

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365950	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/23/2025
NAME OF PROVIDER OR SUPPLIER  Sapphire Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on medical record review, review of hospital records, review of Self-Reported Incidents (SRIs), staff interview, and review of the facility policy, the facility failed to ensure residents were free from physical abuse. This resulted in Actual Harm on 05/27/25 for Resident #12 who was admitted to the hospital and treated for facial bruising and a laceration above the left eye with sutures after being punched in the face by another resident. This affected one (Resident #12) of three residents reviewed for abuse. The facility census was 109 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed an admission date of 08/03/24 with diagnoses including dementia, type two diabetes mellitus, anxiety disorder, and depression.</p> <p>Review of the care plan for Resident #12, initiated 08/04/24, revealed the resident had a behavior problem related to dementia, which included wandering into other residents' rooms. Interventions included the following: attempt to redirect the resident when showing wandering behaviors, anticipate and meet the resident's needs, staff to intervene as necessary to protect the rights and safety of others, remove from situation and take to an alternate location if needed.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #12, dated 03/04/25, revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.)</p> <p>Review of the nurse progress note for Resident #12, dated 05/24/25, revealed the resident continued to go into other residents' rooms taking belongings. Staff redirected Resident #12 several times during the shift, but the resident continued to wander and open doors to other residents' rooms.</p> <p>Review of the nurse progress note for Resident #12, dated 05/27/25, revealed LPN #112 was charting when Resident #20 approached the nurse and reported she witnessed one resident beating up another resident. The nurse responded to Resident # 28's room and found Resident #12 standing in the middle of the room bleeding profusely from his face. The resident, who attacked Resident #12, admitted he had beat the resident with his hands. The nurse applied direct pressure to the bleeding area on Resident #12's face and called 911 to transport the resident to the hospital.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SRI regarding Resident #12, dated 05/27/25, revealed LPN #112 was charting when Resident #20 informed her Resident #28 was physically assaulting Resident #12. LPN #112 responded to Resident #28's room and found Resident #12 standing in the middle of the room with facial bleeding. The two residents were separated, and Resident #12 was sent to the hospital via ambulance for treatment of his injuries. Social Services Designee (#105) interviewed Resident #28, who told the SSD Resident #12 kept coming into his room and Resident #28 became frustrated after several failed attempts to stop the resident from coming into his room. Resident #28 said he reacted by punching Resident #12, because he just couldn't take it anymore.</p> <p>Review of a witness statement per SSD #105, dated 05/29/25, revealed the SSD interviewed Resident #28 who confirmed he had punched Resident #12 on 05/27/25, because Resident #12 kept coming into his room and he had asked him multiple times to stop coming into his room. Further review revealed Resident #28 confirmed he punched Resident #12 because he just couldn't take it anymore.</p> <p>Review of the hospital records for Resident #12, dated 05/27/25 to 05/31/25, revealed the resident was admitted to the hospital as an assault victim. Resident #12 had been hit in the face and had a hematoma and laceration on the left side of his face with admitting diagnoses of periorbital ecchymosis and swelling and facial laceration with stitches.</p> <p>Review of the nurse progress note for Resident #12, dated 05/31/25, revealed the resident was readmitted to the facility. Resident #12 had swelling to the left side of his face, a bruise to his left eye, and a laceration above the left eye with stitches.</p> <p>Review of the medical record for Resident#28 revealed a readmission date of 01/27/25, with diagnoses including stroke, hypertension, peripheral vascular disease (PVD), and dementia.</p> <p>Review of the care plan for Resident #28, initiated 03/03/23, revealed the resident had a behavior problem, which included hitting other residents. Interventions included the following: assist the resident to develop more appropriate measures for coping and interacting, encourage the resident to express feelings appropriately, and a stop sign across the door of the room (added 05/27/25).</p> <p>Review of the MDS assessment for Resident #28, dated 04/09/25, revealed the resident had mild cognitive impairment.</p> <p>Interview on 06/12/25 at 8:00 A.M. with the Director of Nursing (DON) and the Administrator confirmed the facility initiated an SRI when Resident #28 assaulted Resident #12 resulting in facial bruising and a laceration requiring sutures above Resident #12's left eye. The facility did not substantiate abuse because they believed Resident #28 had not intended to hurt Resident #12. Interview confirmed the facility implemented a new intervention after the incident had occurred. After Resident #12 returned from the hospital, the facility decided to place a stop sign across Resident #28's door to prevent unwanted visitors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/12/25 at 12:16 P.M. with LPN #112 confirmed when she walked into Resident #28's room on 05/27/25 she found Resident #12 standing in the middle of the room with his face in his hands because he was bleeding badly. LPN #112 confirmed she asked Resident #28 what happened, and Resident #28 told the nurse he had hit Resident #12 in the face which had caused the injuries. LPN #112 confirmed she separated the residents and sent Resident #12 to the hospital via ambulance for treatment of his injuries. LPN #112 confirmed Resident #12 was free of any bruises or cuts to his face prior to the incident.</p> <p>Observations on 06/11/24 and 06/12/25, between 8:00 A.M. to 4:30 P.M., revealed there was no stop sign to Resident #28's door blocking entry to the room.</p> <p>Interview on 06/12/25 at 12:30 P.M. with Certified Nursing Assistant (CNA) #106 confirmed there was no stop sign to Resident #28's door because Resident #28's roommate had ripped the sign off the wall.</p> <p>Review of facility policy, titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property undated, revealed residents had the right to be free from abuse including resident to resident abuse. Abuse was defined as the willful infliction of injury. Willful meant the individual must have acted deliberately, not that the individual intended to cause harm.</p>		