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	06/25/2026

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 0689 Level of Harm - Minimal harm or potential for 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 record review, observation, resident and staff interviews, and facility policy review, the facility failed to implement new safety interventions after a resident fall. This affected one resident (#42) of four residents reviewed. The facility census was 88.Findings include:Review of the medical record for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, chronic congestive heart failure, retention of urine, need for assistance with personal care, and unsteadiness on feet.Review of the most recent quarterly Minimum Data Set 04/23/26 revealed Resident #42 was assessed as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #42's required at least partial assistance with transferring on and off the commode.Review of Resident #42's task documentation dated 06/14/26 revealed the resident required maximal assistance on this day. Review of Resident #42's care plan report revealed the resident was noted to be noncompliant with asking for assistance with transfers, though there were no interventions in place to directly respond to the resident's known non-compliance with using their call light. Review of interventions revealed common fall interventions such as educating the resident or their representative, ensuring the room is free of hazards, completing fall risk assessments, physical and occupational therapy to evaluate/treat, and ensuring that bed locks are engaged.Observation on 06/23/26 at approximately 12:00 P.M. revealed Resident #42 had significant bruising in a deep purple color, to the left side of their face and along their left forearm.Interview on 06/23/26 at 12:02 P.M. with Resident #42 revealed they had fallen a little over a week prior, and they fell to the floor after slipping on liquid that was on the floor in their restroom when they were trying to help themselves up from the toilet to their wheelchair. Resident #42 stated they had used their call light and kept waiting for staff, kept waiting and waiting and then tried to transfer themself from the toilet to their wheelchair alone when no staff responded to the call light. Resident #42 stated that they slipped and fell on either water or urine that was on the floor, and the fall led to them hitting their head along the left side of their face, hitting their left arm, and bruising the great toe of their left foot. Observations on 06/24/26 at 10:12 A.M. and 11:20 A.M. revealed repeated instances where Resident #42 was observed to have transferred to the bathroom on their own by self-propelling in their wheelchair, and shortly after entering the bathroom, the call light outside the room would come on before nearby staff would notice and CNA #163 would enter to assist the resident with transfer off of the commode.Interview on 06/24/26 at 10:49 A.M. with Certified Nursing Assistant (CNA) #163 revealed Resident #42 will often use his call light once he has gotten to the bathroom and needs to get off of the commode, he often does not use the call light to notify us that he needs to go to the bathroom. Further interview with CNA #163 stated ideally, staff would be alerted of when the resident needed to go to the bathroom, so that they could assist the resident to the bathroom, help them get on the commode, and then staff would be aware that the resident was using the commode so that they would anticipate him needing to come off of the commode. CNA #163 stated Resident #42 should be using the call light to notify us that he needs to go to the bathroom, but (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it is known that he often doesn't use the call light until he has already arrived at the commode.Interview on 06/24/26 at 12:10 P.M. with CNA #163 revealed not all residents on the hall with Resident #42 are automatically considered an every two-hour check and change, rather that each resident has different and unique needs. CNA #163 stated Resident #42 is not someone that is designated to be checked, reminded, or prompted for toileting.Review of a nursing progress note dated 06/14/26 at 11:20 P.M. revealed the resident was found on the bathroom floor with noted bleeding and swelling under their left eye after the resident called for help when the fall occurred. Further review of this progress note revealed the resident was sent to the hospital for further evaluation.Review of the fall investigation/incident form for Resident #42's fall that occurred on 06/14/26 revealed Resident #42's call light was on at the time of the fall, but the resident was using the bathroom unassisted when they slipped and fell, which led to them striking their head. Further review of the fall investigation form revealed upon return from the hospital resident was reminded to call for assistance with toileting and resident voiced understanding. The fall investigation/incident form revealed the facility documented not applicable to care plan updated related to the fall. Review of Residnet #42's care plan revealed the care plan was not updated after the fall on 06/14/26 with new intervention to protect the resident from additional falls. Interview on 06/24/26 at 4:06 P.M. with Regional Registered Nurse (RN) #300 revealed typically it is the facility's process to update the resident's care plan after a fall occurs, to ensure that all necessary safety interventions are in place to meet the needs of the resident and prevent subsequent falls. Regional RN #300 stated Resident #42 was hell bent on assisting himself to the restroom under the belief that he had been cleared by physical therapy staff to do so, even though he was not. Regional RN #300 confirmed Resident #42 is known to be noncompliant with using their call light for assistance to the bathroom, and speaking of Resident #42, Regional RN #300 stated We can't force him to do what he doesn't want to do. He makes his own decisions. Regional RN #300 believed Resident #42 was fully continent, even after verifying that the resident was identified as incontinent of