STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365950	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Court Nursing & Rehabilitation Center	1605 Northwest Professional Plaza Columbus, OH 43220

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on record review, staff interview, resident interview, guardian interview, record review, policy review, and review of Self-Reported Incident (SRI), the facility failed to timely notify the resident representative following a change in condition. This affected one (#69) of three residents reviewed for notification of change in condition. The facility census was 95. Findings include: Review of the medical record for Resident #69 revealed an admitted [DATE]. Medical diagnoses included hemiparesis and hemiplegia following cerebrovascular accident (stroke), lack of coordination, and anxiety. Review of Resident #69's Minimum Data Set (MDS) annual assessment, dated 06/05/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #69 had no recorded behaviors or rejection of care. Review of Resident #69's interdisciplinary progress notes revealed a note dated 07/24/24 at 2:00 P.M., which indicated the resident sustained a wound to her left foot after she jammed her toes into the door while mobilizing in her motorized wheelchair. The resident was assessed for injury, the wound was cleansed and a dressing applied. The note indicated over-the-counter pain medication was administered, the resident declined ice application, and an attempt was made to reach the resident's guardian and was unsuccessful, with a voicemail being left. A subsequent note dated 07/24/24 at 9:28 P.M., revealed Resident #69 stated she felt light headed and confused. The resident's guardian was present in the facility and requested the resident be sent to a local hospital for evaluation of the wound sustained earlier in the day. A note dated 07/25/24 at 2:01 A.M., revealed Resident #69 returned to the facility from the local hospital and had six stitches placed to her left foot. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility SRI #250113, initiated on 07/26/24, revealed Resident #69's guardian had alleged neglect had occurred and that the facility had withheld treatment to the resident following the 07/24/24 incident. An investigation was completed by facility staff. Residents and staff were interviewed, and staff reports indicated treatments had been provided immediately following the incident. The facility concluded the SRI investigation and unsubstantiated neglect, but identified a concern regarding the nurse not timely notifying Resident #69's guardian after the incident. The file contained a written statement authored by Licensed Practical Nurse (LPN) #210 that she phoned the resident's guardian on 07/24/24 at approximately 6:00 P.M. with a voicemail left. The file contained evidence that LPN #210 received one-on-one education on 07/26/24 from Unit Manager (UM) #234 that responsible parties are to be notified within two hours following any incidents. Both UM #234 and LPN #210 signed the one-on-one education. Interview and observations on 08/05/24 at 8:39 A.M., with Resident #69 revealed her lying in bed with her feet elevated on a pillow. A motorized wheelchair was next to the foot of the resident's bed. Resident #69 reported she had an accident a week or two ago where she bumped her foot on the doorway to her room resulting in a deep cut. Resident #69 stated staff bandaged the area, but she later had to go to the hospital when the wound would not stop bleeding and she began to feel lightheaded. Resident #69 reported her guardian came into the facility later in the evening to visit and accompanied her to the hospital. Resident #69 stated she had to get six sutures in her foot, and the would was still in the process of healing. Interview on 08/05/24 at 10:14 A.M., with the Administrator discussed SRI #250113 and Resident #69's incident on 07/24/24 which resulted in an injury. The Administrator stated he was one of the first ones to encounter the resident after she had the accident, and noticed her bleeding. He summoned a nurse, who performed appropriate assessment, cleansing and application of a treatment. The Administrator stated the facility's Nurse Practitioner was in the building at the time and assessed the area and did not believe the area required additional intervention. The Administrator stated the facility timely and appropriately cared for Resident #69's injuries, but verified the facility staff did not timely report the change in condition to the resident's guardian. The Administrator stated the nurse on duty at the time made the notification, but there was an approximate 5.5 hour delay from the time of the incident to when a voicemail was left for the guardian. Interview, via phone, on 08/05/24 at 11:08 A.M., with Resident #69's guardian revealed the resident's injury occurred on 07/24/24 at approximately 1:00 P.M., and she was not notified until just before 7:00 P.M. The guardian got a vague voicemail requesting her call back to the facility to receive an update on a change in condition for Resident #69. The guardian reported she attempted to phone the facility approximately 5 times, all of which had no answer and went to voicemail. The guardian stated she was very concerned, and physically drove to the facility to see Resident #69. When she arrived, she saw multiple staff members at the nurse's station and was notified of the injury to the resident's left toes. The guardian reported a large bandage was in place, but the resident was feeling lightheaded and confused, and she requested the resident be transferred to a local emergency department for evaluation of the lacerated area. The guardian accompanied the resident to the hospital, and the resident required six sutures to her toes to close the lacerated area. The resident returned to the facility on [DATE] between 1:00 and 2:00 A.M. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/05/24 at 2:44 P.M., with LPN #210 revealed she was the nurse caring for Resident #69 on 07/24/24. LPN #210 confirmed she documented that she notified Resident #69's guardian on 07/24/24 at 2:00 P.M. LPN #210 stated she could not recall from what phone she called from, or if she left a voicemail. LPN #210 was unable to recall details of the incident on 07/24/24, whether or not the facility Nurse Practitioner evaluated the resident, or what action was taken following. Interview on 08/05/24 at 2:51 P.M., with the Administrator verified LPN #210 did not phone Resident #69's guardian from a facility phone on 07/24/24, as he is able to pull reports showing what numbers had been called. The Administrator reported LPN #210 used her personal phone, and she was going to check to see if she had the call logs or records on her personal phone to prove she made that phone call. Interview on 08/05/24 at 3:02 P.M., with the Director of Nursing (DON), LPN #210, the Administrator, and Unit Manager (UM) #234 in the DON's office, revealed LPN #210 stated her call logs on her phone did not go back 12 days, and she was unable to show evidence that she did place a call to Resident #69's guardian on 07/24/24 at 2:00 P.M., as she had recorded in the resident's medical record. LPN #210 stated she was reaching out to the owner of her phone plan to retrieve the call logs but was so far unable to provide them. A follow up interview on 08/05/24 at 3:21 P.M., with the DON and Administrator verified the facility was unable to provide evidence Resident #69's guardian was notified at approximately 2:00 P.M. as was recorded in the medical record. The DON and Administrator verified the documentation in Resident #69's medical record, the written staff statements, and the verbal recollection of the events did not match. The DON and Administrator verified the facility had reached a conclusion in the facility's SRI investigation that Resident #69's guardian had not been notified timely, and they had provided necessary re-education to LPN #210 regarding timely notification following a change in condition. Review of the policy titled, Change in Condition Notification, dated 08/09/23, revealed the nurse will notify the resident, the resident's physician/practitioner, and the resident's designated representative when there is an accident or incident involving the resident which results in an injury and has the potential to require physician/practitioner intervention. This deficiency represents non-compliance investigated under Master Complaint Number OH00156281.