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	03/23/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to store food in a safe and sanity manner. This had the potential to affect all 95 residents admitted to the facility. The facility census was 95.Findings include: Observation of the kitchen dry storage on 03/16/26 at 9:19 A.M. revealed about four bags of unnamed/unlabeled breadsticks on top of the dry storage shelving unit. Further observed revealed some of the breadsticks were observed to have a blueish-green spots on the bread. Observation of the stand-alone fridge on 03/16/26 at 9:30 A.M. revealed a tray of about ten cups of juice; two of the cups were not covered and none of the ten cups were dated. Interview with Kitchen Manager #367 on 03/16/26 at 9:20 A.M. confirmed the breadsticks were not stored in the proper location and removed them from the dry storage area and disposed of them. Additional interview with District Manager #374 confirmed the cups in the fridge should all have covers on them and confirmed items in the kitchen should all have dates on them. Review of the facility's Food Storage policy, revised 02/2023, revealed storage areas will be neat, arranged for easy identification, and date marked as appropriate, and all food items will be kept clean, dry, and properly sealed.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on interview and document review the facility failed to ensure kitchen equipment was maintained in safe operating condition. This had the potential to affect all 95 residents residing within the facility. The facility census was 95.Findings include: Interview with District Manager (DM) #374 on 03/17/26 at 8:40 A.M. revealed one of the ovens is under cooking, the second over is over cooking, and the steamer is not fully functional. DM #374 reported the equipment has been in this condition for at least three weeks, and due to this the facility has been using emergency menus. DM #374 confirmed the equipment not being in working condition has been reported to maintenance and the administrator. Interview with the administrator on 03/17/26 at 8:50 A.M. confirmed the ovens were not working properly and was not aware of the issue with the steamer. The administrator reported new parts were ordered and scheduled to be delivered over the weekend. The administrator was unable to confirm when the equipment stopped functioning properly. Additional interview with the administrator on 03/17/26 at 10:02 A.M. revealed the administrator planned to contact someone about the steamer to address the report of it not functioning properly. The administrator further revealed a company came to service the oven in January of 2026 and confirmed the ovens were functional. Additional issues with the oven were identified in February 2026 which resulted in a quote being requested for a new oven range on 02/17/26, and a quote was received the same day. The administrator confirmed the oven was paid for and was supposed to be delivered on 03/13/26 but it did not arrive. The administrator reported he had not yet followed up with the company to inquire about the oven. Interview with Dietitian #370 on 03/17/26 at 11:23 A.M. revealed the kitchen oven had been having issues since November. Dietitian #370 reported she had notified the facility monthly since November about the concerns with broken equipment and stated she had concerns with equipment in the kitchen not being fixed within a timely manner. Dietitian #370 revealed the equipment fix for the oven in January did not last for more than a week and this was when she put her foot down about the facility addressing the need for the oven range to be replaced. Follow-up interview with the Administrator on 03/17/26 at 2:40 P.M. revealed the oven was now scheduled to be delivered on 03/20/26. Interview with Account Manager (AM) #398 on 03/17/26 at 4:30 P.M. revealed the facility did not identify the purchase of the oven range as being an emergency or needing it urgently. AM #398 revealed the item being identified as emergent would not necessarily result in the items being delivered sooner. AM #398 confirmed the oven was purchased and was scheduled for delivery. Review of the Quality Assurance Evaluations on 03/17/26 from November 2025 to March 2026 revealed the following:-11/10/25 - Under essential equipment it is noted the oven does not work well/pilot light issues-12/08/25 - Under essential equipment it is noted the oven was not working properly-01/14/26 - Under essential equipment it is noted the oven was not working, in process of getting it fixed-02/16/26 - Under essential equipment it is noted the oven was not working properly, pellet warmer broken-03/16/26 - Under nutrition/hydration status it is noted an emergency menu was in place due to the oven broken, and under essential equipment it is noted a new oven was ordered and the pellet warmer was broken. Review of work orders on 03/17/26 revealed the following work orders for the kitchen:-12/08/25 - 12/09/25 Pellet warmer does not drain properly-12/08/25 - 01/19/26 Oven does not work well/pilot light issues-01/26/26 - 02/02/26 Oven issues with the comments of the oven and flat top are not heated to the correct temperature and the pilot light was out.-01/26/26 - 01/29/29 Pellet warmer with comments of the pellet warmer was not working-02/04/26 - 02/05/26 The induction plate warmer does not heat-02/04/26 left side of the oven is not working-02/16/26 - 02/19/26 The oven was identified as not working well and/or having pilot light issues Review of invoice #2198351 dated 01/20/26, on 03/17/26, revealed the oven was serviced on 01/14/26 and the range was noted to not be operating. The invoiced revealed the right side was noted to have stopped worked last week while the left side had been intermittent for some time but noted the range had not been serviced in several years. The invoice identified both thermocouples would first be replaced due (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to it being the most cost-effective solution, both ovens were down and would need repair as soon as parts arrived. The invoice note dated 01/16/26 revealed both thermocouples in the oven range were replaced and both ovens were now functional. Review of quote documentation dated 02/17/26, on 03/17/26, confirmed a quote was received on 02/17/26 for a new oven range. Review of requisition information dated 02/23/26, on 03/17/26, revealed an order for a new oven range was placed. Review of the requisition information dated 03/04/26, on 03/17/26, revealed an item described as a thermal on/off switch for a kitchen plate or pallet warmer was ordered. Review of email correspondents between the administrator and supply company on 03/17/26 revealed on 03/10/26 the administrator asked for an estimated time of arrival on the oven range with a response on 03/13/26 being the scheduled delivery date. Review of an additional email correspondent between the administrator and supply company on 03/17/26, reviewed on 03/17/26, revealed the supplier updated the delivery date to 03/20/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure residents had a comprehensive care plan that reflected their current status. This affected four residents (#15, #45, #75, and #96) of 29 sampled residents. The facility census was 95 residents.Findings include:1. Review of Resident 15's medical record revealed an original admission date of 04/24/25 and a readmission date of 02/08/26. Resident #15's diagnoses included limitation of activities due to disability, radiculopathy lumbar region, unspecified convulsions, syncope and collapse, muscle wasting and atrophy not elsewhere classified multiple sites, unsteadiness on feet, chronic pain, muscle weakness (generalized), and need for assistance with personal care. