

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 07/28/2025
NAME OF PROVIDER OR SUPPLIER Crown Pointe Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure a resident's responsible party was notified of a new order for a therapy evaluation. This affected one (#97) of one residents reviewed for a change in condition. The facility census was 89. Review of the medical record of Resident #97 revealed an admission date of 10/15/21. The resident discharged from the facility on 07/15/25. Diagnoses included chronic obstructive pulmonary disease, morbid obesity, hemiplegia and hemiparesis following cerebral infarction affecting left-non-dominant side, hyperlipidemia, atrial fibrillation, depression, dementia, anxiety, legal blindness, mood disorder, insomnia, and dysphagia. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of the medical record revealed an order dated 04/15/25 for the resident to have a physical therapy and occupational therapy evaluation and treatment. The order was signed by Licensed Practical Nurse (LPN) #177. The area on the order for family notification was blank. Further review of the medical record revealed no evidence of Resident #97's responsible party being notified of the new order for therapy evaluation and treatment. Interview on 07/24/25 at 1:17 P.M., LPN #177 verified she was the nurse who signed the order for Resident #97 to receive evaluation and treatments from therapy. LPN #177 stated she assumed she notified Resident #97's responsible party of the new order, however verified there was no documented evidence in the medical record of the responsible party being notified of the new order. Review of the facility policy, dated 04/2013, revealed the unit supervisor or charge nurse will notify the guardian/interested family member of any significant changes in a resident's clinical condition or status, including ADL [activities of daily living] physical functioning and document said notification. This deficiency represents non-compliance investigated under Complaint Number 1327655.</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to ensure staff wore hair nets in the kitchen as required. This had the potential to affect 88 residents in the facility. The facility identified one resident (#03) who did not receive food from the kitchen. The facility census was 89. 1. Observation on 07/23/25 at 7:20 A.M. revealed [NAME] #168 assisting [NAME] #119 with obtaining food temperatures on the steam table. [NAME] #168 was observed with braids which extended approximately 18 inches down her back and was not wearing a hair net. Observation on 07/23/25 at 7:36 A.M., [NAME] #168 was observed briefly leaving the kitchen and returned, wearing a hair net, however her braids still remained hanging outside of the hairnet. [NAME] #168 was then observed tending to food items on the facility stove. Interview on 07/23/25 at the time of the observation., [NAME] #168 verified she had not been wearing a hairnet until she left the kitchen and returned wearing the hair net, which still did not contain all of her hair. 2. Observation on 07/23/25 at 7:47 A.M., Maintenance Director (MD) #213 entered the kitchen without a hair net, walked past the stove and food preparation area, and checked the thermostat above the food preparation area. MD #213 was observed with short hair, approximately one inch in length, and no hair restraint. Interview at the time of the observation, MD #213 verified he was not wearing a hair net upon entering the kitchen and verified he should have applied a hair net prior to entering the kitchen. Review of the facility policy titled, Infection Control-Dietary/Food Handling, dated 02/2016, revealed hair nets or caps must be worn to effectively keep hair from contacting exposed food, clean equipment, utensils, and linens. This deficiency represents non-compliance investigated under Complaint Number 1327653.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation , interview and facility policy review the facility failed to follow proper infection control policies when an outbreak of a contagious skin infection occurred in the facility. This affected two residents (#46 and #87) out of 13 residents who resided in the three hundred unit. The facility also failed to follow appropriate infection control practices by not performing proper hand hygiene after performing catheter care for one resident (#6) . The census was 89. 