| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365839 | A. Building<br>B. Wing | 01/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Columbus Alzheimer's Care Ctr | 700 Jasonway Avenue<br>Columbus, OH 43214 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070<br><br>Based on staff interview, resident interview, family interview, review of the self-reported misappropriation incident investigation and review of the abuse policy, facility failed to ensure allegations of misappropriation were reported to the state agency in a timely manner. This affected one (Resident #89) of one reviewed for misappropriation. The facility census was 96.<br><br>Findings include<br><br>Review of the medical record for Resident #89 revealed an admitted [DATE]. Diagnoses included unspecified dementia, aphasia, vascular disease, diabetes, epilepsy, hemiplegia and hemiparesis, and cognitive communication deficit.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 03 and required extensive assistance for bed mobility and transfers, partial/moderate assist for bathing and dressing, and substantial maximum assistance for personal hygiene.<br><br>Review of the plan of care dated 12/30/24 revealed the resident had a behavior problem and fidgets with most things including jewelry and remote. Interventions included to develop more appropriate methods for coping and interacting, monitor behaviors for delusions and paranoia.<br><br>Review of the Self-reported Incident investigation (SRI) for Misappropriation dated 12/31/24 revealed Resident #89's family member had reported her wedding ring was missing. Facility staff searched for the ring, checked laundry and could not locate the ring. Staff statement from Unit Manager #67 dated 01/03/24 revealed on 12/24/24 Resident #89's sister contacted her to report the missing wedding ring. She revealed she informed family she would look for it and follow up with them on any outcome. She searched for the ring that day without success. On 12/31/24 Director of Nursing was informed by Resident's husband of the missing wedding band and an SRI was initiated.<br><br>Review of disciplinary action dated 01/02/25 with meeting on 01/03/25 revealed Unit Manager #67 received a written warning related to not following the abuse policy. Facility management was not informed timely after a report of the missing wedding ring for Resident #89 and the SRI was therefore not reported in a timely manner.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 01/14/25 at 10:40 A.M. with Unit Manager #67 revealed she was informed of the missing ring by residents family prior to Christmas and looked for it but did not tell anyone as the typical staff she would alert were off work. She revealed she then went on vacation and did not return until after the new year. When she returned she was informed family had brought up the ring again to the Director of Nursing and an investigation was started. Unit Manager reported she received a write up for not reporting the concern to management back on 12/24/24 when it was reported to her.<br><br>Interview on 01/14/25 at 2:20 P.M. with Director of Nursing (DON) revealed Unit Manager should have reported the concern of the missing wedding ring to management on 12/24/24 when it was first reported to her. DON also confirmed this led to a delay in facility reporting the SRI to the Department of Health.<br><br>Review of facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/2023 revealed facility staff shall immediately report all such allegations to the Administrator and Ohio Department of Health in accordance with procedures in this policy. Facility shall ensure staff know how to identify Abuse, neglect and misappropriation of resident property. Events of misappropriation shall be reported to the Ohio Department of Heath (ODH) within 24 hours from the time the incident is known to a staff member.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00161067. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070<br><br>Based on staff interviews, review of self-reported incident investigations (SRI) and policy review, the facility failed to ensure allegations of abuse, neglect, misappropriation and injuries of unknown origin were thoroughly investigated and interventions put in place. This affected eight Residents (#20, #21, #33, #48, #52, #54, #89 and #100) of nine reviewed for abuse, neglect and misappropriation investigations. The facility census was 96.<br><br>Findings include<br><br>1. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included multiple rib fractures, Alzheimer's disease, dementia, aphasia, diabetes, depression, osteoporosis and restlessness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 05 and required substantial assistance for showering bathing and dressing<br><br>Review of SRI 252935 regarding an injury of unknown origin for Resident #54 dated 10/12/24 revealed no resident interviews or statements were completed and an intervention of 15-minute checks was to be initiated. The facility had no evidence of any 15-minute checks being completed for Resident #54.<br><br>Interview on 01/14/25 at 4:42 P.M. with Director of Nursing revealed the facility had no evidence of 15-minute checks being completed. She acknowledged the interventions were not typical for an injury of unknown origin but confirmed it was mentioned multiple times in the investigation.<br><br>2. Review of the medical record for Resident #89 revealed an admitted [DATE]. Diagnoses included unspecified dementia, aphasia, vascular disease, diabetes, epilepsy, hemiplegia and hemiparesis, and cognitive communication deficit.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 was cognitively impaired with a BIMS of 03 and required extensive assistance for bed mobility and transfers, partial/moderate assistance for bathing and dressing, and substantial maximum assistance for personal hygiene.<br><br>Review of SRI 255726 and SRI 255654 for misappropriation involving Resident #89 dated 12/31/24 and 01/03/25 revealed no resident interviews or statements were completed. The investigation did not include the questions asked of staff and was not specific to a missing wedding ring and clothes but included information about a different ring sent home with family.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 01/14/25 at 4:42 P.M. with Director of Nursing revealed facility investigation was a mix of information related to the previous ring that was reported missing and the new ring that Resident #89's family had provided. DON also revealed facility spoke with the abuse department at Ohio Department of Health and did not include any of those interactions in the investigation steps and when new information was found, facility provided no information indicating the abuse officer was updated. The facility also agreed they did not consider staff working prior to the allegation of the ring being missing but only considered and looked at staff working after the allegation was made on 12/24/24. DON revealed the staff would have also worked prior to the allegation.<br><br>3. Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included dementia, catatonic disorder, aphasia, depression, and muscle weakness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively impaired with a BIMS of 00.