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	09/23/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide assistance with bathing and shaving. This affected (Residents #42 and #44) of three residents reviewed for showers. The facility census was 80. Review of the medical record revealed Resident #42 was admitted on [DATE] with diagnoses that included acute embolism and thrombosis of left iliac vein, pulmonary embolism, severe protein-calorie deficiency, schizoaffective disorder, dementia, depression, and bipolar. The annual Minimum Data Set (MDS) dated [DATE] revealed it was very important for Resident #42 to choose the type of bathing. A care plan for activities of daily living dated 01/26/24 revealed Resident #42 required supervision with bathing/showering. Review of the electronic record, therapy notes, and paper documentation revealed in the last 30-days Resident #42 received a bed bath on 09/08/25 and 09/11/25, refused bathing with occupational therapy on 09/18/25, and received a sponge bath on 09/21/25. An observation and interview on 09/22/25 at 12:31 P.M. revealed Resident #42 was sitting in a chair in his room. Resident #42 had a short beard. Resident #42 stated he did not like having a beard and would like to be shaved. Resident #42 also verified he preferred receiving a shower over a bed bath. Interview on 09/22/25 at 2:05 P.M. a family of Resident #42 verified Resident #42 did not like having a beard. The family member also stated Resident #42 was only bathed once a week and preferred a shower. The family member stated they had taken Resident #42 home on a leave of absence so Resident #42 could shower at her house. An interview on 09/22/25 at 4:23 P.M. Director of Nursing (DON) verified Resident #42 was not being bathed and shaved per his preference. The DON verified there was a concerns with bathing being completed as scheduled. 2. Review of the medical record revealed Resident #44 was admitted on [DATE] with diagnoses that included dementia and atrial fibrillation. Review of the annual MDS dated [DATE] revealed Resident #44 had severe cognitive impairment and was dependent on staff for bathing. Review of the electronic record and paper documentation revealed in the last 30 days Resident #44 received a sponge bath on 08/28/25 and a shower on 09/01/25. Interview on 09/22/25 at 4:23 P.M. Director of Nursing (DON) verified there was a concern with bathing being completed as scheduled. This deficiency represents non-compliance investigated under Complaint Number 2584976.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly assess a resident after a fall and timely notify the physician. This affected one resident (#3) of three residents reviewed for falls. The facility census was 80. Findings include: Review of Resident #3's medical record revealed an admission date of 07/10/25 with diagnoses including cognitive communication deficit, dementia, depression, anxiety and fracture of left femur on 08/21/25.Review of Resident #3's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. Since the previous assessment Resident #3 had two falls or more without injury, two falls or more with injury, and one fall with major injury.Review of Resident #3's plan of care dated 07/11/25 revealed the resident was at risk for falls related to impaired balance and lack of safety awareness due to cognitive deficit related to dementia. Interventions included assisting out of bed before meals, assisting with toileting before bedtime, dycem to wheelchair, clearing a pathway in his room, fall mat, low bed, medication review, offering snacks when restless, offering toileting in advance of needs, toileting before laying down after meals, and visual reminder to call before you falls.Review of Resident #3's progress note dated 08/16/25 at 3:00 A.M. revealed staff heard yelling coming from the residents room. The residents roommate was calling for help after the resident fell. Resident #3 was found on the floor lying on his back next to his bed. He was unable to voice what happened. A head-to-toe assessment was completed and no visible injuries were noted. However, the resident was unable to stand and complained of left hip pain. Staff assisted the resident back in bed, groomed him and put him in his wheelchair. He was given as needed pain medication at that time.Review of Resident #3's fall investigation dated 08/16/25 revealed no evidence his range of motion was not assessed and the physician was not notified until 8:00 A.M.Interview on 09/22/25 at 11:10 A.M. with the Director of Nursing (DON) verified that range of motion was not assessed after his fall and should have been.Interview on 09/22/25 at 1:04 P.M. with Certified Nurse Practitioner (CNP) #270 verified they were not timely notified of the fall. The physician was notified of the fall at 7:45 A.M. and they should have been notified at the time of the fall so they could address any concerns at that time.This deficiency represents noncompliance investigated under Complaint Numbers 2593023 and 2584976