1.Review of the medical record for Resident #87 revealed an admission date of 04/23/24 with a brief interview of mental status (BIMS) score of 99 indicating severe cognitive deficits. Diagnoses included cerebral infarction, malignant neoplasm, paroxysmal atrial fibrillation, anxiety, hyperlipidemia , dementia, gastro esophageal reflux disease (GERD) and hypertension. The resident was independent with ambulation and wanders throughout the facility. Review of Resident #87's physician orders revealed a rash appeared on his body around 12/27/24 on his upper chest, back, bilateral forearms, abdomen and left side. The rash was treated with multiple medications until it was diagnosed as scabies (an infestation of the human skin by an itch mite) on 01/23/25. The scabies treatment started on 01/24/25 . Resident #87 was placed in contact isolation from 01/27/25 to 02/08/25 . Review of the Dermatologist progress note on 1/23/25 revealed the resident was diagnosed with scabies. Assessment and Plan included scabies located on his trunk, extremities, umbilicus and genitals: Patient informed of etiology and contagious nature of condition. Treatment options discussed. Start Ivermectin 3 milligrams (mg) tablets take five tablets on day 0, repeat in one week. Risk/ benefit/Side Effect (R/B/SE) and proper use of medication disc. Start TAC 0.1% ointment two times a day to itchy areas. R/B/SE and proper use of medication disc. Return to office in four weeks for rash follow up. Family was present and verbalized understanding and agreed with plan. Review of Resident #87's nurses progress notes from 01/20/25 to 01/31/25 revealed on 01/23/25 he was observed walking throughout the facility with no pants on . After several minutes the resident allowed staff to put his pants on. There was no indication staff were notified to follow contact isolation when treating Resident #87 at this time.Review of the Infection Control Surveillance Log from 01/01/25 to 03/31/25 revealed Resident #87 was not listed on the log for the scabies diagnosis.On 07/24/25 at 9:49 A.M. an interview with the Assistant Director of Nursing (ADON) #177 confirmed only one resident in the facility was diagnosed and treated for scabies. She could not confirm the facility completed skin sweeps on residents in Unit 300 or in the facility when Resident #87 was diagnosed with scabies.On 07/24/25 at 3:30 P.M. an interview with a Former Employee #510 confirmed there were two residents diagnosed with scabies. The Former Employee stated there was no staff education regarding scabies or infectious skin conditions. Resident #87 was allowed to wander throughout the facility going into the dining room for meals, lounge area and congregate with fellow residents and staff, while being on contact isolation. On 07/28/25 at 8:38 A.M. an interview with Licensed Practical Nurse # 184 confirmed Resident #87 would not stay in his room when he had scabies. The nurse verified the resident continued to walk throughout the facility while being treated for scabies. 2. Review of the medical record of Resident #46 revealed an admission date of 01/28/22 with a BIMS score of 15 indicating the resident was cognitively intact. Diagnoses included chronic obstructive pulmonary disease, cerebral infarction, schizoaffective disorder, depression, and anxiety. Resident #46 used a walker for mobility and required one person to assist with activities of daily living. Review of Resident #46's nurses progress notes from 01/20/25 to 01/29/25 revealed the nurses reported to Nurse Practitioner (NP) #500 Resident #46 was complaining of itching all over her body. NP #500 visited Resident #46 on 01/24/25 and determined she had crusted scabies since she did not respond to prednisone taper through 01/23/25. Review of Resident #46's physician orders for 01/01/25 to 01/31/25 revealed she started treatment for scabies on 01/24/25 and was in contact isolation until 02/08/25. Review of the Infection Control Surveillance Log from 01/01/25 to 03/31/25 revealed Resident #46 was not listed on the log for the scabies diagnosis. The infection log had no indication of any residents in the facility being diagnosed and treated for scabies. With surveyor intervention , the Regional Clinical Director #400 submitted additional surveillance log for 01/01/25 to 01/31/25 indicating one resident was treated for scabies.On 07/24/25 at 9:49 A.M. an interview with the Assistant Director of Nursing (ADON) #177 confirmed only one resident in the facility was diagnosed and treated for scabies. She could not confirm the facility completed skin sweeps on the residents in Unit 300 or in the facility when scabies was identified in the facility. On 07/24/25 at 2:00 P.M. the interview with the Regional Clinical Director #400 confirmed the facility had one resident who was diagnosed and treated for</p>		