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	03/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, resident representative interview, staff interview, and review of facility policy, the facility failed to notify the resident's representative of a resident's change in care. This affected one (Resident #21) of four residents review for notification of change. The facility census was 98. Findings include: Review of the probate court of guardianship record dated 05/22/19 revealed Resident #21 has a court appointed guardian pertaining to person only, due to incompetency. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included dementia, traumatic brain injury, and cognitive communication deficit. Review of the care plan dated 08/21/22 revealed Resident #21 has liver disease related to liver cirrhosis and interventions included to report abnormal findings to medical provider and resident/resident representative. Review of the Minimum Data Set (MDS) 3.0 assessment completed 01/01/25 revealed Resident #21 had no cognitive impairment. Review of the progress notes dated 01/08/25 revealed Resident #21 was found with a beer given by another resident. Staff discussed with the resident the risks of consuming alcohol with her medical condition including alcoholic cirrhosis, diabetes as well as prescription of narcotic. These concerns were discussed with the resident, social worker and bedside registered nurse. Pain medication was discontinued at this time and scheduled lidocaine patch ordered. The progress notes from 01/08/25 to 01/21/25 revealed no attempts made to contact the guardian regarding alcohol usage as well as discontinuation of her pain medication, resulting in a change in plan of care. Interview on 02/27/25 at 9:42 A.M. with Resident #21's Court Appointed Guardian #500 confirmed she was never made aware of Resident #21's medication change or alcohol consumption. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 12:11 P.M. with the Director of Nursing (DON) confirmed the facility did not have documentation to support attempts were made to contact the Resident #21's guardian regarding Resident #21's medication change or alcohol consumption. Review of the facility's Notification of Change in Condition policy, undated, revealed the center must inform the resident, consult with the resident's medical practitioner and/or notify the residents representative or legal power of attorney/guardian where there is a change requiring such notification. This includes circumstances that require a need to alter treatment which may include a new treatment as well as discontinuation of current treatment. This deficiency represents non-compliance investigated under Complaint Number OH00162821.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on interview with hematology oncology department, interview with pharmacist, staff interviews, record reviews, and review of facility policy, the facility failed to ensure consistent continuity of care between outside providers including implementing physician orders from outside provider and timely communication and follow up with outside provider. This affected two (Residents #46 and #55) of three residents reviewed for quality of care. The facility census was 98. Findings include: 1. Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including chronic myeloid leukemia and dementia. Review of the physician orders dated 04/23/23 revealed imatinib mesylate (chemotherapy) oral tablet 400 milligrams (mg) one tablet by mouth in the morning for leukemia. Review of the encounter summary from the hematology clinic dated 10/04/25 at 12:01 P.M. revealed no recommendations to change Resident #55's medications. Review of the progress note dated 01/09/25 revealed Resident #55 refused to go to hematology appointment. The nurse spoke with a nurse at the hematology clinic who informed her they may not be able to reschedule this visit, and no new orders were received at this time. Review of the missed visit encounter summary dated 01/09/25 revealed a new order for dasatinib (tyrosine kinase inhibitor) (a chemotherapy medication to treat leukemia) 100 milligrams (mg) tablet by mouth daily with a start date of 01/09/25. This new order was not signed by Hematology Oncology Physician (HOP) #350 until 01/23/25, and it was not sent to the facility until 01/23/25 at 5:12 P.M. The encounter summary did not state to discontinue or continue the use of imatinib mesylate. Review of the laboratory results dated [DATE] at 5:00 P.M. revealed Resident #55's platelet level was at a critical level of 1,442 k/cmm (thousands of cells per cubic millimeter) (a measurement of white blood cells in the blood), whereas the normal range is from 150-450 k/cmm. The progress note dated 01/23/25 at 6:24 A.M. revealed abnormal lab results were called in from the laboratory, and a new order from the facility physician for low-dose aspirin 81 mg was given, with instructions to follow up with the hematology oncology office in the morning. The supervisor was made aware. Review of the hematology telephone encounter note dated 01/23/25 at 9:01 A.M. revealed Licensed Practical Nurse (LPN) #300 called into the hematology oncology office for critical labs for Resident #55. The progress notes dated 01/23/25 at 9:07 A.M. revealed hematology was notified of critical labs. Per the hematology oncology nurse, she would notify the physician, and they will call back for updates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of additional progress notes dated 01/23/25 at 3:17 P.M. and 5:18 P.M. revealed the facility attempted to call the hematology oncology office with no response or answer obtained. Review of the hematology and transplant clinic fax order received 01/23/25 at 5:12 P.M. revealed a new prescription order for dasatinib 100 mg tablet by mouth daily. Hematology asked if the facility could follow up with facility pharmacy to provide this new medication. The fax communication did not state to discontinue or continue the use of imatinib mesylate. From 01/23/25 at 