STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365686	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Healthcare Center	4301 Clime Road North Columbus, OH 43228

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** 07316 Based on observations, medical record review, and staff interview, the facility failed to ensure a resident who was unable to carry out activities of daily living was provided with the necessary services to maintain good personal hygiene. This affected one of five sampled residents (Resident #57). The facility census was 96. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] and diagnoses including dementia, protein-calorie malnutrition, and dysphagia (difficulty swallowing). Review of a Minimum Data Set assessment completed 06/09/24 revealed a brief interview for mental status score of three, indicating severe cognitive impairment. It also stated the resident required substantial/maximal assistance with personal hygiene. Review of the plan of care initiated 06/30/21 and revised on 07/27/24 revealed Resident #57 had an activity of daily living self care performance deficit as evidenced by requires assistance with activities of daily living related to dementia, decreased mobility, and contractures of bilateral lower extremities. Interventions included substantial/maximal assist with personal hygiene (helper does more than half the effort). Observations on 08/21/24 at 10:43 A.M., 12:44 P.M. and 1:20 P.M. revealed Resident #57 to be in bed. Her fingernails were long and had a dark brown substance under the nails. On 08/21/24 at 1:55 P.M. her lunch tray was provided and Nurse Aide #100 was observed to feed the resident. The resident continued with long, dirty fingernails with a dark brown substance under the nails. On 08/21/24 at 3:26 P.M. the resident continued to have long, dirty fingernails with a dark brown substance under the nails. Interview with the Director of Nursing on 08/21/24 at 3:26 P.M. confirmed the resident had long, dirty fingernails with a dark brown substance under the nails. She stated this was not acceptable and the resident needed a manicure. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156977.

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, policy review, and staff interview the facility failed to implement a comprehensive and individualized pressure ulcer prevention program to ensure adequate interventions were in place to promote healing and prevent new ulcers from developing. Actual Harm occurred on 08/13/24 when Resident #57, who exhibited severe cognitive impairment, had a current pressure ulcer present and required substantial/maximal assistance for bed mobility was assessed to have a new in-house developed pressure ulcer. The resident was assessed to have a deep tissue injury (Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) to the right ischium/hip that developed due to the lack of adequate interventions including turning and repositioning. This affected one (Resident #57) of three residents reviewed for pressure ulcers. The facility identified four residents with in-house acquired pressure ulcers, including Resident #57. The facility census was 96. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] and diagnoses including dementia and protein-calorie malnutrition. On 08/08/24 the resident weighed 97.1 pounds. Review of a Minimum Data Set assessment completed 06/09/24 revealed a brief interview for mental status score of 3, indicating severe cognitive impairment. The resident required substantial/maximal assistance with bed mobility, transfers, and personal hygiene. Review of a pressure ulcer risk assessment completed 12/17/23 revealed a high risk for pressure ulcers. Pressure ulcer risk assessments completed 03/17/24 and 08/13/24 only identified a moderate risk for the development of pressure ulcers (even though the resident had pressure ulcers on 08/13/24). Review of the plan of care for Resident #57 initiated 07/27/24 and revised 07/31/24 revealed the resident was at risk for altered skin integrity related to decreased mobility, kyphosis, contractures of bilateral lower extremities, incontinence, and history of pressure ulcers. The plan of care stated the resident had a deep tissue injury of the left medial foot. The goal was to have improved or maintain current skin status. Interventions included weekly skin checks and encourage resident to turn and reposition or assist as needed as resident allows. The resident had a hospital stay from 07/18/24 to 07/27/24 for a left hip fracture. A skin and wound note by the wound nurse practitioner on 07/31/24 stated the resident had a deep tissue injury pressure ulcer on the left medial foot which was present upon admission (readmission) measuring 2.5 centimeters (cm) by 2.0 cm. with 100 percent epithelial. No other pressure ulcers were identified. Recommendations for preventative measures included ongoing pressure reduction and turning/repositioning precautions per protocol. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of nursing progress notes revealed a note from a physician on 08/13/24 indicating being notified that Resident #57 had ecchymosis of the right hip 3-5 cm in diameter. The note stated the resident had a recent left hip fracture and the area was likely due to pressure from offloading the resident off the left hip. The note stated to encourage frequent offloading. It further stated the resident should be up in a chair with meals. Physician's orders were obtained on 08/13/24 to encourage frequent offloading of right hip and should be up in chair with breakfast, lunch, and dinner. However, there was a nursing progress note on 08/14/24 that indicated the resident was unable to sit up in chair with meals due to pain. A skin and wound note by the wound nurse practitioner on 08/14/24 stated the resident had a new, deep tissue injury pressure ulcer of the right ischium measuring 6 cm by 7.5 cm. A new treatment order was given 08/14/24 to cleanse area with wound cleanser, apply Triad to base of wound, leave open to air when in bed and cover with border foam if up in chair. Recommendations for preventative measures included ongoing pressure reduction and turning/repositioning precautions per protocol. A skin and wound note by the wound nurse practitioner on 08/21/24 stated Resident #57 had a deep tissue injury pressure ulcer to the left medial foot measuring 2.5 cm by 2 cm which was improving. She also had a deep tissue injury pressure ulcer on the right ischium measuring 6 cm by 3 cm that was improving without complications. Recommendations for preventative measures included ongoing pressure reduction and turning/repositioning precautions per protocol. Observations on 08/21/24 at 10:43 A.M., 12:44 P.M., 1:20 P.M., 1:55 P.M., and 3:26 P.M. revealed Resident #57 to be in bed on her left side. At 1:55 P.M., Nurse Aide #100 was observed to feed the resident in bed on her left side. Nurse Aide #100 confirmed, at that time, that the resident was on her left side. She stated the resident did not have any pressure ulcers. Observations on 08/22/24 at 7:36 A.M., 9:37 A.M., 10:10 A.M., and 10:43 A.M. revealed Resident #57 to be in bed on her left side. Observation of the treatment for Resident #57 on 08/22/24 at 10:43 A.M. revealed an approximate quarter sized open area on the left medial foot. The open area was red with a white center. The area was cleansed with wound cleanser and the betadine was applied to the area. The right ischium was observed to have a deep reddish/purple area with a small scabbed area in the center. The area was cleansed with wound cleanser and Triad was applied. The skin on the left hip area was clear. The resident was placed back on her left side after the treatment was completed. Interview with Nurse Aide #208 on 08/22/24 at 11:03 A.M. revealed she and Nurse Aide #244 were providing care for Resident #57 on 08/22/24. She stated the resident was to be turned and repositioned every two hours by staff. She stated that she had come on duty at 6:00 A.M. She stated the resident was in bed on her right side from 6:00 A.M. until 9:00 A.M. when she was put on her back for breakfast. Then after eating (20-30 minutes) she was turned to her left side. However, when the surveyor stated she had observed the resident in bed on her left side at 7:36 A.M. (not right side as indicated by Nurse Aide #208) she stated she was not sure and Nurse Aide #244 should be asked about it. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Nurse Aide #244 on 08/22/24 at 11:04 A.M. revealed Resident #57 should be turned and repositioned by staff every two hours. She first stated staff were able to do this. She stated she came on duty at 6:00 A.M. She then stated that the resident had been on her left side since she came on duty on 08/22/24. She stated the resident has pain when laying on her right side. She stated she had not reported this to the nurse. Interview with Licensed Practical Nurse #143 on 08/22/24 at 11:05 A.M. revealed he was the nurse for Resident #57 on 08/22/24. He stated the resident should be turned and repositioned every two hours. He stated staff were able to do that. He then stated he was not aware that the resident could not lay on her right side due to pain and was not aware the resident had been on her left side since 6:00 A.M. (five hours). Interview with the Director of Nursing on 08/22/24 at 11:30 A.M. revealed she was not aware Resident #57 could not lay on her right side. She confirmed the turning/repositioning program had not been revised to develop another plan to prevent pressure ulcers since the resident was having pain laying on her right side/getting up. Review of the facility undated policy titled Pressure Ulcer Prevention: High Risk revealed a care plan would be developed for pressure ulcer prevention. It stated to assist in position change as needed, position with pillows/support devices to assist in maintaining position and comfort, turn and reposition per plan of care. The policy further stated to monitor for consistent implementation of interventions, evaluate effectiveness of interventions, revise intervention and/or goals as indicated, and communicate changes in interventions to the caregiving staff. This deficiency represents non-compliance investigated under Complaint Number OH00156977.