STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365839	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Alzheimer's Care Ctr	700 Jasonway Avenue 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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568 Based on record review, review of the facility Self-Reported Incidents (SRI), review of the facility investigation, review of facility policy and procedure, resident interview, and staff interview, the facility failed to ensure Resident #100 was free from resident to resident physical abuse. Actual harm occurred on 02/03/25 when Resident #57, who had a history of resident altercations and impaired cognition, pushed Resident #100 causing a fall and a right femur fracture. This affected one (Resident #100) of six residents reviewed for abuse. The facility census was 98. Findings include: a. Review of a facility submitted SRI dated 02/03/25 for physical abuse revealed Resident #57 pushed Resident #100 to the ground when Resident #100 wandered into Resident #57's room. Both residents were assessed for injuries. Resident #100 was left immobilized on the floor due to an obvious range of motion deficit to the right hip. Nine-one-one (911) was called for Resident #100's pain and range of motion deficit. Neurological checks were initiated but did not continue due to the transfer to the hospital. The medical provider and families were notified of the incident. Resident #57 was assessed for physical injuries with none noted. Resident #57 was placed on 15-minute checks until he retired for sleep at 11:00 P.M. the same day. The facility unsubstantiated abuse and marked that the evidence indicated abuse, neglect, or misappropriation did not occur. Review of the medical record for Resident #100 revealed an admitted [DATE]. Resident #100's diagnoses included Alzheimer's disease with late onset, vascular dementia, osteoarthritis, and major depressive disorder. The resident was discharged to the hospital on 02/03/25 and did not return to the facility. Review of the physician's order initiated 04/28/24 for Resident #100, revealed the resident had orders for Zoloft and Trazodone, and an order to monitor for side effects for antidepressants and report to physician: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle, tremor, agitation, headache, skin rash, photo sensitivity, and excess weight gain every shift. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 had severe cognitive impairment. Resident #100 was independent for all mobility such as transferring and walking 150 feet. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Columbus Alzheimer's Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Jasonway Avenue 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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the care plan dated 12/20/24 revealed Resident #100 had the potential for mobility limitations with expected fluctuations with chronic medical conditions. Interventions included providing hands on assistance to steady him daily, as needed, when exhibiting weakness or resistance and to monitor his safety with the use of his assistive device. The care plan also identified Resident #100 had a tendency to misperceive information. Interventions included for the chair that he typically sits in, in the common area, to be labeled to reflect that the chair belonged to him and staff would also redirect him away from the [NAME] Pod if observed ambulating in that area, as this is where Resident #57's room was located. Review of a nursing progress note dated 02/03/25 at 11:21 P.M. revealed that Resident #100 stated that another resident [Resident #57] pushed him, and he had a fall. The note also revealed that Resident #100 was in a lot of pain and he received as needed Norco 5-325 milligrams (mg) for pain. The resident was taken to the hospital for further evaluation. Review of a nursing progress note dated 02/03/25 at 3:55 P.M. revealed Resident #100 received a fall risk assessment. The assessment indicated the resident had an unwitnessed fall that occurred in the common area and the resident was injured. The assessment note revealed another resident pushed Resident #100 and he fell . The assessment note also revealed Resident #100 had verbal complaints and facial expressions of pain. The pain was sharp and aching in the right hip and was worse with movement. Daily as needed pain medication, Norco, was administered. Review of the Incident Report dated 02/03/25 for Resident #100, revealed Resident #100 was found lying on his back on the [NAME] Pod near Resident #57's room. Resident #100 stated that a man pushed him, and he fell . Resident #100 was in a lot of pain and was given as needed Norco 5-325 mg for pain. The incident was unwitnessed. Resident #100's vital signs were taken, he was given as needed medication for pain, and neurologic checks were initiated. Resident #100 was immobilized due to an obvious range of motion deficit to his right hip. There were no obvious outward signs of skin impairment. The