his vitals were Blood Pressure (BP) ,d+[DATE] millimeters of Mercury (mmHg) [normal ,d+[DATE] mmHg], pulse (rate) 85 (normal ,d+[DATE] beats per minute), respiration 18 (normal ,d+[DATE] breaths per minute), oxygen saturation (measures the oxygenation of the blood) was 95 % (,d+[DATE] % is normal) and temperature 97.8 Fahrenheit. A decline was noticed in his condition while in his room. Further review of the [DATE] progress notes revealed at 1:40 A.M., 911 was called while in the room with Resident #82, and he was put on a non-rebreather mask (provides more oxygen than a nasal cannula), at 1:47 A.M. the nurse recalled 911 because the resident's condition was declining. At 1:48 A.M., his vitals were BP ,d+[DATE], pulse 90, respiration 20, temperature 97.9 and oxygen saturation 90 %. At 1:50 A.M., 911 arrived BP ,d+[DATE], pulse 50, respiration 12, temperature 97.7 and oxygen saturation was 86%. Further review of the progress notes, dated [DATE], revealed at 1:54 A.M., 911 started chest compressions on patient. At 2:19 A.M., Resident #82 was pronounced deceased . The DON, Med One (the on-call medical provider service) and the patient's family/friend were notified about the incident. A crack pipe, (with) residue and a lighter were found in the patient's shoe. Further review of the progress notes dated [DATE] at 1:56 P.M. and authored by RN #71 revealed Resident #82's body transported from the facility at 1:36 P.M. by the coroner's office. Review of the Coroner's Report: Finding of Facts and Verdict, dated [DATE], revealed the immediate cause of death was cardiomyopathy as a consequence of recent and chronic cocaine use, the manner of death was accidental. Toxicology testing showed benzoylecgonine (cocaine metabolite that can be detected for several days after use of cocaine), nicotine and cotinine (nicotine metabolite). Drug paraphernalia at the scene was positive for cocaine. On [DATE] at 12:03 P.M., an interview with RRN #481 revealed Resident #82 had left the hospital AMA and just showed up here at the facility without any paperwork (A friend dropped him off) but the facility had scheduled to admit him. The facility had called the hospital and asked for discharge paperwork, but the hospital refused to give the facility any instructions due to him leaving AMA. Further interview revealed the facility received the hospital discharge summary on [DATE] and the directive given were to use his home medications (written on the AMA discharge summary). The nurses did not follow through with obtaining the orders, but they were disciplined (RN #15 and #35) and we put a plan in place, so it wouldn't happen again. On [DATE] at 2:35 P.M., an interview with Coroner #486 revealed an autopsy was not completed but an external examination, toxicology and the preliminary drug screen was positive. The coroner's office was treating the case as a drug overdose. He was pronounced dead at 2:19 A.M. and laid there (in the facility) almost 12 hours before they called me, and they collected all the evidence and moved it (referencing the crack pipe). The police were not called so Coroner #486 directed the facility to call the police. On [DATE] at 2:32 P.M., a follow-up interview with Coroner #486 revealed when she arrived at the facility for the assessment of Resident #82, rigor had set in, and his body was very stiff. She confirmed the resident's body was moved to the morgue from the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:44 A.M., an interview with the DON revealed the reason Resident #82's body remained at the facility so long was because of a lack of knowledge from staff and they should have called the police. She stated the staff were waiting for the funeral home to open, as they shared with her, they had contacted the funeral home, but the message provided indicated the funeral home didn't open until 10:00 A.M. The DON verified she contacted the police and the coroner. The police had come but the coroner's office took all the drug paraphernalia, so there was nothing for them to take. The nurse on duty the night of the resident's admission said she called the hospital and was told he had left AMA, and the hospital wouldn't give the facility discharge instructions and none of the nurses followed up. The DON verified the staff should not have accepted the resident due to him leaving the hospital AMA. On [DATE] at 1:34 P.M. an interview with RRN #481 verified the facility had no documentation the medical director was contacted by the facility, and the facility did not have a policy for accepting residents with a drug abuse history. On [DATE] at 1:38 P.M. an interview with Social Service Director (SSD) #339 revealed admissions from the hospital are handled by Central Intake and the Admissions Department. SSD #339 revealed she was unaware Resident #82 was admitted until on [DATE]. On [DATE] at 1:41 P.M. an