

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER Westerville Post Acute.		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 Eastwind 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure a complete investigation was completed to determine root cause analysis when a resident sustained a fall and failed to ensure fall safety interventions were in place as per residents care plan. This affected three residents (#238, #3, and #79) of the six residents reviewed for accidents and falls. Facility census was 83.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #238 revealed an initial admission date of 08/30/2023, a re-entry date of 11/20/2024 and a discharge date of 12/03/2024. Diagnoses included non-traumatic intracerebral hemorrhage, dementia, and hypertension.</p> <p>Review of Resident #238's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 04 out of 15 indicating a severely impaired cognition for daily decision making abilities. Resident #238 was noted to display behaviors including rejection of care. Resident #238 was noted to be free of any impairment to his upper and lower extremities and was noted to be independent with all activities of daily living and mobility.</p> <p>Review of Resident #238's admission Fall Risk assessment dated [DATE] revealed a score of 8 indicating this resident was at a low fall risk.</p> <p>Review of Resident #238's annual Fall Risk assessment dated [DATE] revealed this assessment was incomplete.</p> <p>Review of the progress note dated 11/08/2024 at 9:15 A.M. revealed Patient states he fell last night and ever since he is unable to move his right leg. Upon assessment patient's right hip and leg noted with some redness, unable to do range of motion, patient also noted crying during assessment. He usually walks around the facility but unable to even sit up at this time. Nurse Practitioner instructed nursing to transfer patient to the hospital for further evaluation.</p> <p>Continued review of Resident #238's medical records revealed no evidence to support that a post fall investigation was completed or if this reported fall was reviewed.</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/26/2025 at 3:00 P.M. with Regional Nurse #252 confirmed Resident #238's annual Fall Risk Assessment was incomplete as well as confirming a fall investigation was not completed for the reported fall that was said to have occurred on 11/07/2024 reported by the the resident.</p> <p>Review of the facility policy titled Falls Clinical Policy, revised 03/2018 revealed For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. If the cause of the fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors.</p> <p>3. Review of the medical record for Resident #79 revealed an admission date of 05/28/25, with diagnoses including chronic respiratory failure, hypertension, dissection of the ascending aorta, cerebral infarction, history of transient ischemic attack, metabolic encephalopathy, hemiplegia, and hemiparesis.</p> <p>Review of the hospital Discharge summary, dated [DATE], revealed activity instructions indicating that a helmet should be used during resident transfers and when the resident was out of bed.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment, completed on 06/04/25, revealed Resident #79 was severely cognitively impaired and dependent on staff for all activities of daily living and ambulation.</p> <p>Observation on 06/23/25 at 9:21 A.M. revealed Resident #79 was seated in a recliner, engaged with staff, and wearing a protective head cap during the encounter.</p> <p>Review of the medical record on 06/23/25 showed no documentation specifying the requirement, frequency, or circumstances for wearing head protection.</p> <p>Observation on 06/24/25 at 7:32 A.M. revealed signage in Resident #79 ' s room, located behind the television, stating, STOP NO BRAIN FLAP ON LEFT SIDE. At that time, Resident #79 was lying in bed without the protective head cap.</p> <p>Interview on 06/26/25 at 2:11 P.M. with Registered Nurse #194 confirmed information about the indication and frequency for the use of the protective head covering should be documented either in the care plan or in physician orders.</p> <p>Interview on 06/26/25 at 2:14 P.M. with Assistant Director of Nursing (ADON) #146 confirmed that neither the care plan nor the physician's orders included documentation about the indication, frequency, or rationale for the use of the protective head cap. ADON #146 acknowledged that this information was only added after surveyors requested clarification, and that prior to the request, there was no system in place to ensure staff had consistent guidance on the use of head protection for Resident #79.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00164069, OH00163718.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident # 3's medical record revealed that she was admitted on [DATE] with diagnoses that included diabetes mellitus type 2 with foot ulcer and chronic kidney disease, malnutrition, paraplegia, discitis, borderline personality disorder and chronic pulmonary obstruction. She was alert and oriented.</p> <p>Review of Resident #3's clinical physicians orders dated 05/30/25 revealed no orders for fall interventions.</p> <p>Review of Resident #3's fall risk care plan dated 11/01/24 to 09/16/25 revealed fall interventions for a low bed, initiated on 02/03/25 and a fall mat to the right side of the bed when resident is in bed, initiated on 04/18/25.