resident was taken to the hospital and the injury observed at the time of the incident was determined to be a fracture of the right hip. The report also stated Resident #100 was ambulating without assistance and was very territorial about particular chairs on the unit and he sought out the whereabouts of the male resident he was accusing of pushing him down, to tell him not to take his chair. Review of the Neurological Evaluation Flowsheet dated 02/03/25 for Resident #100 revealed neurologic (neuro) checks were completed at 3:30 P.M. and 3:45 P.M. Resident #100 was in the hospital for any further neuro checks. Review of the Fall Risk Evaluation dated 02/03/25 at 3:55 P.M. for Resident #100 revealed he had one to two falls in the past three months, had intermittent confusion, was ambulatory, had adequate vision, and did not have a change in condition in the last 14 days. Review of the Post Fall Evaluation dated 02/03/25 at 3:56 P.M. for Resident #100 revealed an unwitnessed fall with an injury occurred and the resident was sent to the hospital. The Certified Nurse Practitioner (CNP) #250 was notified on 02/03/25 that there was a resident to resident fall where another resident pushed Resident #100 and he fell . The evaluation noted that Resident #100 had severe right hip pain. Review of the Hospital Transfer Form dated 02/03/25 revealed Resident #100 ambulated independently, and he was alert and disoriented, but could follow simple instructions. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of hospital records for Resident #100 revealed he had an X-ray on 02/03/25 that showed an acute obliquely oriented intertrochanteric fracture of the proximal right femur. Resident #100 received surgery on 02/04/25 for his right intertrochanteric hip fracture with osteopenia. b. Review of the medical record for Resident #57 revealed an admitted [DATE]. Resident #57's diagnoses included dementia, depression, cognitive communication deficit, and conversion disorder with seizures or convulsions. Review of the care plan for Resident #57 dated 01/22/25 revealed he was resistive to care related to dementia, he wandered about the facility, and he had the potential to become agitated if his routine or patterns of behavior were disrupted. The plan noted that Resident #57 liked to rearrange furniture in the common area, he had a history of aggression toward male residents that wandered into his room, and he was rigid with his room. Interventions included psychiatric services to evaluate and treat, provide consistency in care to promote comfort with activities of daily living (ADLs), and to maintain consistency in timing of ADLs, caregivers and routine as much as possible. Review of admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #57 revealed he had severe cognitive impairment. Resident #57 was independent for all mobility such as transferring and walking 150 feet. Review of the nursing progress note dated 02/03/25 at 12:00 A.M. for Resident #57 detailed his History and Physical which revealed Resident #57 transferred from another skilled nursing facility on 01/22/25. The note also revealed there were no previous facility records to review. Review of the nursing progress note dated 02/03/25 at 3:30 P.M. for Resident #57 revealed the resident stated he made contact with another resident. Resident #57 was assessed with no injury noted and his skin was intact. The Director of Nursing (DON), CNP #250, and the residents family member were notified. Fifteen-minute checks were initiated. Review of the incident report dated 02/03/25 at 3:30 P.M. for Resident #57 revealed Resident #57 stated I pushed that man who wandered in my room, out of the room, because I don't want anyone in my room. An assessment of Resident #57 was completed with his skin intact and no injury noted. Resident #57 received 15-minute checks through 11:00 P.M. to ensure he made no further reactive movements toward other residents. Predisposing physiological factors included Resident #57 was confused and had impaired memory. Predisposing situation factors included Resident #57 was a wanderer and he was ambulating without assistance. Resident #57 had a pattern of coming out of his room to straighten chairs and rearrange some of the chairs in the common area. Interventions included 15-minute checks through 11:00 P.M. on 02/03/25 and the activities director was to assist the resident to find activities to distract him from his patterned behavior of moving chairs around in the common area. Review of the 15-minute check log sheet dated 02/03/25 for Resident #57 revealed sign offs every 15 -minutes from 3:30 P.M. to 11:00 P.M. were completed. Review of the written staff statement dated 02/03/25 by Licensed Practical Nurse (LPN) #111 revealed she did not witness the incident, but walked into her shift and noticed Resident #100 was lying on the floor and in pain. LPN #111 gave the resident as needed pain medicine. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Columbus Alzheimer's Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 Jasonway Avenue, Columbus, OH 43214	