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was cognitively intact and independent for eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #15 required substantial/maximal assistance to shower/bathe self. Review of Resident #15's progress notes dated 02/26/26 at 05:43 A.M. revealed the resident was found lying on the floor. Review of Resident #15's Interdisciplinary Team (IDT) Follow Up note dated 02/27/26 at 10:49 A.M. revealed the post-fall intervention put into place was nonskid strips to the floor. Review of Resident #15's risk for falls care plan initiated 10/25/23 and revised on 06/02/25 did not reveal an intervention of nonskid strips to the floor. Interview with Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #426 on 03/18/26 at 8:49 A.M. confirmed Resident #15's risk for falls care plan did not include an intervention of nonskid strips to the floor. 2. Review of Resident #45's medical record revealed an initial admission date of 11/08/24 and a readmission date of 02/20/26. Resident #45's diagnoses included type 2 diabetes mellitus with hyperglycemia, chronic obstructive pulmonary disease unspecified, epilepsy unspecified not intractable without status epilepticus, acquired absence of right leg above knee, and generalized anxiety disorder. Review of Resident #45's Minimum Data Set (MDS) dated [DATE] revealed Resident #45 was cognitively intact. Review of Resident #45's progress note dated 03/05/26 revealed the resident had a diagnosis of other psychoactive substance abuse uncomplicated with a history of overdose leading to hospitalization in 2024. Review of Resident #45's care plan on 03/19/26 revealed there were no goals or interventions in place for substance abuse. Interview with MDS LPN #426 on 3/19/26 at 4:28 P.M. confirmed substance abuse was not included in Resident #45's care plan but should be included. 3. Review of the medical record for Resident #75 revealed an admission date of 02/02/26 with diagnoses of, but not limited to, alcohol abuse, panic disorder, bipolar disorder, depression, and Post Traumatic Stress Disorder (PTSD). Review of the resident's Brief Interview of Mental Status (BIMS) revealed a score of 14 indicating the resident was cognitively intact. Review of the care plan for Resident #75 revealed an initiated date of 02/03/26. Further review of the care plan revealed a psychosocial well-being adjustment goal which mentioned anxiety, depression, and bipolar disorder, but did not mention PTSD. The care plan revealed a focus which stated the resident had a mood problem related to panic disorder but did not mention PTSD. Further review of the care plan revealed a focus that identified Resident #75 had a diagnosis of PTSD however the interventions were not specific to the resident and did not include the triggers, if any, that the resident had nor the cause of the resident's PTSD. 4. Review of the medical record for Resident #96 revealed an initial admission date of 02/10/26 with diagnoses of, but not limited to, depression, generalized anxiety disorder, and PTSD. Review of the resident's BIMS revealed a score of 15 indicating the resident was cognitively intact. Review of Resident #96's care plan revealed focus initiated on 02/20/26 which identified the resident as having a diagnosis of PTSD related to a recent amputation. Further review revealed interventions of the resident to be assisted in identifying what triggers PTSD episode and observe for increased agitation, anxiety, and offer quiet areas and comfort items. The care plan did not have (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident specific interventions to Resident #96's PTSD nor triggers. Interview with Resident #96 on 03/16/26 at 1:40 P.M. revealed the diagnosis of PTSD was partially related to trauma she experienced as a child and identified her recent amputation as not being related to her PTSD. Resident #96 reported she did not feel the facility knew or understood her triggers. Interview with Social Services on 03/19/26 at 10:25 A.M. revealed for residents with PTSD, resident specific triggers and information related to their trauma should be included in their care plan to ensure staff are informed of the residents' needs. Social Services confirmed Resident #75 and Resident #97 both had diagnoses of PTSD and did not have this information in their care plans. Review of the facility policy titled, Plan of Care Overview, not dated, revealed the facility was to provide resident centered care plans that meets the psychosocial, physical, and emotional needs of the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, record review, and review of facility policy, the facility failed to have interventions in place to prevent falls for Residents #52, #15, #97, #103, and #94. Additionally, the facility failed to complete a thorough investigation following a fall for Resident #88. This affected six residents (#52, #15, #97, #88, #103, and #94) of 11 residents reviewed for falls. The facility census was 95 residents.Findings include:1.Resident #52 was admitted [DATE] and has diagnoses that include chronic obstructive pulmonary disease, severe protein-calorie malnutrition, and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident used a wheelchair for mobility and has severe cognitive impairment. Review of the facility incident and accident log revealed Resident #52 suffered falls on 12/24/25 and 01/02/26. Review of the medical record for Resident #52 revealed an order for non-skid strips on the floor near bed for recurrent falls from bed ordered on 12/24/25. Further review of Resident #52's care plan revealed an intervention of fall mat to both sides of bed for resident at risk of falls initiated on 12/25/25 and intervention for non-skid strips to floor near bed initiated 02/24/26. Observation of the Resident #52's room was conducted on 03/17/26 at 12:49 P.M. There were no non-skid floor strips found near the resident's bed and no fall mats placed at bedside. Interview with Licensed Practical Nurse (LPN) #161 was conducted on 03/17/26 at 12:49 P.M. LPN #161 confirmed that there were no non-skid strips and no fall mats near the bed in Resident #52's room. 2. Review of Resident #15's medical record revealed an original admission date of 04/24/25 and a readmission date of 02/08/26. Resident #15's diagnoses included limitation of activities due to disability, radiculopathy lumbar region, unspecified convulsions, syncope and collapse, muscle wasting