STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365421	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inniswood Health and Rehabilitation	1150 Colony Drive Westerville, OH 43081

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to timely report an allegation of involuntary seclusion. This affected one, (Resident #94) of one resident reviewed for abuse. The facility census was 87.Findings include:Review of Former Resident #94's medical record revealed the resident was admitted on [DATE]. Diagnoses included seizure disorder, autism spectrum disorder, aphasia, and cognitive impairment.Review of the Minimum Data Set (MDS) assessment dated [DATE] and the Care Area Assessment (CAA) Trigger Summary dated 01/27/26 revealed the resident demonstrated severely impaired decision-making ability.Review of the Elopement Risk assessment dated [DATE] revealed the resident was independently mobile and exhibited wandering and exit-seeking behaviors, requiring supervision and monitoring for safety.Review of facility-provided email communication revealed no documentation of the reported incident involving placement of a Hoyer lift in front of the resident's door.Interview on 04/09/26 at 3:00 P.M. with Licensed Practical Nurse (LPN) #301 revealed LPN #301 worked on the day of the reported incident and confirmed that a Hoyer lift was positioned in front of Resident #94's door. LPN #301 stated the mechanism of how the lift came to be in that location was unknown.Interview on 04/09/26 at 11:40 A.M. with the Director of Nursing (DON) revealed the facility was notified of the allegation involving the Hoyer lift being placed in front of Resident #94's doorway. The DON stated the facility conducted an internal investigation but was unable to confirm the incident. The DON further stated that a Self-Reported Incident (SRI) was not submitted.Interview on 04/09/26 at 1:10 P.M. with the Administrator revealed during the time of this incident she was off on leave and there was another Administrator, Administrator #428 who was the acting Administrator during her absence. It was revealed according to Administrator #428, an SRI was not submitted after the allegation was reported. The Administrator stated, Administrator #428 contacted the resident's Power of Attorney (POA), who indicated no concerns regarding the reported situation. The Administrator confirmed based on this information, the incident was not reported to the State survey agency. The Administrator further stated under similar circumstances, an SRI would be expected to be submitted.Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, revealed the facility is required to report all allegations of abuse or potential abuse to the State survey agency within required timeframes and conduct a thorough investigation.

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