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	05/04/2026

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the fall investigation, review of hospital records, hospital staff interview, and review of facility policy, the facility failed to ensure that staff followed the established care plan and safety protocols for Resident #99 during the provision of care to prevent an incident/accident resulting in the resident falling from the bed to the floor sustaining serious injuries. This resulted in Actual Harm on 03/26/26 when Certified Nursing Assistant (CNA) #333 had provided perineal care independently to Resident #99 while the resident was in bed. Resident #99, who was incontinent, had a communication deficit, was unable to lay on her side without support and care planned for two staff assistance for rolling side to side, rolled sideways off the bed to the floor from approximately 30 inches high, landing with her left knee on top of the air conditioning unit and was screaming and tapping at her left knee indicating pain. Subsequently, Resident #99 was sent to the local hospital where she was diagnosed with femur fractures in both legs. The left leg was treated with a retrograde nail, and the right leg was amputated for comfort. This affected one resident (#99) of three residents reviewed for accidents. The facility census was 90. Findings include:Review of the medical record for Resident #99 revealed an admission date of 05/10/24. Diagnoses included anoxic brain damage, hypoxic ischemic encephalopathy, spastic hemiplegia affecting right dominant side, morbid (severe) obesity due to excess calories, type two diabetes mellitus without complications, unspecified convulsions, contracture, right elbow, anxiety disorder, major depressive disorder and cognitive communication deficit. The resident's contracture to the right leg was not included as a diagnosis.Review of the fall risk assessment dated [DATE] for Resident #99 revealed Resident #99 was noted to be a total mechanical lift for all transfers because she was unable to bear weight, unable or unwilling to cooperate, was limited in movement and heavy or obese. Resident #99 was noted to be non-ambulatory. Per Section E of the assessment, the resident was identified as a potential risk for falls; however, Section F asked if Section E identified the resident as at risk for falls and ?no' was selected.Review of the care plan entry revised on 07/30/24 noted Resident #99 had a communication problem due to her anoxic brain injury. It was noted she had an iPad for communication, and she was able to use it but didn't like to. The care plan entry noted that she was able to answer yes or no questions without the iPad. Interventions recommended to allow adequate time to respond, repeat as necessary, do not rush, request feedback, clarification from resident to ensure understanding, face the resident when speaking and make eye contact, turn off television/radio as needed to reduce environmental noise, ask yes/no questions if appropriate, and use simple, brief, consistent words/cues.Review of the care plan entry revised on 02/21/25 revealed Resident #99 was at risk for falls due to anoxic brain injury, spastic hemiplegia and convulsions with interventions to assess fall risk quarterly, ensure residents room was free of potential visible hazards, ensure the bed locks were engaged, place call bell within reach, and remind resident to call for assistance. The care plan also noted an activities of daily living (ADL) self-care performance deficit due to the anoxic brain injury, hemiplegia affecting the right dominant side and contractures. The care plan noted Resident #99 was resistive to care, and would yell at and hit at staff during care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The interventions section was reviewed on 02/26/26 and indicated Resident #99 was dependent on care and required assistance of two or more helpers to roll left and right.Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #99 had severe cognitive impairment and was dependent upon staff for toileting, showering, dressing and personal hygiene. Resident #99 was also dependent on staff for transfers from bed to chair, tub/shower, and rolling left and right. Per the coding description within the MDS, dependent upon staff means helper does all of the effort, the resident does none of the effort to complete the activity, or the assistance of two or more helpers was required for the resident to complete the activity.Review of Kardex GG Roll left and right documentation for Resident #99 for 03/10/26 to 03/26/26 revealed on 03/11/26 at 12:09 P.M., 03/12/26 at 2:53 A.M. and 03/26/26 at 12:22 A.M. total dependence of two [staff] was checked, meaning two staff assisted the resident in rolling left to right.Review of the progress note dated 03/26/26 at 6:35 A.M., authored by Registered Nurse (RN) #548 revealed the nurse heard Resident #99 screaming and went in the room to check and found Resident #99 on the floor. CNA #333 was in the room with the resident and had been changing the resident at the time. The nurse and other staff helped Resident #99 back to bed, notified the unidentified on-call Certified Nurse Practitioner (CNP) and obtained an order to send the resident to the emergency room for further evaluation and notified the residents family and the Director of Nursing (DON).Review of the fall investigation revealed on 03/26/26 at 6:30 A.M., Resident #99 fell while a CNA was providing care to the resident, by herself. The resident was lying on her right side in bed. The CNA had her hand on the resident's waist, the resident was [rolled] holding onto the bed frame with her left hand, the resident raised her left hand and pushed up against aide. The CNA released her hand and the resident slid out of bed. The immediate intervention was that the resident was sent to the emergency room (ER) for possible evaluation and treatment of a possible fracture. Fall interventions in place at the time of the fall included call light within reach, bolsters to air mattress in place, bed locks engaged, room free of environmental hazards and observed medication side effects for potential falls. The new intervention was for the resident to be a two person assist with bed mobility. Per Resident #99's care plan dated 02/26/26, the resident was already required to have two staff assistance with rolling from left to right. The fall investigation did not include a Root Cause Analysis for how the fall occurred, but it included a re-enactment of the fall.Review of the undated fall re-enactment of the 03/26/26 incident with Resident #99 and CNA #333 as documented by Regional Director of Clinical Operations (RDCO) #611 revealed CNA #333 introduced herself to the resident and explained what she was going to do. She demonstrated she started with the resident on her back, and she opened the brief and provided perineal care to the front of the resident. She then demonstrated she rolled the resident toward her and did perineal care to the back, tucking the old brief under the patient, and rolling the soiled draw sheet and brief underneath the resident, and a new brief was applied under her as well. She rolled the resident away from her toward the window and over the soiled linen onto her right side, and the resident was scooted down into the bed to where her waist was lateral to the opening in the perimeter mattress and patient reached over the perimeter mattress with her left arm grabbing the bed frame. She stated the bed was elevated to her waist level and she was approximately five feet tall. She stated the soiled linen was not under the patient once she rolled her to her right side as she had tucked them prior to rolling from the left side to the right. She demonstrated that her left hand was on the residents left hip and suddenly the resident removed her left hand from the bed frame and reached back and tapped on her hand that was on the patients left hip, so she removed her hand and at that time the patient slid from the bed; her left knee was bent and on top of the air conditioning unit (AC). She walked around the bed and as she was doing that, the resident pulled her knee off the AC unit and was in a sitting position with her back against the bed. She made sure the resident was in a safe position and went and got the nurse and she reported the resident was tapping at her left knee as if she was in pain.Review of the witness statement from RN #548 as transcribed by the DON dated 03/26/26 at 6:39 A.M. revealed CNA #333 was changing Resident #99 and she fell out of bed. RN #548 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated that she immediately called nine-one-one (911) due to the resident screaming and she notified telemedicine.Review of the progress note dated 03/26/26 at 6:35 A.M. for Resident #99 revealed the nurse conducted a neurological examination and checked the residents vital signs and applied an ice pack to the residents left knee.Review of the hospital notes dated 03/26/26 at 10:36 A.M. revealed Resident #99 was transferred from the initial hospital to another trauma hospital for specialized care after discovery of a left femur fracture.Review of the hospital notes dated 03/29/26 at 11:20 A.M. revealed Resident #99 endorsed that her pain was well controlled on her left lower extremity; however, she indicated persistent right lower extremity pain. The note indicated this was the site of chronic contractures however there was persistent pain and pain on palpation. An x-ray was obtained and demonstrated a right distal femur fracture.Review of the hospital X-ray report of the right femur dated 03/29/26 at 1:21 P.M. revealed the resident had an oblique fracture of the distal femur with posterior displacement of the distal fracture fragment.Review of the hospital progress note dated 04/03/26 at 2:56 P.M. revealed Resident #99 had surgery on 03/27/26 to obtain a left retrograde intramedullary nail. The note further indicated that the left and right femur fractures were pathological due to a combination of diffuse osteopenia and trauma which alone would not have resulted in a fracture. The author noted that initially the plan was for non-operative management for the right leg due to the contracture; however, Resident #99 had significant discomfort and uncontrolled pain.Review of the hospital progress note dated 04/05/26 at 12:02 P.M. revealed orthopedics evaluated the right femur fracture and initially the plan was for non-operative management, but given the residents significant discomfort, and uncontrolled pain, the plan was for a possible above the knee amputation (AKA) on 04/06/26.Review of the hospital progress note dated 04/06/26 at 10:49 A.M. revealed Resident #99 communicated by pointing and gesturing due to her anoxic brain injury. She stated her pain was a 9/10 (on a scale of zero to 10, zero being no pain and 10 being the worst pain). The resident seemed upset about her [AKA] surgery being cancelled due to pain. The writer explained that operating room availability was an issue that day and it was moved to Wednesday [04/08/26].Review of the hospital progress note dated 04/08/26 at 4:11 P.M. revealed Resident #99 had just returned from the operating room from the right AKA. She had a