bowel on their most recent care plan. When asked if any other fall prevention interventions were added to Resident #42's care plan after their fall that occurred on 06/14/26 to prevent future falls, Regional RN #300 stated do you want my opinion, or do you want what's in the record? Regional RN #300 verified no new fall interventions were implemented or added to Resident #42's plan of care to prevent subsequent falls as a result of the fall on 06/14/26, stating no new interventions were done besides continued re-educating the resident.Review of the facility policy titled Plan of Care Overview (no date) revealed it is facility policy to provide resident-centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Further review of this policy revealed safety is a primary concern for residents at the facility. Additional review of this policy revealed that resident care plans should be reviewed as indicated after a significant change occurs, and that care plan documents should be resident specific or resident focused, and reflect the resident's opportunities for participation and preferences regarding their care.This deficiency represents an incidental finding discovered while investigating complaints #3051421, #3046019, #3027695, #3026786, #3025754, #3016703, and #3015583.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews the facility failed to ensure medications were obtained in a timely manner and were administered as per orders. This affected one resident (#89) out of three residents reviewed for medications administered. The facility census was 88.Findings include:Review of Resident #89's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, borderline personality disorder, bipolar disorder, postural orthostatic tachycardia syndrome, and suicidal ideations.Review of the comprehensive Minimum Data Set, dated [DATE] revealed Resident #89 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15.Review of physician orders contained in Resident #89's medical record revealed orders for the following medications: Enoxaparin Sodium solution (a blood thinning medication) 40 milligrams (mg) injected subcutaneously two times a day dated 04/16/26, Vancomycin (antibiotic) 1500 mg given intravenously (IV) every eight hours for sepsis dated 04/16/26, Mupirocin external ointment (anti-infective) applied around the resident's J tube site (an opening in the abdomen) two times daily for seven days dated 05/01/26, and Nystatin (antifungal) powder applied topically to the groin every morning and at bedtime dated 05/05/26.Review of Resident #89's medication administration record (MAR) for April 2026 revealed there was no documentation the Enoxaparin injection was administered on 04/16/26 or 04/17/26, or the IV Vancomycin was administered on 04/16/26 as ordered.Review of Resident #89's MAR for May 2026 revealed there was no documentation the Mupirocin external ointment being administered on 05/06/26, and there was no documentation the Nystatin powder was administered on 05/06/25 as ordered.Interview on 06/25/26 at 4:34 P.M. with the Director of Nursing (DON) verified there was no documentation in Resident #89's MAR or throughout their medical record to indicate the following medications were administered as ordered: Mupirocin external ointment on 05/06/26, Nystatin powder on 05/06/26, Enoxaparin injections on 04/16/26 or 04/17/26, and IV Vancomycin was administered on 04/16/26. Further interview with the DON at this time revealed that although the vancomycin was ordered at 4:00 P.M. on 04/16/26, the expectation was that the medication would either be available or delivered in time to administer the medication as per physician orders, or there would be documentation indicating why the medication was not administered. The DON confirmed there was not documentation to support why the MAR IV vancomycin was not administered as ordered.This deficiency represents non-compliance investigated under Complaint Numbers 3051421, 3025754, 3016703, and 3015583.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and review of the facility policy, the facility failed to ensure call lights were kept within resident's reach. This affected one resident (#2) out of three residents reviewed for call lights. The facility census was 88. Findings include: Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia and paroxysmal atrial fibrillation.Review of Resident #2's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was assessed as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. Resident #2's required partial or moderate assistance with sit to stand transfers, such as standing up from a seated position on the bed.Interview on 06/23/26 at 11:26 A.M. with Resident #2 revealed the resident believed their call light was on the floor just next to his bed, so that his arm could reach down to the floor and reach the call light if he needed to use it. The resident was then observed to reached over the side of his bed, to find that the call light was not where he thought it was, Resident #2 could not reach the call light and stated he did not know where it was.Observation on 06/23/26 at 11:28 A.M. revealed Housekeeper #212 entered Resident #2's room and immediately located the call light behind the head of the bed, near the wall. Housekeeper #212 was observed to picked up the call light from behind the bed and placed it next to Resident #2.Interview on 06/23/26 at approximately 11:30 A.M. with Housekeeper #212 revealed they had deep cleaned Resident #2's room around 9:00 A.M. that morning, and they thought they remembered seeing Resident #2's call light on the floor while cleaning the room. Housekeeper #212 revealed they could estimate how long Resident #2's call light might have been out of reach of the resident.Review of the facility policy titled Resident Rights (no date) revealed residents will be treated with dignity and respect including but not limited to having a method to communicate needs to staff such as a call light or bell access kept within reach of the resident as one method to communicate needs to staff.This deficiency represents non-compliance investigated under Complaint Number 3051421 and 3015583.