and atrophy not elsewhere classified multiple sites, unsteadiness on feet, chronic pain, muscle weakness (generalized), and need for assistance with personal care. Review of the MDS dated [DATE] revealed Resident #15 was cognitively intact and independent for eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #15 required substantial/maximal assistance to shower/bathe self. Review of Resident #15's progress notes dated 02/26/26 at 05:43 A.M. revealed the resident was found lying on the floor. Review of Resident #15's Interdisciplinary Team (IDT) Follow Up note dated 02/27/26 at 10:49 A.M. revealed the post-fall intervention put into place was nonskid strips to the floor. Review of Resident #15's risk for falls care plan initiated 10/25/23 and revised on 06/02/25 did not reveal an intervention of nonskid strips to the floor. Further review of Resident #15's care plan revealed an intervention for a visual reminder to ask for assistance when getting out of bed that was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initiated on 06/10/25 and revised on 03/12/26. Observation of Resident #15's room on 03/16/26 at 9:30 A.M. revealed nonskid strips were not on the floor of the resident's room and the visual reminder to ask for help was not observed in the room. Observation of Resident #15 room on 03/16/26 at 3:00 P.M. revealed nonskid strips were not on the floor of the resident's room and the visual reminder to ask for help was not observed in the room. Observation of Resident #15 on 03/17/26 at 4:05 P.M. revealed nonskid strips were not on the floor of the resident's room and the visual reminder to ask for help was not observed in the room. Interview with Registered Nurse (RN) #470 on 03/17/26 at 4:18 P.M. confirmed nonskid strips were not on the floor of Resident #15's room. Interview with LPN #422 on 03/18/26 at 7:49 A.M. revealed a visual reminder to ask for help would hang on the wall near Resident #15's bed and in the bathroom. Further interview LPN #422 confirmed that the visual reminder to ask for help was not in place for Resident #15. 3. Review of the medical record for Resident #97 revealed an admission on [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis, traumatic hemorrhage of the cerebrum, heart disease and alcohol abuse. Review of the admission MDS completed on 01/04/26 revealed the resident was cognitively intact. He required one person to assist with activities of daily living. Further review of the medical record for Resident #97 revealed he was found on the floor on 02/12/26 at 2:15 P.M. A full investigation was completed, and it was determined Resident #97 was left in his room in his wheelchair after his therapy session. He was sitting in his wheelchair and slid out of it onto the floor. It was an unwitnessed fall with no injuries. The Interdisciplinary team reviewed the fall and added a preventative intervention of Dycem to his wheelchair. Observation and interview on 03/19/26 at 11:00 A.M. of Resident #97 in the therapy department confirmed he did not have Dycem on his wheelchair seat to prevent him from sliding out of it. Therapist #364 and #362 verified there was no Dycem to Resident #97's wheelchair. Interview with Therapist #362 on 03/19/26 at 11:15 A.M. confirmed she was the therapist who placed the Dycem on his wheelchair after his fall and did not know why it was not on it. 4. Review of Resident #88's medical record revealed an admission date of 09/19/24 with diagnoses including anoxic brain damage, chronic obstructive pulmonary disease, dysphagia, contractures of right and left hand, attention-deficit hyperactivity disorder, moderate protein-calorie malnutrition, psychoactive substance abuse, anxiety disorder, and cognitive communication deficit. Review of Resident #88's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. He was dependent on staff for rolling. Review of Resident #88's plan of care dated 08/21/25 revealed the resident was at risk for falls related to mobility, gait problems, and medications. Interventions included assessing risk for falls on admission, educating resident or resident representative, encouraging and assisting resident to up to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chair before dinner, ensuring resident is wearing appropriate nonskid footwear, and ensure room is free from accident hazards. Review of Resident #88's plan of care revised 02/26/26 revealed a self-care performance deficit related to anoxic brain injury, contractures, fearful during care, and will grab at and hold onto staff during care. Interventions included lids on hot beverages, placing splints as ordered, the resident was dependent for toileting hygiene, bathing, personal hygiene, and rolling in bed. Review of Resident #88's progress note dated 02/27/26 at 7:07 P.M. revealed the resident was lowered to the floor during activity of daily living care by the certified nursing assistant (CNA). The resident received a skin tear to the right side of his back during this. Review of Resident #88's fall investigation dated 02/27/26 revealed the conclusion of the event was entered on 03/01/26. It was indicated that the hospice aide was providing care to Resident #88 when they fell out of bed. The resident was assisted to the floor by the CNA, the suspected root cause was the air mattress and turning the resident. The investigation did not identify why the resident needed to be lowered to the floor, who lowered them to the floor, and how he obtained a skin tear. Interview on 03/18/26 at 3:00 P.M. with the Director of Nursing (DON) revealed both a hospice aide and a facility CNA had been present for Resident #88's fall. She reported the resident was totally dependent on care and 'could' have rolled out of bed when the cloth underneath him had been pulled. She reported she had witness statements. Review of the witness statement provided on 03/19/26 revealed the statement was by Unit Manager #365. It indicated the nurse reported to them that the hospice aide was providing a bed bath and our staff was in the room when Resident #88 was being turned, staff CNA controlled a fall from the bed and the resident received a skin tear. Interview on 03/19/26 at 10:51 A.M. with the Director of Nursing (DON) revealed the staff present in the room were contradicting each other on what happened. The only witness statement she had was by Unit Manager #365. She verified it was unclear what happened and how he obtained the skin tear. The DON verified a thorough investigation was not completed. 