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, and staff interview, the facility failed to follow up on dietician recommendations to ensure a resident maintained acceptable parameters of nutritional status, including body weight. This affected one of five sampled residents (Resident #93). The facility census was 96. Findings include: The facility identified two residents as having a significant weight loss in the past 30 days (Residents #93 and #65). Review of the medical record for Resident #93 revealed an admitted [DATE] and diagnoses including malignant neoplasm of the floor of the mouth and protein-calorie malnutrition. The resident received a mechanically altered dysphagia (difficulty swallowing) diet. Review of a Minimum Data Set assessment completed 08/10/24 revealed the resident had a brief interview for mental status score of 15, indicating intact cognition. He was independent with eating and was 70 inches tall (five foot, 10 inches). Record review revealed he weighed 122.4 pounds on 06/13/24 and 07/02/24. On 08/02/24 and 08/07/24 he weighed 123.2 pounds. However, on 08/08/24 it was documented he weighed 112 pounds. This represented an 11.2 pound, 8.9 percent significant weight loss in one day. Review of the plan of care initiated 08/01/24 and revised 08/10/24 revealed Resident #93 was at potential nutritional risk due to cancer and severe protein calorie malnutrition. Interventions included to monitor and address significant weight changes. Review of a nutritional assessment completed by the dietician on 08/10/24 revealed the resident was underweight and had a body mass index of 16.1. It stated his most recent weight on 08/08/24 was 112 pounds with a usual body weight range of 119-123. The assessment stated the new weight appeared erroneous and will request reweight. As of 08/22/24, there was no evidence the resident had been reweighed. Observations on 08/21/24 at 10:40 A.M. revealed Resident #93 to be lying in bed with a thin appearance. On 08/21/24 at 1:45 P.M. his lunch tray was observed in his room but the resident was not in the room and had not eaten anything from the tray. On 08/21/24 at 3:25 P.M. the resident was observed outside smoking. He stated he did not want any of his lunch meal. Interview with Dietician #245 on 08/22/24 at 11:15 A.M. confirmed she recommended a reweight for Resident #93 on 08/10/24. She stated she had sent e-mail requests for the reweight. Interview with the Director of Nursing on 08/22/24 at 11:20 A.M. revealed she did not receive any e-mail requests for a reweight for Resident #93. She confirmed a reweight had not been completed for Resident #93. This deficiency represents non-compliance investigated under Complaint Number OH00156977.

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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** 07316 Based on observations, policy review, medical record review, and staff interview, the facility failed to develop/implement infection control policies to provide a sanitary environment to prevent the development and transmission of communicable diseases and infections. This affected two of five sampled residents (Residents #3 and #57). The facility census was 96. Findings include: 1. Review of the medical record for Resident #3 revealed an admitted [DATE] and diagnoses including multiple sclerosis and quadriplegia. Review of wound and skin notes by the wound nurse practitioner on 08/21/24 revealed the resident had a Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location) on the left buttock and an Unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) on the sacrum. Review of physician's orders revealed an order dated 05/19/24 to cleanse the left buttock ulcer with wound cleanser, apply medical grade honey to wound bed, and cover with bordered gauze. Apply Triad peri-wound. Change daily. An order on 08/15/24 stated to cleanse sacrum wound with wound cleanser, apply medical grade honey, and cover with bordered gauze daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the wound treatments on 08/22/24 at 10:13 A.M. for Resident #3 by Registered Nurse/Assistant Director of Nursing (ADON) #215 revealed ADON #215 laid all of the wound care supplies (a box of gloves, a box of measuring devices, a bottle of wound cleanser, a bottle of hand sanitizer, a large package of 4x4 gauze, and a tube of Triad paste) in Resident #3's bed without any type of barrier. The items were laid directly on the bed linens. Resident #3 was in bed. ADON #215 applied gloves and removed the soiled dressing from the sacrum. She cleansed the sacrum using wound cleanser. She then removed her gloves, and without doing any hand hygiene (handwashing or hand sanitizer), applied a clean pair of gloves. She then used her gloved finger to apply the honey to the bed of the wound. She then applied a clean dressing to the sacrum. She then removed her gloves and used hand sanitizer. She then applied clean gloves and removed the dressing from