</p> <p>Observation on 06/23/25 at 10:20 A.M. revealed Resident # 3 in bed with the bed up in high position and fall mat folded up against the wall near her bed.</p> <p>Interview on 06/23/25 at 10:25 A.M. with Licensed Practical Nurse (LPN) # 152 revealed Resident #3 was a fall risk and confirmed that the low bed with fall mat was not in place.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, record review, policy review and safety data sheet review, the facility failed to ensure Resident #38 was free from significant medication errors. This affected one resident (#38) of one resident reviewed for medication errors. The facility census was 83.</p> <p>Findings Include:</p> <p>Record review revealed Resident #38 was admitted to the facility on [DATE]. Pertinent diagnoses included: type 2 diabetes mellitus with hyperglycemia, long term (current) use of insulin, acquired absence of right foot, acquired absence of left leg below knee, severe obesity and dementia.</p> <p>Review of quarterly Minimum Data Set (MDS) dated [DATE] for Resident #38 revealed he was cognitively intact. The functional assessment rated Resident #38 as independent on eating, hygiene, dressing and transfers, with supervision needed for showers/bathing.</p> <p>Review of Care Plan for Resident #38 dated 11/13/24 revealed Resident #38 was at risk for hyper/hypoglycemic reactions, abnormal lab values and diabetic ulcers due to his diabetes. Interventions for this focus suggested that medications should be given per physician order and that nursing should monitor for signs and symptoms of hypo/hyperglycemia (high/low blood sugar).</p> <p>Interview on 06/23/25 at 11:32 AM with Resident #38 who said nursing staff doesn't give his insulin to him in a timely manner. He said when he asks them they ignore him. He said he sometimes feels lightheaded.</p> <p>Review of physician's orders for Resident #38 revealed an order dated 11/04/24 for HumaLog Solution 100 unit/ml (fast acting insulin) to be injected subcutaneously before meals per sliding scale as follows:</p> <p>If blood sugar is 0 to 150, give 0 units.</p> <p>If blood sugar is 151 to 200, give 2 units.</p> <p>If blood sugar is 201 to 250, give 4 units.</p> <p>If blood sugar is 251 to 300, give 6 units.</p> <p>If blood sugar is 301 to 350, give 8 units.</p> <p>If blood sugar is 351 to 400, give 10 units.</p> <p>If blood sugar is greater than 400, call provider.</p> <p>Additionally, there was a physician order dated 11/23/24 for Resident #38 for Lantus (long acting insulin) SoloStar Solution Pen Injector for 25 units to be injected subcutaneously one time per day. Resident #38 had physician order dated 01/27/25 for Basaglar (long acting) Kwikpen Solution Pen-Injector 100 unit/ML (Insulin Glargine) 30 units to be injected subcutaneously at bedtime for diabetes.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/24/25 at 2:01 P.M. with Resident #38 shared he did not receive his medications the previous evening. He said he told the nurse and she just walked away.</p> <p>Review of Medication Administration Record (MAR) for Resident #38 for 06/23/25 appeared to confirm that Resident #38 did not receive his evening insulin medication (Basaglar), although the documentation indicated that he had refused the medication on the evening of 6/23/25. Further review revealed that the 6/22/25 scheduled 7:00 P.M. long acting insulin dose was documented as having been administered on 06/23/25 at 3:08 A.M. The documentation further indicated that on 06/23/25, less than five hours later, Resident #38 received his morning short acting insulin dose at 8:36 A.M. as well as his morning dose of long acting insulin at 8:39 A.M. Resident #38 had a recorded blood sugar of 214 at that time and he was administered 4 units of the short acting insulin. Per the MAR documentation, the resident was not available in the afternoon of 06/23/25 and there was no recorded blood sugar that day until 4:24 P.M. when the resident's blood sugar was 283 and he was administered 6 units of insulin.</p> <p>Interview on 06/24/25 at 3:02 PM with Registered Nurse (RN) #122 verified that the MAR indicated Resident #38 received his 6/22/25 evening dose of long acting insulin at 03/23/25 at 3:08 A.M. RN #122 said that if the medication is scheduled at bedtime you want to make sure you give it at the time the resident goes to bed. She said she does not look at previous evening's MAR and therefore would not know a resident received the bedtime dose in the early morning. She said Resident #38 does go out sometimes (in daytime) and that if he was gone at the time he should have received his insulin and he returned near dinner time, she would hold off on the dose.</p> <p>Interview on 06/24/25 at 4:40 PM with the Director of Nursing (DON) verified the MAR indicated Resident #38 received his 06/22/25 evening dose of insulin the following morning at 3:08 A.M. The DON said the bedtime administration of insulin could be variable if the resident goes to bed at different times. The DON said he was not concerned with the dose being administered so late because he said the blood sugar test would've caught any issues. Regarding the missed insulin dose on the evening of 06/23/25, he said that perhaps the resident was out of the building.</p> <p>Interview on 06/24/25 at 5:05 PM with Regional Director of Clinical Services #252 confirmed an order for bedtime medication administration should be given between the hours of 7:00 P.M. and 11:00 P.M. He verified the MAR record appeared to indicate the 06/22/5 evening dose of insulin was administered on 06/23/25 at 3:08 A.M. and confirmed that time was outside the accepted parameters.