5. Review of Resident #103's medical record revealed an admission date of 03/04/26 major depressive disorder, borderline personality disorder, unspecified mood disorder, convulsions, personal history of other mental and behavioral disorders, conversion disorder with seizures or convulsions, anxiety disorder, and fibromyalgia. Review of Resident #103's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #103's plan of care dated 03/06/26 revealed the resident was at risk for falls related to being a new admission, potential medication side effects, and a history of seizures. Interventions included assessing risk for falls, education, ensuring the residents room is free from potential hazards, ensuring bed locks were engaged, medication review, placing call bell in reach, and added 03/09/26 fall mats. Review of Resident #103's progress note dated 03/08/26 revealed the resident fell from bed during seizures and was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #103's interdisciplinary fall follow up dated 03/09/26 revealed on 03/08/26 at 6:55 P.M. the resident had been observed with seizure activity on the floor at bedside. The intervention was to put fall mats in place to both sides of the bed. Observation on 03/16/26 at 11:00 A.M. and on 03/19/26 at 8:40 A.M. revealed Resident #103 was in bed and fall mats were not in place. Interview on 03/19/26 at 8:40 A.M. with the Director of Nursing (DON) revealed the intervention for Resident #103's first fall was a fall mat. The DON verified Resident #103's fall mat was not in place at that time. 6. Review of the medical record for Resident #94 revealed a readmission date of 12/10/25 with diagnoses of, but not limited to, acquired absence of left leg above knee, polyneuropathy, muscle weakness, and muscle wasting atrophy. Review of Resident #94's Brief Interview of Mental Status revealed a score of 15 indicating the resident was cognitively intact. Review of the progress note dated 02/09/26 revealed the resident had gone out of the facility with a company driver to attend dialysis and while going toward the van the resident fell forward out of the wheelchair and hit his head. According to the progress note staff were reported to have gotten the resident up from the floor and transferred Resident #94 back into his wheelchair, transported him back inside the facility, and notified the nurse. The nurse was reported to have completed a body assessment, neurological checks, and range of motion to extremities. There were no noted changes in range of motion, and a small abrasion was noted to the right leg below the knee and vital signs were normal. Per the progress note the facility contacted a 24/7 clinical coverage provider and the resident was assessed via video and orders were placed for x-ray due to the resident complaining of right shoulder and cervical spine pain. Review of the Interdisciplinary Team (IDT) Fall Follow-up dated 02/10/26 revealed Resident #94 was being transferred in a wheelchair out of the facility when their right leg was caught up in the wheel and the resident fell forward. The IDT Fall Follow-up identified the cause of the fall to be the resident needed their right food pedal placed on the wheelchair and initiated a post fall intervention of the right food pedal to be put in place when the resident was being transported via wheelchair. Interview with Therapy Manager (TM) #364 on 03/18/26 at 3:45 P.M. revealed a resident with a wheelchair is always given foot pedals. TM #364 reported a resident can refuse the foot pedals but if they do their foot pedals are returned to therapy or kept in the residents' room, and the refusal would be noted in the residents' chart. TM #364 revealed Resident #94 always used foot pedals when in their wheelchair, including coming to and from therapy and when exiting the building. Interview with the Director of Nursing (DON) on 03/19/26 at 11:25 A.M. confirmed Resident #94's fall was due to his foot going underneath the wheel of the wheelchair while the dialysis company was transporting him from the facility to the van for dialysis. DON confirmed the resident did not have the right foot pedal on his wheelchair when leaving for dialysis and this was implemented as a care plan intervention post fall. Additional interview with TM #364 on 03/23/26 at 11:15 A.M. revealed the resident should have always had the foot pedals on, especially when leaving the facility for dialysis. TM #364 revealed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #94 could not take the pedal off themselves. TM #364 also confirmed the resident could not self-propel and therefore the pedals would not be taken off for him to do so. Review of the facility policy titled, Fall Prevention and Management, not dated, revealed the facility would identify risk factions that can minimize the potential for falls. The policy further revealed the facility would obtain information about the resident from other sources when identifying their risk for falls including but not limited to physical assessments, diagnoses, and the residents current Activities for Daily Living (ADL) status. Further review revealed a fall investigation should begin once the resident was safely transferred following a fall. The resident should be asked what they were doing when they fell, even if they have dementia, and witnesses should be identified and asked to write a written statement immediately. In order to put in a post fall intervention the facility was to attempt to identify why the resident fell. During the interdisciplinary team review the team should discuss the fall, potential causes, interventions in place, and a deep root cause investigation should be discussed. This violation represents noncompliance investigated under complaint 2647719, 2595291, and 2795028.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to provide showers per resident choice. This affected one (Resident #53) of two residents reviewed for choices. The facility census was 95 residents.Findings include:Review of Resident #53's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included cellulitis of the left lower limb, chronic diastolic (congestive) heart failure, other specified chronic obstructive pulmonary disease, obesity class 3, unsteadiness on feet, muscle weakness (generalized), need for assistance with personal care, and muscle wasting and atrophy not elsewhere classified multiple sites. Review of the Minimum Data Set (MDS) assessment, dated 01/05/26, revealed Resident #53 was cognitively intact and required substantial or maximal assistance for shower or bathing self. Review of Resident #53's Nursing admission Evaluation dated 12/29/25 revealed Resident #53 preferred a shower in the evening. Review of Resident #53's Activities of Daily Living (ADL) Self Care Performance care plan dated 02/15/26 did not reveal Resident #53's preference for a shower. Review of Resident #53's shower/bathe self-task documentation revealed Resident #53's last shower was 02/28/26. Resident #53 received a bed bath on 02/24/26, 03/03/26, 03/10/26, 03/13/26, 03/18/26 and 03/21/26. Interview with Resident #53 on 03/16/26 at 9:08 A.M. revealed the resident's last shower was 3 weeks ago. Resident #53 reported staff provided a basin at the bedside for the resident to bathe self. Resident #53 stated he prefers to take a shower. Interview with Risk Management #366 on 03/18/26 at 12:30 P.M. revealed that shower sheets could not be provided for Resident #53 because they were not part of the medical record and shower sheets may or may not be filled out. Interview with Unit Manager Registered Nurse (RN) #365 on 03/19/26 at 10:15 A.M. confirmed the admission assessment was used to identify resident shower or bath preference. Interview with Certified Nurse Aide (CNA) #261 on 03/23/26 at 09:46 A.M. confirmed resident should be asked preference for a shower or bath prior to providing care. Interview with RN #470 and Licensed Practical Nurse (LPN) #422 on 3/23/26 at 2:10 P.M. confirmed Resident #53's last shower was two to three weeks ago. RN #470 and LPN #422 confirmed the shower was provided to Resident #53 because Resident #53 complained of not receiving a shower. Review of the facility policy ?Resident Rights' undated revealed residents will be treated with dignity and respect. Dignity included respecting resident choice.