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and policy review, the facility failed to ensure Resident #3's pain was timely and appropriately addressed. This affected one resident (#3) of four residents reviewed for falls. The facility census was 80.Findings include: Review of Resident #3's medical record revealed an admission date of 07/10/25 with diagnoses including cognitive communication deficit, dementia, depression, anxiety and fracture of left femur on 08/21/25.Review of Resident #3's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. Since the previous assessment Resident #3 had two falls or more without injury, two falls or more with injury, and one fall with major injury. Review of Resident #3's physician order dated 07/10/25 revealed an order for Acetaminophen Tablet 325 milligrams (mg) two tablets by mouth every four hours as needed for a fever above 101 degrees Fahrenheit. Review of Resident #3's physician order dated 07/10/25 revealed an order for Acetaminophen Suppository 650 mg, one suppository insert rectally every four hours as needed for pain. Review of Resident #3's plan of care dated 07/11/25 revealed the resident was at risk for pain and discomfort related to cancer and history of fractures. Interventions included educating the resident and family regarding pain management, notifying the physician if interventions are unsuccessful, observing and reporting to the nurse resident complaints of pain or requests for pain treatment, observing for probable cause of pain, pain medications as ordered, and reporting to the nurse any changes in usual activity.Review of Resident #3's plan of care dated 07/11/25 revealed the resident was at risk for falls related to impaired balance and lack of safety awareness due to cognitive deficit related to dementia. Interventions included assisting out of bed before meals, assisting with toileting before bedtime, dycem to wheelchair, clearing a pathway in his room, fall mat, low bed, medication review, offering snacks when restless, offering toileting in advance of needs, toileting before laying down after meals, and visual reminder to call before you fall.Review of Resident #3's progress note dated 08/16/25 at 3:00 A.M. revealed staff heard yelling coming from the resident's room. The residents roommate was calling for help after the resident fell. Resident #3 was found on the floor lying on his back next to his bed. He was unable to voice what happened. A head-to-toe assessment was completed and no visible injuries were noted. However, the resident was unable to stand and complained of left hip pain. Staff assisted the resident back in bed, groomed him and put him in his wheelchair. He was given as needed pain medication at that time.Review of Resident #3's progress note dated 08/16/25 at 3:10 A.M. revealed the resident was given acetaminophen 325 mg for left hip pain.Review of Resident #3's progress note dated 08/16/25 at 8:06 A.M. revealed the certified nurse practitioner (CNP) was notified of the residents' left hip pain after a fall, and an x-ray was ordered.Review of Resident #3's progress note dated 08/16/25 at 5:24 P.M. revealed the nurse was aware of Resident #3's unwitnessed fall where he landed on his left thigh. The resident had been noted moaning and groaning during their shift. The nurse notified the physician and was given an order to transfer them to the hospital.Review of Resident #3's progress note dated 08/17/25 at 3:53 A.M. revealed the resident returned from the hospital and his x-ray results were negative for fracture.Review of Resident #3's hospital after visit summary dated 08/16/25 revealed his diagnosis was closed fracture of the left hip. Handwritten on this after visit summary was ‘no fx (fracture)'. In the hospital the resident had been given Fentanyl for pain.Review of Resident #3's CT exam of his pelvis revealed there was a previous fracture present, however, there was a new mildly displaced comminuted fracture along the lateral base of the left trochanter which extended to the anchoring stem of the unit.Review of Resident #3's CNP #270 note dated 08/18/25 revealed the resident reported left hip pain, he was sore, and it hurt to move. Resident #3 had a fall on 08/16/25 and was sent to the emergency room for left hip pain with a negative x-ray. She recommended the facility continue fall precautions, nursing interventions, and neurochecks. His medications were reviewed, his current medications had no concern for polypharmacy to cause sedation or side effects leading to falls. In an addendum on 08/19/25 CNP #270 indicated the hospital notes had a CT scan which revealed a nondisplaced greater trochanter fracture. Orthopedics recommended nonsurgical management, weight bearing as tolerated with walker until pain free, limited abduction, and follow up in three weeks.Review of Resident #3's progress note dated 08/19/25 revealed the resident had pain with turning and completing activities of daily living. CNP #270 was notified and gave a verbal order for new pain medications.Review of Resident #3's physician order dated 08/19/25 to 09/08/25 revealed an order for oxycodone five mg one tablet by mouth every six hours as needed for pain.Review of Resident #3's Medication Administration Record from