history of prior anoxic brain injury and was minimally ambulatory and communicative at baseline. The resident pointed to her right leg which was painful. She pointed to the 10/10 pain on the FACES pain scale (a pain scale with different faces representing someone's level of pain).Review of the hospital progress note dated 04/10/26 at 2:29 P.M. revealed Resident #99 was seen on morning rounds, was described as initially very agitated and appeared to be in pain.Review of the hospital progress note dated 04/13/26 at 12:32 P.M. revealed Resident #99's severity of pain was to be expected given the left and right femur fractures and extensive surgical intervention, and this was five days after her right AKA. The note indicated the resident pointed to her right leg, which was painful, she pointed to a 10/10 pain on the FACES pain scale.An interview on 04/23/26 at 12:43 P.M. with Psychiatric Mental Health Nurse Practitioner (PMHNP) #400 revealed Resident #99 would only let one or two people help her and it had to be a certain time of day. She was a larger person and if she was going to turn on her side, she would need assistance to stay on her side. PMHNP #400 noted that when Resident #99 was in a bad mood, her cognition was poor. PMHNP #400 said if you didn't know Resident #99 well, it would be hard to communicate with her.A telephone interview on 04/23/26 at 2:07 P.M. with CNA #333 revealed she had cared for Resident #99 before and noted Resident #99 would yell a lot. She said she had watched others do perineal care by themselves with Resident #99, but this was the first time she had done perineal care with her by herself. She said that Resident #99 would hold up one or two fingers to tell you if she wanted one or two people to change her. She noted Resident #99 was very particular about where she lay on the bed and liked to be on the edge. She would hold onto to bed with her left hand. CNA #333 said that she was done with changing Resident #99 and was smoothing everything out on the pad. She said she had her hand on Resident #99's hip and the resident let go of the bed to swat her away. She said she wouldn't ever want to keep her hands on someone who didn't want to be (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	touched and so she removed her hand and that's when the resident slipped off the bed. She said when she demonstrated what had happened, she was told she should have rolled the resident towards her. She said how could you do that as Resident #99 was over 200 pounds. She denied resident required two-person assistance for toileting because she watched other aides change Resident #99 by themselves. She said she felt really bad about what happened though she didn't think she did anything wrong because she did what she saw others do.An interview on 04/23/26 at 2:54 P.M. with CNA #355 revealed that usually Resident #99 required one-or-two-person assistance. She said she usually had two though. She said she never had Resident #99 resist care with her, but she wasn't sure about the others. She said she looked at the care plan to know what care a resident needed.An interview on 04/23/26 at 3:21 P.M. with Crisis Nurse #622 confirmed the ADL care plan for Resident #99 indicated that Resident #99 required assistance of two or more helpers to roll left and right and confirmed that when an aide provided perineal care in the bed, it would require rolling the resident.An interview on 04/23/26 at 3:26 P.M. with RDCO #611 revealed that the care plan indicated Resident #99 required one person assistance for toileting. He provided and confirmed the aide Kardex documentation of times when aides used one person or two-person assistance with Resident #99.An interview on 04/27/26 at 9:43 A.M., with the Director of Risk #633 revealed they did not have a policy defining what parameters (such as over a certain weight or diagnosis such as spasticity) they would automatically use two aides to assist with a resident. She said they didn't have that because their care plans were individualized.An interview on 04/27/26 at 10:29 A.M. with CNA #377 revealed Resident #99 was very particular on how to handle her. If you didn't know her and how to communicate with her, it could be a problem. If you had a hard time understanding her, she would get upset and worked up and start yelling. She stated her one leg [indicating her right leg] was bent permanently. CNA #377 admitted she hadn't provided perineal care for Resident #99, but she believed her to be a two person assist because of the contracture.An interview on 04/27/26 at 11:36 A.M. with MDS Nurse #515, she stated she determined what she entered into the MDS assessment based on interviews with staff and record review. She said if there were three times during a lookback period where two staff were used [for care], then that was what she was required to say. She confirmed there were three times in the lookback period in which two aides assisted Resident #99. She said Resident #99 was very noncompliant and her moods varied. She said because she had known Resident #99 for a long time, she theoretically could change Resident #99 by herself also because she had been working in the industry for a long time; however, she wouldn't do that due to safety reasons. She said how things would go with Resident #99 would depend on whether Resident #99 was having a good day or a bad day and you wouldn't know when you walked into the room which it was going to be. She said she was very surprised to hear about the fall but was not surprised to hear about Resident #99 swatting at the aide. She said they even had Resident #99's behaviors of swatting