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to maintain clean and sanitary bed curtains. This affected one (Resident #45) of three residents reviewed for environment. The facility census was 95 residents.Findings include:Review of Resident #45's medical record revealed an initial admission date of 11/08/24 and a readmission date of 02/20/26. Resident #45's diagnoses included type 2 diabetes mellitus with hyperglycemia, long term (current) use of insulin, chronic obstructive pulmonary disease unspecified, moderate protein-calorie malnutrition, epilepsy unspecified not intractable without status epilepticus, presence of right artificial shoulder joint, acquired absence of right leg above knee, polyneuropathy unspecified, anemia unspecified, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #45 was cognitively intact. Observation of Resident #45's bed curtain on 03/16/26 at 10:31 A.M. revealed three dark red stains splattered on the curtain. The largest stain measured approximately one centimeter (cm). The other two stains measured approximately 0.5 cm. Further observation of Resident #45's bed curtain also revealed linear black stains. Interview with Resident #45 on 3/16/26 at 10:31 A.M. revealed the resident requested the bed curtain be cleaned, but the facility never cleaned the curtain. Interview with Certified Nurse Aide (CNA) #249 on 03/16/26 at 10:56 A.M. confirmed stains were present on Resident #45's bed curtain. Interview with Risk Management #366 on 3/23/26 at 3:28 P.M. revealed the facility does not have an environment policy. Risk Management #366 confirmed environmental concerns would be included in the facility ?Resident Rights' policy as residents have the right to a safe, clean, home-like environment. Review of the facility policy ?Resident Rights' undated revealed residents will be treated with dignity and respect. Dignity included providing safe and secure housing.This deficiency represents non-compliance investigated under Complaint Numbers 2631443 and 2795028.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of facility policy, the facility failed to provide nail care for Residents #66, and #88 who were dependent on staff for care. This affected two residents (#66 and #88) of seven residents reviewed for activities of daily living. The facility census was 95.Findings include: 1. Review of Resident #66's medical record revealed an admission date 07/25/25. Resident #66's diagnoses included chronic obstructive pulmonary disease unspecified, repeated falls, dysphagia following cerebral infarction, unspecified protein-calorie malnutrition, essential (primary) hypertension, dysphagia oropharyngeal phase, alcohol use unspecified uncomplicated, anxiety disorder unspecified, and depression unspecified. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively intact. Resident #66 was dependent for putting on and taking off footwear. Observation of Resident #66 on 03/16/26 at 12:22 P.M. revealed long, jagged toenails. Interview with Resident #66 on 03/16/26 at 12:22 P.M. revealed staff do not provide toenail care. Interview with Certified Nurse Aide (CNA) #116 confirmed Resident #66 toenails were long and jagged. Further interview with CNA #116 revealed the CNA was uncertain if permitted to trim toenails in the facility. Interview with Director of Social Services #129 on 03/18/26 at 12:13 P.M. revealed Resident #66 declined podiatry care on 01/23/26. Interview with Director of Nursing (DON) on 03/23/26 at 1:45 P.M. confirmed CNAs can trim toenails if the resident does not have a diagnosis of diabetes. However, further interview with the DON confirmed, since Resident #66's toenails were in such poor condition, the resident should be re-referred to podiatry for toenail care. Review of the facility job description 'Certified Nurse Aide' revealed it was the responsibility of the Certified Nurse Aide to provide personal care functions to residents. Review of facility policy 'Routine Resident Care' undated revealed routine daily care will be provided to residents. 2. Review of Resident #88's medical record revealed an admission date of 09/19/24 with diagnoses including anoxic brain damage, chronic obstructive pulmonary disease, dysphagia, contractures of right and left hand, attention-deficit hyperactivity disorder, moderate protein-calorie malnutrition, psychoactive substance abuse, anxiety disorder, and cognitive communication deficit. Review of Resident #88's comprehensive MDS assessment dated [DATE] revealed the resident had severely impaired cognition. He was dependent for personal hygiene and bathing. Review of Resident #88's plan of care revised 02/26/26 revealed a self-care performance deficit related to anoxic brain injury, contractures, fearful during care, and will grab at and hold onto staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during care. Interventions included lids on hot beverages, placing splints as ordered, the resident was dependent for personal hygiene. Review of Resident #88's plan of care dated 10/28/24 revealed the resident had bilateral hand contractures and impaired functional range of motion. Interventions included administering medications as ordered, monitoring for increase in pain, monitoring skin condition under splint upon removal and report any areas of concern, placing splints as ordered, therapy as ordered. Review of Resident #88's medical record revealed no documentation indicating when his nails were cleaned or cut. Observation on 03/16/26 at 10:15 A.M. and 1:45 P.M. of Resident #88 revealed his right hand was contracted with his thumb and index finger extended. The nails observed on his right hand and all the nails on his left hand were observed to be long (approximately one centimeter past his fingertips) and had a dark brown substance underneath them. Observation on 03/16/26 at 3:30 P.M. of Resident #88 revealed his fingernails remained long and dirty. He declined to open his contracted hand or have assistance opening it. Interview on 03/16/26 at 3:30 P.M. with CNA #396 verified the condition of Resident #88's nails. She reported a service came in to take care of residents nails, she then indicated she thought hospice took care of Resident #88's nails. CNA #396 went to confirm with Registered Nurse (RN) #470, who reported that she thought hospice was responsible. CNA #396 then spoke to the Director of Nursing (DON) who reported the CNAs were responsible for nail care. This deficiency represents non-compliance under Complaint Numbers 2631443 and 2579770.

