STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Pointe Care Center	1850 Crown Park Court Columbus, OH 43235

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 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31404

Based on staff interview, record review, review of the facility's Self-Reported Incidents and investigations, and policy review, the facility failed to thoroughly investigate and obtain statements from staff for an injury of unknown origin for Resident #50 and Resident #101. This affected two (Resident #50 and #101) of three residents reviewed for abuse. The facility census was 85.

Findings include:

1. Record review of Resident #50 revealed an admitted [DATE] with diagnoses including aphasia, disorder of bone density and structure, generalized osteoarthritis, Alzheimer's disease, osteoarthritis, presence of right artificial hip, and age related osteoporosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was rarely or never understood and does not use and mobility devices.

Review of the progress note dated 09/27/24 at 8:32 A.M. revealed Resident #50 was experiencing pain in lower extremities. Nurse Practitioner notified and ordered bilateral x-rays of hips and pelvis. The progress note dated 09/27/24 at 4:00 P.M. revealed the x-ray results revealed a right femoral neck fracture. Resident #50 to be sent to the emergency room for evaluation.

Review of a facility self-reported incident (SRI) control number 252375 dated 09/27/24 revealed Resident #50 was found to have a fracture of the femoral neck. All steps immediately taken to ensure the resident was protected which included additional staff interviews, resident interviews, and comprehensive investigation to follow.

The facilities investigation revealed the facility did not have statements from the staff. There was no documented interviews with staff asking if they had seen anything out of the ordinary with Resident #50. The facility had a basic SRI Investigation form that was evidence of training. The form was signed by trained employees that asks have you witnessed any staff, resident, or visitor be abusive toward any resident. Have you ever committed abuse, neglect or mistreated a resident? Do you know who to report to? The bottom of the paper stated I acknowledge that my answers are accurate and I understand the inservice provided to me. There was no evidence of a statement from Licensed Practical Nurse (LPN) #12 or State tested Nursing Assistant (STNA) #14, who were the staff working when they identified fracture, was obtained by the facility.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365929	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Pointe Care Center	1850 Crown Park Court Columbus, OH 43235

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement dated 10/01/24 and signed by the Director of Nursing (DON) stated she designated the Assistant Director of Nursing #11 to interview all nurses and STNA on duty the night of 09/26/24 to the morning of 09/27/24. Per all nursing staff and STNA, nothing unusual or out of the ordinary occurred during the shift. Interview with the Administrator on 10/10/24 at 10:40 A.M. verified the facility did not have any further information on the SRI investigation including staff interviews/statements. Interview with Assistant Director of Nursing #11 on 10/10/24 at 11:20 A.M. stated she just called the staff and interviewed the staff by telephone but she did not have any documented interviews. Interview with LPN #12 on 10/10/24 at 11:37 A.M. stated Resident #50 would not get out of bed on 09/27/24. LPN #12 stated normally she could walk by herself unassisted sometimes, but usually needed help. LPN #12 stated she was not asked to write a statement about the incident. Interview with STNA #14 on 10/10/24 at 11:49 A.M. stated the morning of 09/27/24, Resident #50 yelled in pain when she put her sock on. STNA #14 went and got the nurse on duty. She thought the nurse told her to write a statement but she was unsure if she wrote a statement or not. 2. Record review of Resident #101 revealed an admitted [DATE] and he passed away in the facility on 09/03/24. Diagnoses included dementia without behaviors, traumatic subdural hemorrhage without loss of consciousness, and age related osteoporosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #101 was severely cognitively impaired and used a wheelchair to aid in mobility. Review of the progress note dated 08/15/24 at 5:40 P.M. revealed Resident #101 had pain in his right leg starting at right foot radiating up the leg. Slight warmth to the touch minimal swelling. The progress note dated 08/16/24 at 4:56 A.M. revealed right hip two view x-ray stat was ordered. The progress note dated 08/16/24 at 10:47 A.M. revealed Resident #101 was sent to the hospital due to a fracture of the right hip. Review of the facility's self-reported incident (SRI) control number 250845 dated 08/16/24 revealed an injury of unknown origin was reported to the State Survey Agency. On 08/16/24, Resident #101 was found to have a right hip fracture. The facility's investigation did not include staff statements or staff interviews asking if they had seen anything out of the ordinary for Resident #101 except for one. The Director of Nursing (DON)'s statement stated the Nurse Practitioner said it was possible the hip was just dislocated itself since it was replaced [AGE] years prior. The facility had a basic SRI Investigation form that was evidence of training. The DON stated she spoke with each STNA that worked the night of 08/15/24 into the morning of 08/16/24. Each STNA stated there was nothing out of the ordinary with this resident. There was no documented interview with any of the staff in the investigation. The form was signed by trained employees that asked have you witnessed any staff, resident, or visitor be abusive toward any resident. Have you ever committed abuse, neglect or mistreated a resident? Do you know who to report to? The bottom of the paper stated I acknowledge that my answers are accurate and I understand the inservice provided to me. The facility's SRI investigation revealed there was no evidence of a statement from Licensed Practical Nurse (LPN) #12 or State tested Nursing Assistant (STNA) #14. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 10/10/24 at 10:40 A.M. verified the facility did not have any further information on the SRI investigation including staff interviews/statements. Interview with LPN #12 on 10/10/24 at 11:37 A.M. revealed Resident #101 could not get up safely out of bed and she was not interviewed about his dislocated femur. LPN #12 stated she was not asked to write a statement about the incident. Interview with STNA #14 on 10/10/24 at 11:49 A.M. revealed she was not asked to write a statement about Resident #101's dislocated femur. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation of Resident Property Policy dated 11/21/16 revealed in response to abuse, neglect, exploitation, or mistreatment, the facility must have evidence that alleged violations are thoroughly investigated. This deficiency represents non-compliance investigated under Complaint Number OH00158297.