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	11/05/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, staff interview and policy review, the facility failed to provide timely, necessary and adequate care and services following an acute change in condition involving Resident #88. The facility failed to ensure changes in the resident's medical condition were comprehensively assessed, that high blood glucose levels were communicated to the medical provider, and individualized interventions were implemented. This resulted in Actual Harm with subsequent hospitalization when on 06/23/25 Resident #88 had a high blood glucose reading of 471 milligrams per deciliter (mg/dL) (normal ranges from 80 to 130 mg/dL in adults with type two diabetes) requiring notification to a medical provider, which was not completed. On 06/26/25 and 06/27/25, Resident #88 presented with symptoms of hyperglycemia with changes in mental status, drowsiness, incontinence, and dietary changes. Certified Nursing Assistant (CNA) #127 and CNA #135 reported the changes to nursing staff. Certified Nurse Practitioner (CNP) #200 was informed of the blood glucose reading high (indicating a reading over 500 mg/dL) on 06/27/25 after lunch and the staff began to treat the residents blood sugar with insulin. On 06/27/25 the resident was sent to the hospital and diagnosed with diabetic ketoacidosis (DKA) (a life threatening complication of diabetes that occurs when the body does not have enough insulin), acute metabolic encephalopathy and acute kidney injury, in addition to a blood glucose reading of 1157 mg/dL. This affected one (Resident #88) of three residents reviewed for changes in condition. The facility census was 87. Findings include:Review of the medical record for Resident #88 revealed an admission date of 07/31/24 and a discharge date of 06/27/25. Diagnoses included heart disease, heart failure, muscle weakness, cognitive communication deficit, muscle wasting, hemiplegia and hemiparesis, vascular disease and type two diabetes. Review of the physician orders revealed an order dated 08/01/24 to monitor for signs and symptoms of hypo/hyper glycemia (sweating, tremor, pallor, tachycardia, palpitations, nervousness, headaches, confusion, light headedness, slurred speech, lack of concentration, irritability, and staggering gait). Review of the physician orders revealed an order dated 08/05/24 for a blood glucose check (accu-check) in the morning once weekly on Mondays for hypo/hyperglycemia monitoring. The instructions on the order were to notify the physician if the blood sugar was under 60 or over 400 mg/dL. Review of the plan of care dated 08/05/24 revealed Resident #88 had diabetes mellitus with interventions to administer medications per medical provider orders, observe for side effects and effectiveness and report abnormal findings, observe for signs and symptoms of hyperglycemia (increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep, rapid and labored breathing), stupor and coma) and report findings to the medical provider, report findings of hypoglycemia (sweating, tremors, increased heart rate, confusion, blurred speech, lack of coordination) to medical provider, obtain and monitor laboratory (lab) results and diagnostic studies, obtain blood sugars according to physician orders, and offer snack and provide diet as ordered. Review of Resident #88's physician orders revealed an order dated 10/22/24 for Farxiga oral tablet 10 milligrams (mg) with instructions to administer one tablet by mouth once daily for diabetes. There were no standing insulin orders. Review of the lab results dated 02/27/25 revealed Resident #88 had a blood glucose of 159 mg/dL with a reference range for non-fasting of 65-125 mg/dL and a hemoglobin A1C (a blood test that shows an average levels of blood sugar levels over a two to three month period) of 6.5 percent (with a reference range of 4.1-6. 1 percent) and a mean glucose of 140 mg/dL (with a reference range of 70-120 mg/dL). Review of Resident #88's blood sugar checks from 03/03/25 to 06/16/25 revealed results from 122 to 300 mg/dL with five readings in the 100's, ten readings in the 200's and one at 300 with results trending up over the last six months. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 had intact cognition and was independent with activities of daily living (ADL). Resident #88 only required supervision/touching assistance with ambulation and bathing. The MDS assessment stated the resident was always continent of bowel and bladder and received a hypoglycemic medication but was not receiving insulin injections. Review of the lab results dated 05/27/25 revealed Resident #88 had a blood glucose of 214 mg/dL, a hemoglobin A1C of 7.9 percent, and a mean glucose of 180 mg/dL. Review of the progress note dated 05/28/25 revealed Certified Nurse Practitioner (CNP) #200 reported Resident #88 had elevated blood glucose from 120 to 300 mg/dL with a plan to add Glipizide 5 mg daily and to continue the Farxiga. The note included an addendum of further discussion with the resident and pharmacist and it was thought the