5:12 P.M. to 01/28/25, there was no follow up documentation related if the facility answered the hematology and transplant clinic faxed question or a follow-up related to the critical laboratory result from 01/22/25. The progress notes dated 01/28/25 revealed the pharmacy called to confirm if the physician wanted a new order for dasatinib to be administered with the current order of imatinib. The nurse contacted the unit manager and confirmed both orders were active and were to be followed up accordingly with pharmacy. There was no documentation the facility followed up with the physician or hematology oncology department regarding the pharmacies question whether both medications (dasatinib and imatinib) should be administered simultaneously or discontinue the use of imatinib. Dastanib was not administered to Resident #55 until 01/31/25. Review of the medication administration from 01/31/25 to 02/02/25 revealed Resident #55 received both dasatinib and imatinib for treatment of leukemia/cancer. The progress note dated 02/03/25 revealed Resident #55 went to hematology appointment with transfer to the hospital due to abnormal laboratory results received during the visit. Interview on 03/03/25 at 11:31 A.M. with Unit Manager (UM) #212 confirmed she was asked by LPN #115 when pharmacy called to confirm if imatinib mesylate oral tablet 400 mg was to be discontinued when treatment with dasatinib was started. UM #212 denied calling the hematology oncology clinic before and after the orders were sent in to confirm if the imatinib should be given concurrently with another drug in the same class. UM #212 confirmed no follow-up was made to clarify the concurrent use of these medications with the hematology oncology office. She acknowledged that additional communication with the hematology oncology office could have helped clarify the situation. Interview on 03/03/25 at 11:35 A.M. with LPN #115 confirmed she spoke with the hematology oncology office on 01/09/25 to notify them Resident #55 refused to go to the appointment. LPN #115 did not ask if there were any changes to the care, such as new medications or labs that needed to be drawn. She was only notified by the office that they may not continue to see the resident due to recurrent refusals. LPN #115 was unaware of new orders for dasatinib. Interview on 03/03/25 at 11:47 A.M. with Nurse Practitioner (NP) #310 stated the facility staff had difficulties contacting the hematology oncology office. NP #310 initiated low-dose aspirin 81 mg to help decrease Resident #55's elevated platelet levels. However, she was unaware of any additional guidance provided to the facility staff on 01/23/25 regarding the resident's leukemia medication. NP #310 stated she did not alter the special leukemia medications, as it is outside her specialty, and all further guidance regarding medication adjustments should be directed to the hematology oncology clinic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/03/25 at 12:13 P.M. with Contracted Pharmacist #301 revealed that pharmacy staff called the facility on 01/28/25 regarding a potential medication duplication for Resident #55. The concern involved a new order for dasatinib while the resident was concurrently receiving imatinib, both of which are tyrosine kinase inhibitors. The pharmacy staff spoke with LPN #115 to discuss this issue and sought confirmation on whether the continuation of imatinib was intended alongside the new dasatinib order. While the pharmacy could not make the final decision, they emphasized that it is typically the prescriber's responsibility to conduct a risk/benefit analysis to determine whether the duplicate medications were necessary. After being informed that imatinib was to be continued, the pharmacy proceeded with dispensing the new medication. Contracted Pharmacist #301 also confirmed that the pharmacy did not receive the new order for dasatinib until 01/27/25, four days after the hematology oncology clinic had faxed the facility regarding the medication. Interview on 03/03/25 at 12:36 P.M. with the Director of Nursing (DON) confirmed the new order for dasatinib was not transmitted to the pharmacy until 01/27/25, due to the fax being directed to the admissions department's fax machine. The DON further confirmed that no additional attempts were made or documented by herself, the UM, or the floor nursing staff to follow up with the hematology oncology office for orders or guidance on 01/24/25. Additionally, the DON denied receiving any orders for the initiation of dasatinib during her visit to the hematology oncology clinic on 10/03/24. Interview on 03/03/25 at 1:04 P.M. with HOP #350 confirmed that the office was notified of critical lab results and subsequently sent orders to the facility to initiate dasatinib for the treatment of elevated platelets. HOP #350 indicated the initial intention to start this medication was during their visit on 10/03/24, but the facility did not initiate the treatment as planned. HOP #350 was unable to provide clarity on how or if this change in medication was communicated to the facility. On 02/03/25, the resident was seen at the hematology clinic for a routine visit, where it was noted that the resident was receiving both dasatinib and imatinib. The medication was reviewed, with notes indicating that dasatinib had been ordered, and imatinib should continue until dasatinib was delivered and available. During this visit, Resident #55's labs were drawn, revealing elevated Blood Urea Nitrogen (BUN) at 28 mg/dL and elevated creatinine at 3.0 mg/dL. Due to these elevated lab results, the resident was admitted to the hospital with suspected acute kidney injury. The cause of the injury was attributed to several risk factors, including heart failure, dementia, and the use of multiple nephrotoxic medications such as metoprolol and Lasix. HOP #350 expressed concerns regarding inconsistencies and failures in treatment for Resident #55, attributing these issues to poor communication with the nursing staff at the facility. Interview on 03/03/25 at 1:42 P.M. with LPN #300 and Registered Nurse (RN) #141 confirmed that they spoke with the hematology office at the same time in the morning on 01/23/25 regarding the abnormal lab results. Both nurses denied receiving any new orders or guidance during this conversation, noting that the only information provided was that the hematology office would follow up with them. They confirmed they made two additional follow-up calls on 01/23/25 to the hematology office after notifying them of the critical lab results, but no new orders were issued until they received a fax later in the day with a new medication order for dastanib. 2. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including fractures of the left femur, right tibia, and left fibula, and fractures of the T11-T12 vertebra. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 01/03/25 revealed Resident #46 has impaired skin integrity at the left and right knee. Interventions included administering treatments as ordered by the medical provider. Review of the hospital after-visit summary dated 01/03/25 revealed Resident #46 was discharged with instructions for surgical wound care, which included cleansing the bilateral posterior knees with Vashe, applying Triad (zinc barrier cream) impregnated Adaptic (used to prevent dressing adherence to the wound bed), followed by padding with an absorbent pad, and wrapping with Kerlix and ACE wraps, to be changed daily. Review of the physician orders from 01/04/25 revealed instructions to cleanse the bilateral knees with wound cleanser, pat dry, and apply Triad cream. The wounds were then to be covered with ABD pads and wrapped with Kerlix and ACE wraps. Adaptic (used to prevent dressing adherence to the wound bed) was missing from the wound treatment order. This physician order continued through 02/19/25. The treatment administration record (TAR) for January 2025 confirmed these orders were followed on the following dates: 01/04/25, 01/06/25, 01/07/25, 01/08/25, 01/09/25, 01/10/25, 01/13/25, 01/14/25, 01/17/25, 01/18/25, 01/19/25, 01/20/25, 01/22/25, 01/24/25, 01/25/25, 01/26/25, 01/27/25, 01/28/25, 01/29/25, 01/30/25, and 01/31/25. Review of the wound assessment report dated 01/06/25 revealed Wound Nurse Practitioner #355 ordered for the surgical wounds dressings were to be changed daily, cleansed with normal saline with primary treatment of surgeon's request and completed with other dressing supplies including bordered gauze. Review of the Minimum Data Set (MDS) 3.0 assessment completed 01/10/25 revealed Resident #46 had intact cognition. Resident #46 had surgical wounds requiring ongoing care, including the use of a pressure-reducing bed device, surgical wound care, and the application of non-surgical dressings, ointments, and medications. The updated physician orders from 01/11/25 specified additional treatments for the left and right lower extremities. For the left leg, the instructions were to rinse the wound with normal saline and apply a wet-to-dry dressing until the resident was seen by the wound clinic. These treatments were documented as completed on the following dates: 01/11/25, 01/12/25, 01/14/25, 01/15/25, 01/16/25, 01/19/25, 01/21/25, 01/22/25, and 01/23/25. For the right leg, the updated orders included rinsing with normal saline, patting the wound dry, and leaving it open to air. These treatments were documented as completed on the following dates: 01/11/25, 01/12/25, 01/14/25, 01/15/25, 01/16/25, 01/19/25, 01/21/25, 01/22/25, 01/24/25, 01/26/25, 01/27/25, 01/28/25, 01/29/25, and 01/30/25. From 01/11/25 to 01/31/25, the physician orders started on 01/04/25 were intermittently substituted with the new order from 01/11/25. Review of an outpatient wound care visit summary dated 01/23/25 revealed orders for posterior left and right knees to be cleaned with soap and water, Vashe, or normal saline, and to be dressed with Xeroform, absorbent pads, Kerlix, and ACE wraps. This physician order was not started until 02/08/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent outpatient visit summary on 01/30/25 indicated the wounds on the posterior aspect of both knees were healing, with some areas showing incomplete healing but healthy granulation tissue. The plan included continuing with wet-to-dry dressing changes to the bilateral lower extremities and following up with surgery for the next steps in healing. On 01/31/25, updated orders were issued to rinse both the left and right lower extremity posterior knee incisions with normal saline, pat them dry, and dress them with wet-to-dry dressings daily for ongoing wound care. Interview with the Director of Nursing (DON) on 03/03/25 at 11:01 A.M. confirmed Resident #46's treatment orders were not started according to the hospital's after-visit summary. The DON confirmed Adaptic was missing from the wound treatments and acknowledged there were two different types of treatment listed for both the left and right lower extremities without clarification on which treatments should be completed. The DON confirmed after the 01/23/25 wound clinic visit, the facility did not discontinue the two old physician orders. The DON confirmed the wound recommendations dated 01/23/25 which included Vashe, Xeroform, and covering with absorbent pads, Kerlix, and ACE Wraps were not implemented until 02/08/25. Interview on 03/03/25 at 2:24 P.M. with Licensed Practical Nurse (LPN) #115 confirmed she has provided care for Resident #46's wounds but did not notice the duplicate orders. She also confirmed seeing several instances of incorrectly documented wound care orders that needed to be corrected by the physician. Review of the facilities Skin Care and Wound Management Overview, undated, revealed the facility aims to prevent skin impairment and promote the healing of existing wounds. This includes applying treatment protocols based on clinical best practice standards to promote wound healing. This deficiency represents non-compliance investigated under Complaint Number OH00162795 and Complaint Number OH00162318.