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	05/13/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **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 non-pharmacological interventions were utilized and adequate assessments of pain were completed prior to administering as needed pain medications. This affected one (Resident #94) of three residents reviewed for pain management. The census was 93.Findings Include:Review of the medical record revealed Resident #94 was admitted to the facility on [DATE]. Diagnoses included alcoholic cirrhosis of the liver with ascites, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, other chronic pain, polyneuropathy, hyperlipidemia, hypertension, alcohol dependence, morbid obesity, insomnia, restlessness and agitation, mood disorder, vitamin D deficiency, and unspecified convulsions. Review of Resident #94's Minimum Data Set (MDS) assessment, dated 04/10/26, revealed he was cognitively intact.Review of Resident #94's current physician orders, revealed the resident was ordered as needed pain medications including the narcotic oxycodone-acetaminophen tablet 5-325 milligrams (mg) every eight hours as needed for pain, ibuprofen oral tablet 200 mg every six hours as needed for pain management, and acetaminophen oral tablet 325 mg every six hours as needed for breakthrough pain. There was no evidence to support specific parameters or instructions, related to pain levels, for when each as needed pain medication should be administered.Review of Resident #94's medication administration records (MAR), from 03/24/26 to May 2026, revealed as needed pain medications were administered for indication of a pain level of zero on a 10-point pain scale or with no documented pain level. In March 2026, oxycodone-acetaminophen 5-325 mg was administered eight times with no pain assessment completed or with a pain level of zero. In April 2026, acetaminophen 325 mg was administered five times for a pain level of zero, ibuprofen 200 mg was administered 13 times with a pain level of zero, and oxycodone-acetaminophen 5-325 mg was administered 14 times with a pain level of zero. In [NAME] 2026, acetaminophen 325 mg was administered three times for pain level of zero, ibuprofen 200 mg was administered eight times for a pain level of zero, and oxycodone-acetaminophen 5-325 mg was administered six times for a pain level of zero.Review of Resident #94's current physician orders revealed his pain level was to be assessed every shift and the facility was to document non-pharmacological pain intervention prior to as needed pain medication administration. Non-pharmacological interventions included repositioning, ice, distraction, and relaxation.Review of Resident #94's MARs and treatment administration records (TARs), dated 03/24/26 to May 2026, revealed no documented attempts for non-pharmacological interventions prior to the administration of as needed pain medications.Interview with Registered Nurse (RN) #195 on 05/13/26 at 9:03 A.M. and Licensed Practical Nurse (LPN) #178 on 05/13/26 at 9:10 A.M. confirmed they would not give as needed pain medication to residents with a pain level of zero. They also confirmed the nurses are to attempt and document the attempt and completion of non-pharmacological interventions prior to administering as needed pain medications. Both RN #195 and LPN #178 confirmed they would expect as needed pain medications to have parameters on when to give the medication, especially if a resident had multiple types of as needed pain medications ordered.Interview with [NAME] President of Clinical Services (VPCS) #403 on 05/13/26 at 12:40 P.M. confirmed there was no documentation (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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for non-pharmacological interventions attempted for Resident #94 when administering as needed pain medications on the occasions mentioned above in March, April, and May 2026, and confirmed there should have been. VPCS #403 confirmed there should not be as needed pain medication provided to a resident with a pain level of zero, which she confirmed there was documentation for Resident #94 receiving as needed pain medication administered for pain levels of zero as mentioned above.Review of the undated facility pain management and assessment policy revealed to the extent possible and in consideration of cognitive abilities, the nurse will provide a thorough assessment by observation of activities and treatment/relief for detection of pain and to attempt to identify location and any limitations imposed by pain. Additionally, the basis for the pain management includes but was not limited to resident's needs and goals, and source, type, and intensity of pain. The facility will document medication pain relief and response, non-pharmacological measures attempted and the resident's response, and care plan updates as needed. This deficiency represents non-compliance investigated under Complaint Number 3006435 and Complaint Number 3002091.

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a facility staff schedule, the facility failed to provide adequate staffing to meet the behavioral safety needs of all residents. This affected one (Resident #41) of three residents reviewed for behavior management. The census was 93.Findings Include:Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, systemic inflammatory response syndrome, borderline personality disorder, postural orthostatic tachycardia, disorientation, mood disorder, suicidal ideations, convulsions, personal history of other mental and behavioral disorders, conversion disorder, anxiety disorder, headache, bipolar disorder, post-traumatic stress disorder, insomnia, muscle weakness, muscle wasting, dysphagia, and fibromyalgia. Review of Resident #41's Minimum Data Set (MDS) assessment, dated 04/29/26, revealed she was cognitively intact.Review of Resident #41's progress notes, dated 04/21/26, revealed she was placed on facility issued one-on-one staff supervision on 04/21/26. As of 05/13/26, there was no documentation to support Resident #41 was taken off one-on-one staff supervision. Interview with Certified Nurse Aide (CNA) #160 on 05/13/26 at 11:13 A.M. confirmed she was working in the facility on 05/01/26. CNA #160 confirmed the schedule had her listed as one-on-one staff on 05/01/26, but it did not indicate with which resident she was assigned to. CNA #160 stated the schedule also had her listed as working on the back of the 100 hall. CNA #160 stated she started in Resident #41's room as one-on-one staff, but later, a female staff person pulled her and indicated she was to be working on the back of 100 hall as the facility did not have any staff there. CNA #160 stated, about 40 to 45 minutes later, a night shift nurse supervisor came to her and stated she needed to be in Resident #41's room because that was where she was assigned. CNA #160 confirmed she was not aware of anyone being in Resident #41's room for the time she was not in there on 05/01/26 and also confirmed the night shift nurse supervisor stated no one had been in Resident #41's room.Interview with the Administrator and [NAME] President of Clinical Services (VPCS) #403 on 05/13/26 at 11:25 A.M. confirmed the staff schedule on 05/01/26 had CNA #160 listed as being one-on-one for her assignment, even though it did not indicate which resident the one-on-one supervision was for. The Administrator and VPCS #403 also confirmed CNA #160 was assigned to the back of 100 hallway on 05/01/26 as well. Review of facility staff schedule, dated 05/01/26, revealed CNA #160 was scheduled to work the back of 100 hall, but next to her name was indicated 1:1.This deficiency represents non-compliance investigated under Complaint Number 3007315.