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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** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a midline dressing was changed as ordered. This affected one (Resident #53) of one resident reviewed for intravenous access line care. The facility census was 95 residents.Findings include:Review of Resident #53's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included cellulitis of the left lower limb, chronic diastolic (congestive) heart failure, other specified chronic obstructive pulmonary disease, and obesity class Review of the Minimum Data Set (MDS) assessment, dated 01/05/26, revealed Resident #53 was cognitively intact. Review of Resident #53's Midline Insertion Record completed 02/27/26 at 12:05 P.M. revealed a midline catheter (a vascular access device used for intravenous therapy) was placed in the left cephalic vein (a vein located in the left upper arm) on 02/27/26. Further review of Resident #53's Midline Insertion Record revealed a transparent dressing was placed over the midline catheter. Review of Resident #53's order dated 03/03/26 revealed an order to measure external catheter length with each dressing change ordered for every day shift on Fridays and to change the needleless connector with the site change every week ordered for every day shift on Fridays. Review of Resident #53's Treatment Administration Record (TAR) for March 2026 revealed the external catheter length was measured with each dressing change and the needleless connector was changed with each site change on 03/06/26 and on 03/13/26. Observation of Resident #53's midline insertion site on 03/16/26 at 9:08 A.M. revealed a dressing covering the site dated 02/27/26. Interview with Registered Nurse (RN) #470 on 03/16/26 at 9:21 A.M. confirmed the dressing covering the midline insertion site was dated 02/27/26 and should have been changed. Review of facility policy 'PSG Infusion Intravenous (IV) Access Line Maintenance Protocol' effective 04/15/23 revealed a transparent dressing covering a midline catheter should be changed 24 hours after insertion, then weekly and as needed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interviews, the facility failed to provide timely treatment to maintain Resident's #1 hearing abilities. This effected one resident (#1) of one resident reviewed for hearing issues. The facility's census was 95.Record review for Resident #1 revealed this resident was admitted to the facility on [DATE] with diagnoses including: Chronic obstructive pulmonary disease, muscle weakness, acute and chronic respiratory failure with hypoxia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 12. This resident was assessed to require staff supervision for mobility and self care. Review of the medical record of Resident #1 revealed on 03/09/26, he notified staff he was having trouble hearing out of one of his ears and thought something might be stuck in it.Review of the physician orders of Resident #1 revealed on 03/10/26 he was prescribed Carbamide Peroxide Solution 6.5 % ear drops, to be administered twice per day for excessive cerumen for 3 days.During an interview with Resident #1 on 3/17/26 at 10:15 A.M. he stated he was still having the same issues with his hearing and would like a doctor of examine it. He said he had advised two nurses between 03/13/26 and 03/15/26 that the ear drops had not resolved the issue, but had not had any follow-up care Observation on 03/16/26 at 11:54 AM revealed Resident #1 notified Licensed Practical Nurse (LPN) #161 his ear was continuing to bother him, so he wanted to see a specialist physician. LPN #161 said she would notify the resident's provider.During an interview on 03/17/26 at 10:15 A.M. Resident #1 verified he has not received any additional treatment for his ear.During an interview on 03/18/26 at 9:45 A.M. with Unit Manager #365 revealed she had previously been made aware of Resident #1's hearing complaints and she had spoken to Resident #1's certified nurse practitioner for an Ear, Nose and Throat, (ENT) referral.During an interview on 03/19/2026 at 9:20 A.M. with Certified Nurse Practitioner #901 revealed she denied being informed that Resident #1 was still experiencing hearing issues after he completed his ear drops on 03/13/26 until 03/18/26. She said once she was made aware of the issue, she submitted an ENT referral for the resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review, and facility policy review, the facility failed to obtain weekly weights as ordered for Resident #52. This affected one resident (#52) of seven residents reviewed for nutritional issues. The facility census was 95.Resident #52 was admitted [DATE] and has diagnoses that include chronic obstructive pulmonary disease, severe protein-calorie malnutrition, and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident used a wheelchair for mobility and had severe cognitive impairment. Further review of Resident #52's medical record revealed an order for weekly weights written on 12/04/25. Further review of Resident #52's medical record demonstrated there were no recorded weights for the timeframe between 12/17/25 and 01/08/26. Additionally, there were no recorded weights in the medical record for the timeframe between 02/26/26 and 03/17/26. Dietician #370 was interviewed via telephone about 8:35 A.M. on 03/19/26. She stated that Resident #52 had significant weight loss since November 2025. Interview with Registered Nurse (RN) #453 at 1:02 P.M. on 03/19/26 confirmed there were no weights in Resident #52's medical record between 12/17/25 and 01/08/26 or between 02/26/26 and 03/17/26. Review of facility policy titled, Resident Height and Weight, (undated) stated weights will be obtained monthly or as ordered by the physician or practitioner.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to change oxygen tubing as required and failed to ensure the humidifier solution was not empty. This affected one resident (#1) of four residents reviewed for respiratory care. The facility's census was 95.Record review for Resident #1 revealed this resident was admitted to the facility on [DATE] with diagnoses including: Chronic obstructive pulmonary disease, muscle weakness, and acute and chronic respiratory failure with hypoxia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 12. This resident was assessed to require staff assistance with mobility and self-care assistance. Review of the care plan dated 02/12/26 revealed Resident #1 is dependent on continuous oxygen therapy related to a medical history of shortness of breath and respiratory failure. Observation and interview on 03/16/26 at 11:15 A.M. revealed Resident #1's nasal cannula oxygen tubing on 03/16/26 revealed a date on the tubing of 03/03/26. Resident #1 verified his oxygen tubing had not been changed in two weeks and also stated his humidifier solution had been empty for over a week. Further observation revealed the humidifier solution was empty. Interview with Licensed Practical Nurse (LPN) #161 at 11:42 A.M. confirmed oxygen tubing was to be changed once every week. She confirmed Resident #1's oxygen tubing had not been changed in two weeks. She also confirmed the empty bottle of solution for the resident's humidifier. Review of the facility's policy, Supplemental Oxygen using Nasal Cannula, revealed nasal cannulas and tubing are changed weekly or when soiled or contaminated.