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	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Rehabilitation and Care 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to properly provide bathing/shower services and oversite for residents that were dependent on staff for care. This affected one (Resident #27) of three residents reviewed for bathing/showering. The census was 96.Findings Include:Resident #27 was admitted to the facility on [DATE]. Her diagnoses were depression, anxiety disorder, hyperlipidemia, atherosclerotic heart disease, dementia, adult failure to thrive, hypertension, hypo-osmolality and hyponatremia, and non-traumatic intracerebral hemorrhage in hemisphere. Review of her minimum data set (MDS) assessment, dated 04/04/26, revealed she had a severe cognitive impairment. Review of Resident #27 MDS Assessment, section GG, dated 04/04/26, revealed she required substantial physical assistance with her baths/showers.Review of Resident #27 care plans, dated 05/07/26, revealed she did not have a care plan related to refusal of baths/showers until it was brought to the attention of facility management on 05/07/26. A revision was made on 05/07/26 to her impaired cognitive function/dementia or impaired thought processes care plan, which added often refuses showers. An intervention for refusals of showers was also added on 05/07/26, which stated, frequent shower refusals: reapproach and offer shower again.Review of Resident #27 Bath and Skin Report, dated 03/02/26 to 04/27/26, revealed the following dates in which Resident #27 refused to take a bath/shower: 03/02/26, 03/07/26, 03/09/26, 03/16/26, 03/21/26, 03/23/26, 03/28/26, 03/30/26, and 04/27/26. There was nothing documented on the bath and skin report about staff reapproaching the resident at a later time to offer a bath/shower again. There was no documentation to support the facility provider was contacted to inform them of the constant refusals as well. Also, on 04/04/26, there was a bath and skin report started with Resident #27 name on it, but there was no other documentation to indicate if a bath/shower was offered and/or completed. Finally, there was no documentation to support a bath/shower was offered to Resident #27 after 04/27/26. Interview with Director of Nursing (DON on 05/11/26 at 11:25 A.M. confirmed Resident #27 care plan was revised to reflect her refusals of baths/showers. Initially, she stated it was already in the care plan, and was just added to the Kardex on 05/07/26, but she confirmed she could not explain why the revisions in the electronic medical record did not reflect that the refusals had already been addressed prior to 05/07/26. She confirmed there was no documentation to support that staff had attempted to reapproach Resident #27 during her documented refusals. She confirmed the care plan and intervention for Resident #27 refusal of baths/showers was not available to be seen by the floor staff because it was not added to the kardex until 05/07/26.This deficiency represents non-compliance investigated under complaint number 2991473 and 2997253.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and facility policy review the facility failed to maintain infection prevention and control during medication administration. This affected two (Resident #62 and #64) of three residents observed during medication administration. The census was 98. Findings include:1. Review of Resident #62 medical record revealed an admission date of 02/20/22. Medical diagnoses include anxiety, chronic respiratory failure with hypoxia, paraplegia, neuromuscular dysfunction of the bladder, essential (primary) hypertension and radiculopathy.Review of Resident #62 Minimum Data Set (MDS) 3.0 dated 03/27/26 revealed resident was cognitively intact.Review of Resident #62 Medication Administration Record (MAR) revealed orders for the following medications for the morning observed morning medication administration pass; Furosemide tab 20 mg 1 tab one, Gabapentin cap 300 mg 2 capsules, Spironolactone tab 25 mg 1 tab, 1Baclofen tab 20 mg 1 tab, take with 10mg, Baclofen tab 10 mg 1 tab- take with 20mg, Bethanechol chloride tablet 10 mg 1 tab, Buspirone tab 5 mg 1 tab, Fluoxetine HCl Oral capsule 40 mg, Hydrochlorothiazide oral tablet 12.5 mg 1 tablet, Losartan potassium oral tablet 100 mg 1 tablet, and Jardiance 10 mg tab.Observation on 05/06/26 at 9:19 A.M. with Registered Nurse (RN) #300 revealed RN #300 removed each of Resident #62 medications housed in a blister pack onto her hand and then placing the medication in the medication cup2. Review of Resident #64 medical record revealed an admission date of 04/03/26. Medical diagnoses include essential (primary) hypertension, anxiety, and depression.Review of Resident #64 Minimum Data Set (MDS) 3.0 dated 04/07/26 revealed resident was cognitively intact.Review of Resident #64 Medication Administration Record (MAR) revealed orders for the following medications for the morning observed morning medication administration pass; Carvedilol 12.5 mg give 1 tablet, Eliquis (Apixaban) oral tablet 5 mg 1 tab, Sertraline tab 100 mg, Metoprolol 100 mg 1 tab, and Amlodipine 5 mg 1 tab.Observation on 05/06/26 at 9:27 A.M. with RN #300 revealed RN #300 removed each of Resident #64 medications housed in a blister pack onto her hand and then placing the medication in the medication cup.Interview on 05/06/26 at 10:10 A.M. with RN #300 confirmed she opened each medication housed in a blister pack onto her hand then placed the medication in a medication cup. Review of the facility's policy titled, Administering Medications dated February 2026 confirms staff follow established facility infection control procedures (handwashing, aseptic technique, gloves, isolation precautions, etc.) for administration of medications, as applicable.This deficiency is based on incidental findings discovered during the course of this complaint investigation.