at staff and being resistant to care in the care plan.An interview on 04/28/26 at 9:16 A.M. with RDCO #611 confirmed the most recent fall risk assessment he could find for Resident #99 prior to the one completed on 03/26/26 was dated 05/24/24. He said he would typically expect them to be done quarterly and wasn't sure why one wasn't done more recently. He noted that perhaps one hadn't been done more recently because she hadn't had a fall.An interview on 04/28/26 at 9:57 A.M. with CNA #388 revealed she had helped to change Resident #99 previously and felt she knew her well. She said Resident #99 would indicate to you where she would let you touch her. She said for safety purposes she always had two aides for perineal care. She said technically, one person might be able to do it alone but for your own safety and for the residents' safety, it would be better to have two because of the contracture. She said she was there the day the incident happened and she heard the resident screaming. She said Resident #99 was very picky with care. She said Resident #99 had never swatted at her, but she knew that was a behavior of hers.An interview on 04/28/26 at 10:06 A.M. with Licensed Practical Nurse (LPN) #526 revealed Resident #99 would scream because she wasn't able to communicate and she would indicate with hand gestures where she hurt. She said she usually saw (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	two aides doing perineal care for Resident #99 and they would know that based on the admission assessment. She said Resident #99 never swatted at her.An interview on 04/28/26 at 10:12 A.M. with Medication Technician #537 revealed he almost always saw two people providing care for Resident #99 because one person wouldn't be able to turn her.An interview on 04/28/26 at 10:33 A.M. with Hospital RN Case Manager (RNCM) # 411 revealed Resident #99 was in an extreme amount of pain in the hospital. She said Resident #99 just kept screaming out that she needed medication. She said when they were talking about discharge planning, Resident #99 would get upset because she didn't want to leave because of the pain. She said this was after the left leg surgery and before the right leg amputation. She said she saw Resident #99 pointing to her right leg to indicate the pain. RNCM #411 said she saw Resident #99 after the amputation and that Resident #99 appeared to still have pain but wasn't as animated about the pain as she was before. She said Resident #99 was adamant about not wanting to return to the facility and would vigorously shake her head no. RNCM #411 said she was able to establish that Resident #99 wasn't afraid to go to a facility, it was specifically that she didn't want to return to the facility where she had been.An interview on 04/28/26 at 10:51 A.M. with hospital trauma service Certified Nurse Practitioner (CNP) #422 revealed they discovered Resident #99's osteopenia when they did a computed tomography (CT) scan in the hospital. She said it would be really hard for someone of Resident #99's age to break a femur and so the osteopenia was part of the reason for the fracture, but that the fall was definitely a contributing factor. She said [Resident #99] wouldn't have broken those bones from the osteopenia alone. She said it was clear that Resident #99 was in pain the way she was crying out.Interview on 04/28/26 at 1:11 P.M. with RDCO #611 revealed the care plan entry regarding Resident #99 requiring two people for rolling left and right was originally initiated on 08/18/25 and was reviewed on 02/26/26. He said there was nothing that was changed related to this on the 02/26/26 date. He confirmed the last known weight they had for Resident #99 was 246.8 pounds on 06/01/24; however, he thought she weighed less because she had been on Trulicity for approximately six months and she had lost weight from that. He stated the 2024 weight was the last weight as the resident had since refused to be weighed.Review of the undated Fall Prevention and Management policy revealed a Fall Risk Assessment should be completed upon admission, quarterly and with any significant change of condition. Information about resident should be obtained from many different sources. Other factors should include the environment, medications, physical and mental diagnosis as well as the residents' current ADL status. If the resident is identified to be at risk for falls, a care plan should be initiated that includes a plan to potentially diminish the risk for falls. The care plan can include interventions that address environmental factors, ADL factors, risk factors that result from dementia and other mental diagnosis, and medical diagnosis that put the resident at higher risk. Issues such as toileting, eating, transferring and impulsiveness should be considered. The policy suggested once the resident was safe, a fall investigation should begin. The policy suggested to ask the resident what they were doing when they fell, identify if there were any witnesses to the fall. Ask them what they saw and have them write a statement if possible. The policy noted immediately written statements would provide more detail than asking later. The policy suggested attempting to put an intervention in place that could prevent further falls, such as, if the resident was going to the bathroom, assist them to the toilet. If the resident was getting a drink and overreaching, place the drink within range. It stated to attempt to identify why the resident fell and put an immediate intervention in place.This deficiency represents an example of continued non-compliance investigated under Complaint Number 2984816.