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to provide services to treat a resident's anxiety. This affected one (#65) of one resident reviewed for behavioral health. The facility census was 95. Record review for Resident #65 revealed this resident was admitted to the facility on 01/14 26 with diagnoses including: multiple fractures of the bilateral ribs, anxiety disorder, fracture of the pelvis, fracture of the right lower leg, depression, and insomnia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require hygiene and mobility assistance from staff.Review of the care plan dated 01/14/26 revealed Resident #65 is at risk of impaired psychosocial well-being. Interventions included a psychiatric mental health consultation and counseling services.Review of the practitioner progress notes of Resident #65 revealed on 01/14/26 during his initial assessment with the physician, the resident requested Hydroxyzine to manage his anxiety, as he was previously taking prior to facility admission. The physician advised the resident this medication is not used for long-term management of anxiety. When Resident #15 persisted, the physician requested a psychiatric consultation for the resident. During an interview with Resident #65 on 03/16/26 at 12:47 P.M. he confirmed as of this date, he is still waiting to see a psychiatric provider to manage his anxiety. During an interview on 03/18/26 at 12:32 P.M. with Therapy Manager #364 she confirmed that Resident #65 has refused therapy multiple times because he was feeling anxious. During an interview on 03/17/26 at 5:20 PM with Social Worker, she confirmed Resident #65 has not had a psychiatric provider visit.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the social service director job description, the facility failed to timely arrange and follow up on guardianship for Resident #78 according to the expert evaluation. This affected one resident (#78) of one resident reviewed for guardianship. The facility census was 95.Findings include: Review of Resident #78's medical record revealed an admission date of 03/22/23 with diagnoses including chronic myeloid leukemia, chronic obstructive pulmonary disease, chronic heart failure, aphasia, dementia, epilepsy, spondylosis, gout, and depression. Review of Resident #78's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #78's hospital social work Discharge summary dated [DATE] revealed the social worker had spoke to the facility about starting guardianship and they were in agreement. Review of Resident #78's statement of expert evaluation completed 03/05/25 revealed it concluded that guardianship should be established or continued. Review of Resident #78's progress note dated 04/24/25 revealed the social worker submitted a referral to [NAME] County Probate Investigator following the completed expert evaluation. Review of Resident #78's progress note dated 07/08/25 revealed the social worker sent correspondence to [NAME] County Probate to inquire about services and the referral sent by the previous social worker. The social worker was waiting on a response and would update with facility team and discuss next steps. Review of Resident #78's medical record from 07/09/25 to 03/23/26 revealed no additional documentation about Resident #78 obtaining a guardian. Interview on 03/19/26 at 12:39 P.M. with Director of Social Services #129 revealed she believed the guardian process had been delayed because the resident had a house nobody had been aware of. She did not know if this had been followed up on since her last note on 07/08/25, and would have to check. Further interview on 03/23/26 at 9:50 A.M. revealed she had no further information. She had submitted information for guardianship but had not heard anything and had not followed up. Interview on 03/19/26 at 9:55 A.M. and 12:40 P.M. with Regional Business Office Manager #393 revealed she was unaware of any housing situation that would prevent guardianship and has asked the social worker to follow up. Review of the position description for Social Service Director, dated June 2019, revealed the position provided planning, assessing, coordinating and implementing services to enhance each residents social and psychosocial well being and assure that care standards are met. The social service director was to perform all duties involved in resident advocacy. They were to perform applications for supplementary services to be used while in the facility. This deficiency represents non-compliance under Complaint Number 2749140

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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 interview and record review, the facility failed to ensure medications were administered timely for two residents (#101 and #103) of two residents reviewed for timely administration of medications. The facility census was 95.Findings include:1.Review of Resident #103's medical record revealed an admission date of 03/04/26 with diagnoses of major depressive disorder, borderline personality disorder, disorientation, unspecified mood disorder, suicidal ideations, unspecified convulsions, personal history of other mental and behavioral disorders, conversion disorder with seizures or convulsions, anxiety disorder, dysphagia, uninhibited neuropathic bladder, and fibromyalgia. Review of Resident #103's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #103's physician orders active on 03/15/26 revealed the following orders: Aprepitant oral capsule 125 milligrams (mg) one time a day for nausea and vomiting, Cariprazine oral capsule three mg one capsule one time a day for antipsychotic, Esomeprazole Magnesium 40 mg for reflux one packet a day for Gastroesophageal reflux disease, fludrocortisone acetate 0.1 mg one time a day for hypotension, Gabapentin 600 mg two tablets two times a day for neuropathy, Linzess 290 micrograms (mcg) one capsule one time a day to promote bowel movements, Levetiracetam oral tablet 500 mg one tablet two times a day for anti-seizure, Rimegepant Sulfate oral tablet 75 mg one tablet by mouth one time a day every other day for migraine prevention, Clonazepam oral tablet one mg by mouth three times a day for anxiety, Azithromycin 250 mg one time a day for pneumonia, Amoxicillin-Pot Clavulanate extended release 1000-62.5 mg two tablets two times a day for pneumonia for five days, Amitriptyline 10 mg one tablet two times a day for depression, and melatonin five mg one tablet at bedtime for sleep aide. Review of Resident #103's medication administration audit report revealed on 03/15/26 morning medications were to be administered between 7:00 A.M. and 8:00 A.M. and were not administered until between 10:35 A.M. and 11:07 A.M. The late medications included Aprepitant, Cariprazine, Esomeprazole Magnesium, fludrocortisone acetate, Gabapentin, Linzess, Levetiracetam, Rimegepant Sulfate, Clonazepam, Azithromycin, Amoxicillin, and Amitriptyline. Evening medications were due on 03/15/26 at 9:00 P.M. and were not administered until 03/16/26 between 4:45 A.M. to 4:49 A.M. The late evening medications included Amitriptyline, Esomeprazole Magnesium, Clonazepam, Amoxicillin, gabapentin, levetiracetam, and melatonin. Interview on 03/16/26 at 11:01 A.M. with Resident #103 revealed her medications had been late on 03/15/26. Interview on 03/18/26 at 3:00 P.M. with the Director of Nursing (DON) verified Resident #103's medications were late. Medications were to be administered within the range of one hour before or one hour after the administration time. She was unable to find the cause of the late administration. 