

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  02/20/2026
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to ensure incontinent care was provided at least once every shift. This affected five (Resident #1, #2, #3, #4, and #17) out of nine residents reviewed for incontinence care. The facility census was 78. Findings include: 1. Review of the medical record revealed Resident #1 was admitted on [DATE] with diagnoses that included acute and chronic respiratory failure, cerebral infarction, hemiplegia and hemiparesis, aphasia, anxiety disorder, and benign prostatic hyperplasia. Review of Resident #1's care plan dated 05/08/24 revealed Resident #1 had alteration in elimination and required assistance with toileting. Interventions included to provide incontinence care as needed. Review of Resident #1's bowel and bladder assessment dated [DATE] revealed Resident #1 was always incontinent of bowel and bladder. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment and was dependent on staff for toileting. The MDS revealed Resident #1 was frequently incontinent of bowel and bladder. Review of the bowel and bladder elimination documentation by Certified Nursing Assistants (CNA) revealed Resident #1 had incontinent care provided one out of two shifts on 01/25/26, 01/30/26, 02/02/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/12/26, 02/13/26, 02/16/26, and 02/17/26. Resident #1 did not have incontinent care provided on 01/29/26 and 02/11/26. 2. Review of the medical record revealed Resident #2 was admitted on [DATE] with diagnoses that included Parkinson's disease, multi-system degeneration of the autonomic nervous system, chronic kidney disease, dementia, and benign prostatic hyperplasia. Review of Resident #2's care plan dated 08/05/25 revealed Resident #2 had alteration in elimination and was completely incontinent of bowel and bladder. Interventions included to provide incontinence care as needed. Review of the quarterly MDS dated [DATE] revealed Resident #2 had severe cognitive impairment and was dependent on staff for toileting. The MDS revealed Resident #2 was frequently incontinent of bowel and bladder. Review of Resident #2's bowel and bladder assessment dated [DATE] revealed Resident #2 was always incontinent of bowel and bladder. Review of the bowel and bladder elimination documentation by CNA's revealed Resident #2 had incontinent care provided one out of two shifts on 01/25/26, 01/29/26, 02/02/26, 02/05/26, 02/7/26, 02/08/26, 02/09/26, 02/13/26, 02/16/26, and 02/17/26. Resident #2 did not have incontinent care provided on 02/11/26.3. Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included Type II Diabetes, dementia, and hypertension. Review of Resident #3's care plan dated 04/27/21 revealed Resident #3 had alteration in elimination and was dependent on staff for incontinence care. Interventions included to provide incontinence care as needed. Review of Resident #3's bowel and bladder assessment dated [DATE] revealed Resident #3 was always incontinent of bowel and bladder. Review of the quarterly MDS dated [DATE] revealed Resident #3 had moderate cognitive impairment and required substantial/maximal assistance with toileting. Resident #3 was occasionally incontinent of bowel and bladder. Review of the bowel and bladder elimination</p> <p>(continued on next page)</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>documentation by CNA's revealed Resident #3 had incontinent care provided one out of two shifts on 01/23/26, 01/24/26, 01/25/26 01/29/26, 01/31/26, 02/06/26, 02/07/26, 02/08/26, 02/11/26, 02/12/26, 02/13/26, 02/17/26. Resident #3 did not have incontinent care provided on 02/05/26. 4. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses that included dementia, osteoarthritis, and chronic pain syndrome. Review of Resident #4's care plan dated 02/05/24 revealed Resident #4 may require assistance with care. Interventions included Resident #4 required assistance with toileting. Review of Resident #4's bowel and bladder assessment dated [DATE] revealed Resident #4 was frequently incontinent of bowel and bladder. Review of the annual MDS dated [DATE] revealed Resident #4 had moderate cognitive impairment and required partial/moderate assistance with toileting. The MDS also revealed Resident #4 was frequently incontinent of bowel and bladder. Review of the bowel and bladder elimination documentation by CNA's revealed Resident #4 had incontinent care provided one out of two shifts on 02/07/26, 02/08/26, 02/11/26, 02/12/26, and 02/13/26. 5. Review of the medical record revealed Resident #17 was admitted on [DATE] with diagnoses that included Type II Diabetes, acute kidney failure and anorexia. Review of Resident #17's care plan dated 04/15/24 revealed Resident #17 had alteration in elimination and was frequently incontinent of bowel and bladder. Interventions included to provide incontinence care as needed. Review of the quarterly MDS dated [DATE] revealed Resident #17 was cognitively intact and was dependent on staff for toileting. The MDS revealed Resident #17 was frequently incontinent of bowel and bladder. Review of Resident #17's bowel and bladder assessment dated [DATE] revealed Resident #17 was always incontinent of bowel and bladder. Review of the bowel and bladder elimination documentation by CNA's revealed Resident #17 did not have incontinent care provided on 01/26/26 and 02/19/26. Resident #17 had incontinent care provided one shift on 01/26/26, 01/28/26, 01/30/26, 02/01/26, 02/05/26, 02/09/26, and 02/15/26. During an interview on 01/20/26 at 8:12 A.M. a Resident that requested to be anonymous stated that there was not enough staff. The resident stated staff did not check residents frequently for incontinence. The resident stated she complained once and the staff refused to provide any care and incontinence care was not provided for 17 hours. During an interview with the Director of Nursing (DON) on 02/20/26 at 1:47 P.M. the DON verified the CNA documentation revealed incontinent care was not being provided every shift for Resident #1, #2, #3, #4, and #17. The DON stated staff were being educated about charting, but The DON could not verify that incontinent care had been provided. During an interview with Resident #4's family on 01/20/26 at 2:16 P.M. the family stated they found Resident #4 frequently incontinent and had asked that Resident #4 be checked and changed every two hours, but it was not being done. This deficiency represents non-compliance investigated under Complaint Number 2717356.</p>		