

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/09/2025
NAME OF PROVIDER OR SUPPLIER  Mother Angeline McCrory Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  5199 East Broad Street Columbus, OH 43213	

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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/09/2025
NAME OF PROVIDER OR SUPPLIER  Mother Angeline McCrory Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  5199 East Broad Street Columbus, OH 43213	
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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of medical records, observation, interview, policy review and review of provided videos and pictures, the facility failed to ensure residents with trauma received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This affected one resident (#55) out of three residents reviewed for abuse. Findings Include: Review of Resident #55's medical Record revealed an admission date of 06/05/25 and medical diagnosis of covid-19, weakness, need for personal assistance with care, pain due to trauma, cerebral vascular accident, abnormal gait and mobility, dysphagia, traumatic subarachnoid hemorrhage without loss of consciousness, wedge compression fracture of fifth lumbar vertebra, hyperlipidemia, cervical disc degeneration, depression, anxiety, dementia mild with mood disturbance, muscle wasting and atrophy. Review of the undated document titled Care for [Resident #55] revealed the residents family brought up some care related concerns and that the resident preferred not to have male care givers. Review of Resident #55's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status score of 06 revealing severe cognitive impairment and the need for personal assistance requiring one to two staff members for activities of daily living and incontinence care. Review of Resident #55's care plan dated 06/07/25, revealed the resident was resistive to care with interventions to reassure the resident, leave and return 5 to 10 minutes later and try again. Further review of the care plan, last updated 11/17/25, revealed the resident had a self-care performance deficit related to dementia and preferred female caregivers only related to showers and checks/changes due to a past assault when she was in the community. Interventions included one to two staff assistance with showering/bathing, bed mobility, dressing, eating, personal hygiene/oral care, toilet use, and transfers. Review of Resident #55's psychiatric note dated 09/15/25 revealed per the residents family she had history of trauma growing up as well as when a man entered her home when she was a new mother, and she encountered a stranger in her staircase in her home. Review of Resident #55's lab draw dated 10/24/25 revealed the resident had a lab draw to the back of the left hand. Review of Resident #55's November and December 2025 physician orders revealed an order dated 10/11/25 for Aspirin 81 milligrams (mg) oral tablet with instructions to give one table in the morning as an antiplatelet. Review of Resident #55's Medication Administration Record (MAR) for November 2025 revealed the resident received Aspirin 81 mg's daily. Review of Resident #55's lab draw dated 11/07/25 revealed the resident had a lab draw to the back of the right hand. Review of Resident #55's fall report dated 11/15/25 revealed the resident had an unwitnessed fall and sustained no injuries. Review of Resident #55's skin assessment dated [DATE] revealed no documented skin issues, including no documented bruising. Review of the facility Self-Reported Incident (SRI) dated 11/17/25 revealed on 11/17/25 the facility was contacted by Resident #55's Power of Attorney (POA) with concerns of abuse provided by two male caregivers (Certified Nursing Assistant (CNA) #4 and Agency Nurse #687) during incontinence care on 11/17/25 at approximately 5:45 A.M. The facility placed both caregivers on administrative leave pending the investigation. A skin assessment was performed on 11/17/25 by Unit Manager #141 and Assistant Director of Nursing (ADON) #71 and revealed unmeasured black round marks on the back of Resident #55's bilateral hands and no fresh, bright red or maroon bruising were noted to the bilateral hands arms, or wrist. Additional assessments revealed Resident #55 denied pain or discomfort, nor did she express non-verbal pain indicators. The facility also contacted the local Police Department and filed a police report. Review of the preliminary police report #250847274, dated 11/17/25 revealed the residents responsible party noticed two male employees, and RN and an aide, at the residential home were her mother resided, changed her clothing and generally tended to her. It noted Resident #55 had a past trauma event involving males in general and also had dementia. Resident #55 was advising the two males to stop what they were doing and stated that they were hurting her. The resident's family believed this was assault and had the video saved from the incident. Review of Resident #55's video footage dated 11/17/25 at approximately 6:00 A.M. revealed two male caregivers (CNA #4 and Agency Nurse #687) providing incontinence care for Resident #55. Resident #55's bed was against the wall and the two male caregivers backs were facing the camera. The resident was addressed by name, was told by staff to hold their hand while they performed incontinence care. Resident #55 objected to incontinence care and yelled no multiple times. The two caregivers proceeded with incontinence care and the resident then yelled, you are breaking my hand. The video then showed a night gown was removed from the resident and placed on the top of the</p>		