

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 03/19/2026
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, interviews, and policy review, the facility failed to administer a SARS-CoV-2 (COVID-19) vaccination as requested by Resident #59. This affected one out of three residents reviewed for vaccinations. The facility census was 96. Findings include: Review of Resident # 59's medical record revealed an admission date of 04/17/25 with diagnoses including but not limited to asthma, malnutrition and vertigo. Review of Resident # 59's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview in Mental Status (BIMS) of 15 indicating the resident had intact cognition. The resident required assistance from staff with transfers and personal hygiene. Review of Resident immunization history revealed the resident had received a total of four SARS-CoV-2 (COVID-19) vaccinations, with the last being administered on 10/29/24. Review of Resident #59's progress note with effective date 12/30/25 at 2:00P.M. by Licensed Practical Nurse Unit Manager (LPNUM) # 400 revealed the resident requested a SARS-CoV-2 (COVID-19) vaccination and the nurse practitioner was made aware and provided an order for the facility to administer the vaccination. Review of Resident # 59's physicians orders revealed that on 12/31/25 an order was placed for Comirnaty Intramuscular Suspension 30 micrograms (mcg)/ 0.3 milliliters (ML) (COVID-19 (SAR-CoV-2) mRNA Virus Vaccine; instructions to inject 0.3 ML intramuscularly one time a day for Vaccine for one administration with an end order date of 01/08/26. Review of Resident #59's Medication administration Record (MAR) dated January 2026 revealed that on 01/07/26, Licensed Practical Nurse (LPN) # 316 signed the ordered (COVID-19 (SAR-CoV-2) mRNA Virus Vaccine off with code NM for Med Not Available. Further review of January 2026 and February 2026 MARs revealed no administration of the vaccine. Review of progress note dated 02/03/26 at 12:06 P.M. revealed the resident complained of cough, medications were administered as ordered, vital signs were within normal limits and the resident independently called Emergency Medical Services (EMS 911) and was transferred to the hospital. Interview with Resident #59 on 03/18/26 at 8:00 A.M. revealed the resident contracted COVID-19 and double pneumonia in February. She stated when she got sick the evening before she went out she was not feeling well and the nurse offered to send her to the hospital but she would wait until the next day and then she called 911 herself to go to the hospital. She stated she was in the hospital for eight days on isolation. She stated she had requested the COVID-19 vaccination from the facility and was told she would receive it on 01/07/26 however had not received it being told it was on back order. She said the only option she was offered from the facility was that she could go to the local pharmacy to get the vaccine, but she stated it was too cold to go out. Interview on 03/18/26 at 3:03 P.M. with LPNUM # 400 revealed she did not recall Resident #59 requesting the COVID-19 vaccination and was unsure why she had not received it. Further interview confirmed that LPNUM # 400 placed the order for the vaccination on 12/31/25 and revised the order on 01/07/26. Interview on 03/18/26 at 3:30 P.M. with LPN # 316 revealed on 01/07/26 the COVID-19 vaccine was not available to administer, she stated she called the pharmacy to send the vaccine and was told by the pharmacy that paperwork had to be filled out prior to them sending the vaccination. LPN # 316 stated she notified someone in the facility (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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>but could not recall who it was. Interview on 03/19/26 at 10:37 A.M. with Assistant Director of Nurses (ADON) LPN # 472 revealed when nurses order vaccines they should call the pharmacy to confirm the order was received and give any information the pharmacy may need to send the medication. She also confirmed that vaccinations should be offered and given to residents who want them yearly, and any time the resident requests with a doctor's order. Interview with Pharmacy Staff #555 via telephone on 03/19/26 at 11:22 A.M. revealed the COVID-19 vaccination had not been on back order, however the pharmacy needed the facility to complete the vaccine request form for the pharmacy to send the vaccination to the facility and that had not been done so the pharmacy was unable to release the vaccination to the facility. Pharmacy Staff #555 verified the COVID-19 vaccination was available in November and December of 2025 and January, February, and March of 2026. Review of facility policy titled Vaccinations of Residents dated 2001 last revised 2016 revealed all residents will be offered influenza, pneumonia and covid vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. This deficiency represents non-compliance investigated under Complaint Number 2739120.</p>		