the left buttock. She then cleansed the area with wound cleanser. She then removed her soiled gloves and, without doing any hand hygiene, applied a clean pair of gloves. She used her gloved finger to apply honey to the wound bed. She then removed one glove, and with no hand hygiene, applied a clean glove. She then applied a clean dressing to the left buttock. She then removed the gloves, used hand sanitizer, and applied clean gloves to cleanse the buttocks around the dressings. She then removed the gloves, and without hand hygiene, applied new gloves and applied Triad paste to the buttocks around the dressings. She then removed the gloves, and without hand hygiene, applied clean gloves and got in the resident's dresser to look for a clean disposable incontinent brief. The bottle of wound cleanser fell on to the floor. ADON #215 applied a clean incontinent brief. She then removed her gloves, and without hand hygiene, applied clean gloves. She then moved the wound care supplies from the bed to the resident's dresser (no barrier on dresser). She then removed her gloves and used hand sanitizer. She placed the hand sanitizer (which had been laying in the resident's bed) back into her pocket without cleansing the outside of the bottle. She then placed all of the wound care supplies back into the treatment cart without cleansing the outside of any of the items (all had been laying in the resident's bed and the bottle of wound cleanser had been dropped on the floor). The treatment cart contained supplies for other residents who require treatments. ADON #215 then proceeded directly to complete the wound treatments for Resident #57. 2. Review of the medical record for Resident #57 revealed an admitted [DATE] and diagnoses of dementia and protein-calorie malnutrition. A skin and wound note by the wound nurse practitioner on 08/21/24 stated Resident #57 had a deep tissue injury pressure ulcer to the left medial foot measuring 2.5 cm by 2 cm. She also had a deep tissue injury pressure ulcer on the right ischium measuring 6 cm by 3 cm. ((Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the wound treatments on 08/22/24 at 10:43 A.M. for Resident #57 by ADON #215 revealed she got the supplies out of the treatment cart needed for the wound care. She put on a gown and gloves. The supplies were placed on the bedside table without any type of barrier on the table. The left medial foot was observed to have an open area. ADON #215 attempted to cleanse the area with wound cleanser but the bottle would not spray. She confirmed it was the bottle that had dropped on the floor in Resident #3's room. Another bottle of wound cleanser was obtained. ADON #215 laid the bottle of wound cleanser in Resident #57's bed near her rectal area. She then removed her gloves, and without hand hygiene, applied clean gloves. She used a 4x4 to apply betadine to the left foot. She then removed her gloves and used hand sanitizer from her pocket. She applied clean gloves. She then used the wound cleanser to cleanse the right ischium with a 4x4. Triad paste was then applied. She then removed her gloves and, without hand hygiene, applied clean gloves. The resident's incontinent brief was then changed. She then removed her gloves and used the hand sanitizer from her pocket. The supplies used were placed back into the treatment cart without sanitizing them. (treatment cart contained supplies for other residents who have treatments). Interview with ADON #215 on 08/22/24 at 11:00 A.M. confirmed she was to wash her hands or use hand sanitizer after removing gloves and she did not always do that. She confirmed she was to use some type of barrier under the treatment supplies in the resident rooms to keep the items from being contaminated and she did not do that. She confirmed she placed all of the wound care supplies back into the treatment cart after they had either been in resident's beds or on their bedside furniture with no barriers under them. Review of the facility policy (dated 10/21/14 and revised 04/01/17) and titled Standard Precautions revealed hand hygiene was the cleaning of hands by using either handwashing or antiseptic hand rub. It stated practicing hand hygiene is a simple but effective way to prevent the spread of infections by breaking the chain of infection. Proper cleaning of hands can prevent the spread of germs, including those that are resistant to antibiotics and are becoming resistant to antibiotics. When hands are not visibly soiled, alcohol-based hand sanitizers are the preferred method for cleaning hands in this healthcare setting. Use soap and water when hands are visibly dirty or soiled. It stated hand hygiene was to be performed after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings and after glove removal. Interview with Regional Clinical Director of Operations #246 on 08/22/24 at 2:15 P.M. revealed the facility did not have a policy/procedure on the steps to follow to complete a dressing change, including the use of a barrier to prevent contamination of wound care supplies. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156977.