interview with Admissions Director (AD) #332 revealed she was not aware Resident #82 left the hospital AMA as he was a planned discharge at 6:00 P.M. on [DATE]. The AD stated she had left for the day at 5:30 P.M. ([DATE]) and found out about his admission and leaving the hospital AMA on [DATE]. The AD stated the hospital did not notify the facility the resident left AMA, but the facility was not to admit residents that leave the hospital AMA. The plan was either family or a taxi was to bring him to the facility. The hospital did not let the facility know he left AMA. The AD stated the facility did an onsite visit with the resident while he was in the hospital and the facility's expectations would be discussed with the resident by the hospital liaison. The AD verified the nurse should have contacted the medical director about the resident's admission, or the facility has central admission staff available 24 hours a day. On [DATE] at 1:53 P.M. an interview with the DON revealed she was not aware until Monday ([DATE]) that Resident #82 was admitted to the facility. There was no communication from the hospital he left AMA, but the nurse should have called the medical director. On [DATE] at 2:26 P.M. an interview with RN liaison #400 revealed she had gone to the hospital to see Resident #82 either [DATE] or [DATE] and discussed the facility no smoking, no drug, no alcohol policy and he said, don't worry I don't smoke. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:08 P.M. an interview with Risk Management RN #400 from the hospital where Resident #82 was a patient prior to admission to the facility, revealed the hospital did not contact the facility to let them know that the patient left AMA but it was on a Friday late ([DATE]), and it appeared that it was after the Case Manager or Social Worker left for the day or was not aware of the resident leaving AMA. The weekend team would not have known to follow up as he would have been out of the hospital (documentation) system. She verified the hospital was not planning on the resident discharging that day ([DATE]) since he was not medically cleared to discharge but was planning to discharge the next day ([DATE]) and the facility was aware of him coming the next day. The RN verified there was no record of the facility calling the hospital requesting the discharge paperwork or a report. The RN stated Resident #82 reported that he had an extensive substance abuse history to the hospital licensed social worker. On [DATE] at 11:01 A.M. an interview with RN #35 revealed when Resident #82 showed up at the facility, she was not aware he had left the hospital AMA. She had looked through his bag and found no discharge paperwork, so she called the hospital and spoke to the charge nurse on the floor he was on, but the hospital didn't have anything to provide. She verified she did not call the medical director but said she called and texted the Assistant Director of Nursing (ADON) #91 but never received any response. The RN stated she only worked on [DATE] but had no problems with Resident #82 (that night). On [DATE] at 11:04 A.M. an interview with the Medical Director revealed she was not aware, and no one contacted her team to notify anyone on her team that Resident #82 was admitted to the facility and did not find out until [DATE]. Her expectation would be for the facility to contact her (or her team) regarding admission. Further interview revealed when a resident who is admitted to a facility with a known history of drug abuse, generally they are already through the withdrawal window so usually all they (the facility) do is supportive care because this is their home. She also shared the facility was not a drug rehabilitation facility, so the facility didn't provide any type of supervision (related to drug use prevention). On [DATE] at 9:43 A.M. an interview with Records Manager #500 at the Columbus Police Department (CPD) revealed the facility called the CPD at 12:42 P.M. regarding drug paraphernalia. The CPD did not arrive at the facility until 3:40 P.M. and the call was cleared at 3:42 P.M. The records manager verified there was no report to review. Review of the Facility Assessment, revised [DATE], revealed the facility was able to provide care for residents with drug use or abuse (alcohol dependence/substance dependence). Review of the facility Admission Policy, dated [DATE] and revised [DATE], revealed a physician must personally approve, in writing, a recommendation that an individual be admitted to the facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility Abuse: Identification of Types policy and procedure, issued [DATE] and revised [DATE], revealed it is the policy of this facility to identify abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is not limited to identifying and understanding the different types of abuse and possible indicators. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. a. Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (e.g., suctioning, transfers, use of equipment), lack of sufficient staffing to be able to provide the services, lack of supplies, or staff lack of knowledge of the needs of the resident. This deficiency demonstrates non-compliance investigated under Complaint Number OH00163381.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568 Based on record review and staff interviews, the facility failed ensure care plans were comprehensive and addressed problems as stated in a self-reported incident (SRI). This affected one resident (#43) of three residents reviewed for care plans. The facility census was 81. Findings include. Review of the medical record for Resident #43 revealed an admitted [DATE]. The resident was admitted with diagnoses including idiopathic aseptic necrosis of left femur, unsteadiness on feet, history of falling, type II diabetes mellitus, and memory deficit following a cerebral infarction. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) of 11 out of a score of 15, indicating moderate cognitive impairment, and was dependent for showering/bathe self and lower body dressing. Resident #43 was independent for oral hygiene, toileting hygiene, putting on/taking off footwear, and personal hygiene. Review of SRI #257139 regarding physical abuse for Resident #43 dated 02/12/25 revealed the facility changed Resident #43's silverware to plastic and the resident had an updated care plan for aggressive behaviors and racial expletives. Review of the Care Plan dated 02/14/25 revealed plastic silverware, aggressive behaviors, and racial expletives were not reflected in the care plan. Interview on 03/06/2025 at 10:35 A.M. with the Director of Nursing (DON) revealed the aggressive behaviors should have been addressed in the care plan when the SRI indicated the information would be added to the resident's care plan. The DON also verified the plan was not updated for aggressive behaviors and racial expletives. Interview on 03/06/2025 at 3:59 P.M. with the DON revealed nursing staff were not aware of the intervention added in the SRI. She also revealed any intervention discussed should be on the care plan. Review of the Care Planning- Baseline, Comprehensive, and Routine Updates policy dated 11/25/24, stated Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. The policy also stated Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc. and clearly state the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns. This is an incidental finding discovered during the complaint investigation.

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 03/21/2025
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)
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** 19571 Based on medical record review, observation, staff interview and facility policy review, the facility failed to ensure comprehensive care related to tracheostomy care. This affected two (Resident #65 and #66) of three resident records reviewed for tracheostomy care. The census was 81. Findings include: 1. Review of Resident #65's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, cerebral aneurysm, liver transplant, tracheostomy, dysphagia and Hepatitis C. Review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed her cognition was rarely/never understood, she was dependent on staff for eating, oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. She was always incontinent of bowel and bladder. Review of the physician's orders dated 03/25 revealed no orders for tracheostomy care. There was no documented evidence of a plan of care for tracheostomy care or documentation on the treatment record tracheostomy care had been completed. 2. Review of Resident #66's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis. dysphagia, acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), protein calorie malnutrition, tracheostomy and history of cancer to the head, face and neck. Review of the admission MDS assessment dated [DATE] revealed her cognition was intact. She required setup or clean up assistance with eating, oral hygiene, partial/moderate assistance with toileting, shower/bathing, dressing, and personal hygiene and the resident was occasionally incontinent of urine and always incontinent of bowel. Review of the physician's orders dated 03/25 revealed no orders for tracheostomy care. There was no documented evidence of a plan of care for tracheostomy care or documentation on the treatment record tracheostomy care had been completed. On 03/06/25 at 3:25 P.M. interview with the Director of Nursing (DON) verified they did not have documentation on the treatment records or physician orders of tracheostomy/stoma care. This deficiency demonstrates non-compliance investigated under Complaint Number OH00163322.