<br><br>Review of the medical record for Resident #100 revealed an admitted [DATE] and discharge date [DATE]. Diagnoses included dementia, muscle weakness, bipolar disorder, and pulmonary disease.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 was cognitively impaired with a BIMS of 10.<br><br>Review of SRI 253374 for physical abuse of a resident-to-resident altercation between Resident #52 and Resident #100 dated 10/27/24 revealed no resident interviews or statements were completed. An intervention of 15-minute checks was to be initiated for 24 hours. The facility provided evidence of 15-minute checks being completed for Resident #100 showed the incident occurred at 9:00 A.M. missing entries 10/27/24 from 9:00 A.M. to 9:30 A.M., at 3:15 P.M., 3:45 P.M. to 4:15 P.M., 6:30 P.M., 7:00 P.M., 8:15 P.M., and 9:00 P.M.<br><br>Interview on 01/14/25 at 4:42 P.M. with Director of Nursing revealed the facility had no additional evidence of 15-minute checks being completed. She acknowledged the interventions were missing multiple entries and documentation was missing several sections. DON revealed each box should be completed and confirmed staff used lines and arrows for shorthand and confirmed several sections were left with no documentation to prove 15-minute checks were completed.<br><br>4. Review of the medical record for Resident #33 revealed an admitted [DATE]. Diagnoses included heart disease, depression, hypertension, aphasia, chronic pain, and muscle weakness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 was cognitively impaired with a BIMS of 07.<br><br>Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included dislocation of left humerus, Alzheimer's disease, malnutrition, aphasia, heart disease and vascular dementia.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was cognitively impaired with a BIMS of 08.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of SRI 254391 for physical abuse of a resident-to-resident altercation between Resident #33 and Resident #48 dated 11/22/24 revealed no resident interviews or statements were completed. An intervention of 15-minute checks was to be initiated for 24 hours. The facility provided evidence of 15-minute checks being completed for Resident #48 which showed the incident occurred at 10:39 P.M. and was missing all entries on 11/23/24 from 2:00 A.M. to 9:30 A.M.<br><br>Interview on 01/14/25 at 4:42 P.M. with Director of Nursing revealed the facility had no additional evidence of 15-minute checks being completed. She acknowledged the interventions were missing multiple entries.<br><br>5. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included vascular dementia, hemiplegia and hemiparesis, aphasia and diabetes.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively impaired with a BIMS of 08.<br><br>Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included vascular parkinsonism, insomnia, aphasia, vascular dementia and cognitive communication deficit.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively impaired with a BIMS of 01.<br><br>Review of SRI 254574 for physical abuse of a resident-to-resident altercation between Resident #20 and Resident #21 dated 11/28/24 revealed no resident interviews or statements were completed. An intervention of 15-minute checks was to be initiated for 24 hours. The facility provided evidence of 15-minute checks being completed for Resident #20 showed the incident occurred at 9:00 P.M. and had two separate forms dated 11/29/24 completed by two different staff and stated resident was in two different locations for the entirety of this time period 3:00 P.M. through 3:45 P.M.<br><br>Interview on 01/14/25 at 4:42 P.M. with Director of Nursing revealed facility had no additional evidence of 15-minute checks being completed. She acknowledged the intervention was completed on different forms for the same time period and provided no reasoning for two different staff completing the checks and different information being provided for the same residents at the same times.<br><br>Review of facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/2023 revealed facility staff shall immediately report all such allegations to the Administrator. Facility shall complete an investigation into the alleged violation within five working days. The actions to be taken include interview the resident, the accused, and all witnesses including anyone who come in contact with the resident(s) the day of the incident. If there were no direct witnesses, interviews should be expanded for example all staff on the shift in question. For injuries of unknown origin facility may generally interview staff working on the shift the injury was discovered as well as shifts prior to the incident. Facility shall review all applicable medical records and document all evidence of the investigation. At the end of the investigation, facility shall make a conclusion whether to substantiate the claim vs unsubstantiated the claim. Facility shall follow up by completing any necessary staff education and implementing any other measures deemed appropriate.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00161067. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070<br><br>Based on observations and staff interviews the facility failed to ensure call lights were in reach and accessible for resident use. This affected two residents (#35 and #54) of two observed laying in their bed in their rooms. Facility census was 96.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included dementia, osteoarthritis, aphasia, and anxiety.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively impaired with a BIMS of 99 (unable to determine due to lack of responses in answering) and required extensive assistance of two staff members for bed mobility and extensive assistance of one staff member for transfers.<br><br>Observation and interview on 01/14/25 at 9:35 A.M. revealed Resident #35's call light was not within reach. It was hung back behind the headboard over the clock hanging on the wall about 6 feet from the ground. Registered Nurse (RN) #53 confirmed the call light was hung up over the wall clock and was out of reach for the resident. She revealed possibly the staff feeding her hung it up then forgot to give it back. RN #53 confirmed the call light should be left in resident reach at all times, while she was in bed.<br><br>2. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included multiple rib fractures, Alzheimer's disease, dementia, aphasia, diabetes, depression, osteoporosis and restlessness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was cognitively impaired with a BIMS of 05 and required substantial assistance for showering bathing and dressing<br><br>Observation and interview on 01/14/25 at 12:20 P.M. revealed Resident #54's call light was not within reach. It hung from the plug against the wall and under the bed at the foot board end of the bed. RN #53 confirmed the call light was on the floor under the foot board side of the bed and had to climb around the bed to retrieve it. RN #53 confirmed the call light should always be left in resident reach, while the resident was in bed.<br><br>Interview on 01/14/25 at 2:30 P.M. with Administrator and Director of Nursing revealed they did not believe the facility had a policy related to residents having access to their call light devices but would check. No policy was provided. |