2. Review of Resident #101's medical record revealed an admission date of 03/12/26 with diagnoses including chronic obstructive pulmonary disease (COPD), other disorder of circulatory system, peripheral vascular disease, follicular lymphoma, depression, anxiety, cervicalgia, and age related osteoporosis. Review of Resident #101's physician orders active on 03/15/26 revealed the following orders: pantoprazole delayed release 20 mg two times a day for reflux, duloxetine delayed release 30 mg one time a day for depression, Amlodipine Besylate 10 mg one time a day for hypertension, Aspirin 81 mg one time a day for pain, Gabapentin 300 mg two capsules three times a day for neuropathy, Levetiracetam 500 mg one tablet twice a day for seizures, ducosate sodium 100 mg one time a day for constipation, baclofen five milligrams three times a day for muscle spasms, atorvastatin 20 mg one time a day for hyperlipidemia, MiraLax powder 17 grams by mouth one time a day for constipation, Incruse Ellipta Inhalation Aerosol Powder 62.5 micrograms per actuation one puff one time a day for COPD, and Melatonin three mg at bedtime for sleep aid. Review of Resident #101's medication administration audit report revealed on 03/15/26 morning medications were to be administered at 7:00 A.M. but were administered from 11:37 A.M. to 11:50 A.M. (continued on next page)

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	03/23/2026

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The late medications included pantoprazole, duloxetine, amlodipine besylate, aspirin, gabapentin, levetiracetam, ducosate sodium, baclofen, atorvastatin, MiraLax, and Incruse Ellipta. Evening medications were due on 03/15/26 at 9:00 P.M. and were administered between 11:28 PM and 11:30 P.M. The medications included Melatonin, pantoprazole, duloxetine, gabapentin, levetiracetam, and baclofen. Interview on 03/16/26 at 10:48 A.M. with Resident #101 revealed her medications had been late on 03/15/26. Interview on 03/18/26 at 3:00 P.M. with the Director of Nursing (DON) verified Resident #101's medications were late. Medications were to be administered within the range of one hour before or one hour after the administration time. She was unable to find the cause of the late administration.

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	03/23/2026

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on resident record review, interview, and facility policy review, the facility failed to follow parameters for blood pressure medication. This affected one resident, Resident #58, of six reviewed for unnecessary medications. The facility census was 95.Findings include: Review of Resident #58's medical record revealed an admission date of 02/09/26 with diagnoses of, but not limited to, type two diabetes, atrial fibrillation, and hypertension. Review of the Brief Interview for Mental Status (BIMS) dated 02/09/26 revealed a score of 12 indicating the resident was cognitively intact. Review of Resident #58's orders on 03/17/26 revealed an order for propranolol hydrochloric acid (HCl) 20 milligram (MG) oral tablet with direction to give on tablet by mouth two times a day for hypertension. Further review of the order revealed parameters for the medication to be held if the resident had a systolic blood pressure of less than 110. Review of Resident #58's Medication Administration Record (MAR) revealed propranolol HCl 20MG was administered to the resident on the following days with corresponding blood pressures:-March: 03/02/26 with a blood pressure of 108/63, 03/09/26 with a blood pressure of 101/55, 03/14/26 with a blood pressure of 109/72, and 03/15/26 with a blood pressure of 106/81-February: 02/02/26 with a blood pressure of 108/80, 02/04/26 with a blood pressure of 98/74, 02/09/26 with a blood pressure of 101/66, 02/15/26 with a blood pressure of 102/53, 02/16/26 with a blood pressure of 105/62, 02/23/26 with a blood pressure of 102/54, 02/25/26 with a blood pressure of 105/60, and 02/28/26 with a blood pressure of 104/60-January: 01/13/26 with a blood pressure of 103/59 and 01/31/26 with a blood pressure of 100/69 Interview with Licensed Practical Nurse (LPN) #161 on 03/18/26 at 9:10 A.M. revealed when administering medications with parameters, nurses must take vitals prior to administering and after administering. LPN #161 confirmed prior to administering Resident #59's propranolol, the resident's blood pressure needed to be taken and if it was under 110, the medication was to be held. LPN #161 confirmed on the days Resident #59's blood pressure was below 110, the medication should have been held and not administered unless the physician indicated otherwise. Review of the facility's policy titled, Medication Administration, not dated, revealed medications are to be administered only as prescribed by the doctor.

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	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of facility policy, the facility failed to store medications appropriately when found at Resident #45's bedside. This affected one resident (#45) of one resident observed for medication storage. The facility census was 95 residents.Findings include:Review of Resident #45's medical record revealed an initial admission date of 11/08/24 and a readmission date of 02/20/26. Resident #45's diagnoses included type 2 diabetes mellitus with hyperglycemia, chronic obstructive pulmonary disease unspecified, epilepsy unspecified not intractable without status epilepticus, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #45 was cognitively intact. Observation of Resident #45's bedside table on 03/16/26 at 10:31 A.M. revealed a medication cup resting on the edge of the resident's bedside table outside the reach of the resident. The medicine cup contained five unidentified pills. Interview with Resident #45 on 03/16/26 at 10:31 A.M. revealed the medication cup contained the resident's morning medications. Interview with Certified Nurse Aide (CNA) #249 on 03/16/26 at 10:56 A.M. confirmed a medication cup was present on the bedside table of Resident #45. Review of Resident #45's Medication Administration Record (MAR) revealed on 03/16/26 the resident was administered ferrous sulfate (an iron supplement), pantoprazole (a medication to reduce stomach acid), divalproex sodium (a seizure medication), gabapentin (a medication used to treat nerve pain), and tizanidine (a medication used to treat muscle spasms) the morning of 03/16/26. Interview with the Director of Nursing on 03/17/26 at 2:45 P.M. revealed nurses should observe the resident taking the medication, and medications should not be left at the bedside. Review of the facility policy, ?Medication Administration,' revealed the individual administering the medication will remain with the resident until the medication is swallowed. Further review of the policy revealed medications should not be left at the bedside.