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 03/21/2025
NAME OF PROVIDER OR SUPPLIER Mayfair Village Nursing Care C		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Bethel Rd Columbus, OH 43230	

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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 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. 19571 Based on observation, staff interview and review of facility policy and procedure, the facility failed to ensure medications were secured to prevent unauthorized access. This had the potential to affect seven (Residents #35, #42, #43, #48, #50, #56 and #58) of 24 residents on 300 hallway identified as cognitively impaired and independently mobile. The census was 81. Findings include: Observation on 03/10/25 at 8:28 A.M. of medication administration by Licensed Practical Nurse (LPN) #25 revealed while preparing medication for Resident #38, she left the medication cart unattended leaving cards of hydroxide HCL(antihistamine) 25 milligrams (mg), Potassium Chloride ER (extended release) 20 meq (milliequivelants), Spironalactone (blood pressure medication) 25 mg, toresmide (diuretic) 20 mg, Venlafaxine (antidepressant) HCL 100 mg, Venlafaxine HCL 25 mg and a bottle of Miralax on top of the medication cart unattended and out of her sight. Interview with LPN #25 on 03/10/25 at 8:34 A.M. verified she had left the medications on top of the medication cart unattended and out of her sight. Review of the Administration of Medications policy and procedure dated 04/24/19 and revised 02/13/23 revealed no reference to leaving medications unlocked and unattended. This deficiency is an incidental finding discovered during the investigation.

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 03/21/2025
NAME OF PROVIDER OR SUPPLIER Mayfair Village Nursing Care C		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Bethel Rd Columbus, OH 43230	

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation, staff interview and facility policy and procedure review, the facility failed to ensure proper infection control guidelines were maintained during tracheostomy care. This affected one (Resident #65) of two residents reviewed for tracheostomy care. The census was 81. Findings include: Review of Resident #65's medical record (SR #3) revealed she was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, cerebral aneurysm, liver transplant, tracheostomy, dysphagia and Hepatitis C. Review of the quarterly MDS dated [DATE] revealed her cognition was rarely/never understood, she was dependent on staff for eating, oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Review of the physician's orders dated 03/25 revealed no orders for tracheostomy care. There was no documented evidence of a plan of care for tracheostomy care or documentation on the treatment record tracheostomy care had been completed. On 03/06/25 at 11:16 A.M. observations of tracheostomy care revealed the Licensed Practical Nurse (LPN) #85 washed her hands and donnedf gloves. Then placed a pulse oximeter on the resident's finger and removed the resident's speaking valve and placed it in a container. The LPN then removed her gloves and washed her hands. LPN #85 then donned new gloves and removed the old dressing under the tracheostomy cuff and then moved the trash can closer to her. LPN #85 then removed her gloves and donned the sterile gloves from the tracheostomy kit, without washing her hands. She opened the normal saline and peroxide and placed them in the provided basin. Then she cleansed around the tracheostomy, under the cuff, with the provided Q-tips and dried the area with a 4 x 4 gauze provided. LPN #85 then removed her gloves and donned new gloves without washing her hands and placed a split 4 x 4 gauze under the cuff, around the tracheostomy. Next, the LPN was observed to remove her gloves and washed her hands and donned new gloves, removed the inner cannula and replaced it with a new clean inner cannula. The LPN removed her gloves and washed her hands. On 03/06/25 at 11:30 A.M. interview with LPN #85 verified she had not washed her hands in between all glove changes. Review of the Hand Hygiene policy and procedure dated 03/06/2019 and revised 06/03/2024 revealed associates are to perform hand hygiene even if gloves are used in the following situations: After removing personal protective equipment(e.g., gloves, gowns, eye protection, face mask). This deficiency demonstrates non-compliance investigated under Complaint Number OH00163322.