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the written staff statement dated 02/03/25 by Certified Nursing Aide (CNA) #112 revealed she heard a noise and saw Resident #100 laying down and observed Resident #57 standing in front of his room looking angry. Review of the written staff statement dated 02/03/25 by Registered Nurse (RN) #14 revealed she was sitting at the nurses station and heard a scream from the common area. She saw Resident #100 on the floor on his left side. RN #14 and staff assessed Resident #100. They tried getting Resident #100 off the floor, but he was in too much pain to move around. RN #14 called 911. Review of the written interview statement dated 02/03/25 by Resident #57 revealed Resident #57 initially denied knowledge of any interaction with Resident #100. Resident #57 then stated he pushed Resident #100 out of his room because he walked in. Resident #57 stated he didn't want strangers in his room. Review of the nursing progress note dated 02/04/25 at 1:52 P.M. for Resident #57 revealed he had an altercation with another male resident who he indicated, wandered into his room. Resident #57 had some rigid behaviors involving repositioning chairs. The note indicated that activities staff would be working with him to find one on one activities to distract him. Resident #57 stated, I feel sorry the guy got a fracture. Review of physician's orders dated 02/11/25 for Resident #57 revealed the resident was to be seen by psychiatric services to evaluate and treat. An interview on 02/21/25 at 11:37 A.M. with Resident #57 revealed he had not been a part of or witnessed resident abuse. Resident #57 also revealed he had not been involved in a resident to resident altercation. An interview on 02/21/25 at 12:08 P.M. with LPN #6 confirmed Resident #100 fractured his hip during a resident to resident altercation. An interview on 02/21/25 at 12:25 P.M. with RN #23 revealed he was not at the facility for the altercation, but if two residents had an altercation it would be considered resident to resident abuse. An interview on 02/21/25 at 6:17 P.M. with the DON revealed Resident #57 had ridged behaviors of moving chairs around and Resident #100 had a chair that he [Resident #100] liked. Resident #57 moved the chair and Resident #100 went into Resident #57's room and Resident #57 pushed Resident #100 resulting in a fall. The DON stated she thought Resident #100 intimidated Resident #57, but that no one knew why Resident #100 went into #57's room. The DON confirmed that Resident #100 was injured from the shove, with a right hip fracture. The DON stated it wasn't resident to resident abuse, because the residents didn't know what they were doing based on their BIMS scores. The DON revealed they were both reacting on impulse, she didn't think they were plotting to hurt each other. (continued on next page)

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	365839	A. Building B. Wing	03/10/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 02/21/25 at 6:31 P.M. with the Administrator revealed Resident #100 liked to have his table and chair a certain way and Resident #57 liked to move chairs around the tables. Resident #100 entered Resident #57's room and Resident #57 didn't want Resident #100 in his room, so he pushed him. Resident #100 fell and was sent out [to the hospital] subsequently. The Administrator revealed she received an update after Resident #100 was sent out and he was going to have surgery. The Administrator confirmed Resident #100 had a right hip fracture when he was injured from the shove and fall. The Administrator did not claim the situation was abuse, because it was a resident to resident altercation with no intention to cause harm. The Administrator revealed the nature of the facility was dementia and they did not have an intent to harm. An interview on 02/24/25 at 12:11 P.M. with the Administrator revealed residents did not have intent and they were reacting. The Administrator also revealed nobody could be held liable for abuse of somebody else at the facility and law enforcement had told her this in the past. The Administrator explained that the residents had to have a dementia status to be at the facility and she couldn't think of a time she had ever substantiated two residents abusing each other. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated October 2023, revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The facility policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. If another resident was accused or suspected of abuse, the policy also stated the facility would ensure other residents were protected as determined by the circumstances, which may include but were not limited to, increased supervision of the alleged perpetrator and/or other residents, room or staffing changes, and immediate transfer or discharge, if indicated. This deficiency represents non-compliance investigated under Master Complaint Number OH00162994 and Complaint Number OH00162478.