</p> <p>Interview on 06/25/25 at 9:10 A.M. with Resident #38 confirmed he did not leave the property on the evening of 06/22/25. He admitted he had been outside the dining room at the smoking area with other residents. He said he thought he came in around 10:00 or 11:00 P.M. He said he did not remember what time he received the 06/22/25 evening dose of insulin and said he did not refuse his insulin the evening of 06/23/25 and had not left the building that night either.</p> <p>Interview on 06/25/25 at 3:29 P.M. with the DON who said he spoke with the nurse who administered the insulin dose that was recorded at 3:08 A.M. on 6/23/25. He said that she relayed she was having internet troubles and had administered the dose earlier. He said she did not record the actual administration time on paper and he said there were no other residents who had late medication administration charted.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the May and June 2025 MAR for Resident #38 revealed the evening administration of Basaglar was documented as being administered outside of the 7:00 P.M. to 11:00 P.M. time frame on the following dates: 05/10/25 at 1:31 A.M., 05/13/25 at 11:44 P.M., 05/15/25 at 5:39 A.M., 05/20/25 at 11:21 P.M., 05/23/25 at 11:31 P.M., 05/30/25 at 11:29 P.M., 06/06/25 at 11:51 P.M., and 06/09/25 at 11:28 P.M</p> <p>Review of facility policy titled, Administering Medications revised April 2019 stated medications are administered in accordance with prescriber orders including any required time frame. Medication should be administered within one hour of prescribed time unless otherwise specified such as after meals. The policy stated that if resident is not in room or otherwise unavailable, the MAR may be flagged and the nurse will return to administer the dose.</p> <p>Review of the Safety Data Sheet for Bagaslar Insulin pen revised 07/2021 emphasized the importance of administering the medication at the same time every day. The safety data sheet stated that the median time to maximum effect of the medication is 12 hours. The data sheet warned that the risk for hypoglycemia is highest when the glucose lowering effect of the insulin is maximal and noted that changes in administration can increase risk. The safety data sheet also noted that symptomatic awareness of hypoglycemia may be less pronounced in patients with longstanding diabetes.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164069.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure enhanced barrier precautions were maintained during skin care. This affected one resident (#35) out of 16 residents on enhanced barrier precautions. The facility census was 83.</p> <p>Findings include:</p> <p>Review of Resident #35's medical record revealed an admission date of 06/22/18 with diagnoses including hemiplegia and hemiparesis affecting the left side, type 2 diabetes mellitus, aphasia, hypertension, dysphagia, and cognitive communication deficit.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood.</p> <p>Review of Resident #35's physician order dated 06/17/25 revealed an order for treatment of moisture-associated skin damage to the back of the head. Staff were instructed to cleanse the area with soap and water daily and as needed, pat dry, and leave open to air.</p> <p>Review of physician order dated 02/18/25 required enhanced barrier precautions for high-contact care, including dressing changes, requiring staff to wear a gown and gloves.</p> <p>Observation on 06/25/25 at 10:04 A.M. of moisture-associated skin damage care by Licensed Practical Nurse (LPN) #236 and Certified Nursing Assistant (CNA) #101 revealed both staff members touched the resident's blanket, remote, pillow, and head upon entering and throughout the care. LPN #236 and CNA #101 introduced themselves and gathered catheter supplies. Enhanced barrier precautions (EBP) signage was posted on the door. However, neither staff member donned Personal Protective Equipment (PPE) while providing direct care. When asked about the signage, staff stated it applied to the neighboring resident and that PPE was not required for Resident #35.</p> <p>Interview on 06/26/25 at 2:54 P.M. with the Director of nursing (DON) confirmed Resident #35 had current orders for enhanced barrier precautions during care, which includes the use of gowns and gloves when providing care involving high-contact areas. The DON also confirmed that both LPN #236 and CNA #101 should have worn appropriate personal protective equipment (PPE), specifically gowns and gloves, while performing moisture-associated skin damage (MASD) skin care due to the placement of Resident #35's feeding tube.</p> <p>Review of enhanced barrier precautions signage, undated, revealed everyone must, clean their hands, including before entering and when leaving the room and providers and staff must also wear gloves and a gown for high-contact resident care activities which includes dressing, bathing/showering, changing linens, providing hygiene and wound care (any skin opening requiring a dressing).</p> <p>Review of the Enhanced Barrier Precautions policy, dated December 2024, revealed enhanced barrier precautions are implemented to prevent the transmission of multi-drug resistant organisms (MDROs) to residents during high-contact care activities. The policy specifies that this is achieved by wearing gowns and gloves during such care.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00166198.		