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	06/16/2026

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.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital medical record review, staff interviews, interview with dialysis center, and policy review, the facility failed to ensure a resident had a safe discharge from the facility. This affected one (Resident #99) of three residents reviewed for discharge. The facility census was 96. Findings include:Review of the medical record for Resident #99 revealed an admission date of 02/19/26. Diagnoses included vascular dementia, cognitive communication deficit, muscle wasting and atrophy, chronic viral hepatitis B, dependence on renal dialysis, and end stage renal disease.Review of the discharge care plan initiated 03/03/26 revealed the resident's plan was to discharge to home with his [daughter]. Resident #99 dialysis's care plan dated 03/03/26 revealed he attended dialysis three times week, Monday, Wednesday and Friday.Review of a hand written care note dated 05/29/26 revealed Resident #99 was discharging home on [DATE]. Resident #99's sister will be in [NAME] at this time (06/03/26) but there were other family members in the apartment to provide assistance. Home Health Service (HHS) #500 to provide home therapies. No durable medical equipment (DME) was needed as Resident #99 had a wheelchair at home. Dialysis already set up. Resident #99's sister joined the care conference by telephone. The care plan note did not address if Resident #99 would have 24-hour care, assistance with medication management, transportation needs to attend dialysis, and if family members would be able to assist Resident #99 with transfers and ambulation.Review of the Occupational Therapy (OT) Discharge summary dated [DATE] revealed Resident #99's prognosis to maintain Current Level of Function (CLOF) was with good with strong family support. On OT discharge date d 06/01/26, Resident #99 required supervision to partial assistance with medication management with independence and good safety awareness to improve independence in daily routines. Prior living arrangement was in a apartment with his daughter. Unsure accuracy of information as the resident appears to be a poor historian. Resident #99 had no awareness of diagnosis and prognosis.Review of the Physical Therapy (PT) Discharge summary dated [DATE] revealed Resident #99 required moderate to minimum assistance from a person with rest stop with maximum cues going up and down eight steps. Discharge recommendations stated 24-hour care for Resident #99. Resident #99's prognosis to maintain CLOF was excellent with consistent staff support. Resident #99 had no awareness of diagnosis and prognosis. Resident #99 was discharged to reside in the long-term care facility.Review of the social services progress note dated 06/02/26 revealed Resident #99 had a planned discharge this date as he was out of skilled days and chooses not to pay privately. HHS #500 was in place. Resident #99 resided with family and attended dialysis. The note did not address if Resident #99 would have 24-hour care, assistance with medication management, transportation needs to attend dialysis, and if family members would be able to assist Resident #99 with transfers, steps, and ambulation.Review of the nursing progress noted dated 06/03/26 (Wednesday) revealed Resident #99 was discharged from the facility. Vital signs were stable at the time of discharge. Resident #99 was transported via the facility transportation.Review of the Discharge summary dated [DATE] revealed Resident #99 was physically dependent on person for walking and required the use of a walker. A current reconciled medication list (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided to Resident #99 upon discharge.Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #99 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 13. Resident #99 was independent with bed mobility, required setup assistance from staff for transfers, and required supervision or touching assistance from staff for ambulation.Review of the hospital medical records dated 06/08/26 revealed Resident #99's dialysis center called the police to do a wellness check and Resident #99 was found wandering around outside his house. Resident #99 was oriented times three in the emergency department (ED). Resident #99 stated that his daughter who usually took care of him recently moved back to [NAME] and will be gone for three months. Resident #99 stated that he feels unsafe living at home, he was unable to cook for himself, and the last time he ate was the previous day. Resident #99 stated he felt lightheaded. Resident #99 stated that he used a cane to walk around, but it was difficult for him to walk. Resident #99 met with a case manager (CM) for a bedside consult for discharge needs. Resident #99 stated there were three flights of stairs to enter his apartment. He does have walker but was unable to use with the stairs so he uses his cane. Resident #99 stated that he cannot cook for himself and forgets to eat. The hospital CM discussed where Resident #99 could go upon discharge until his daughter returns home and Resident #99 was not sure. Resident #99 stated that he tried to get in touch with his son (#1) but could not reach them. The hospital CM discussed with Resident #99 to investigate possible Medicaid services if qualifies. The hospital CM attempted to contact daughter, and the telephone call went straight to voicemail. The hospital CM attempted to contact son (#1), which Resident #99 stated has access to his bank account and it went to voicemail which was not setup. The hospital CM spoke with Resident #99's other son (#2) who was not aware his father was in the hospital and was not clear on whether Resident #99 left the rehabilitation facility on his own or was discharged . Resident #99's son stated he did not know why Resident #99 was at the apartment because there was no one there to take care of him. The hospital CM placed a call to Adult Protective Services (APS) with [NAME] County, Ohio. The progress note dated 06/11/26 revealed the physician assessed Resident #99 as incapacitated to make his own decisions. Resident #99's son agreed to long-term care placement.Interview with Dialysis Social Worker (DSW) #800 on 06/15/26 at 11:04 A.M. revealed Resident #99 did not show up to his dialysis scheduled appointment on Friday (06/05/26) and did a wellness check on Resident #99. DSW #800 spoke to one of Resident #99's son and the son set up a driver pick up for Monday (06/08/26). On 06/08/26, Resident #99's driver pick up did not show up so dialysis got another driver to pick up Resident #99. The second driver took Resident #99 to the dialysis appointment, but Resident #99 arrived late, and the second driver said he had Resident #99 in his car but Resident #99 could not get out of the car. Resident #99 told DSW #800 that he did not feel safe at home, his one son [NAME] him things but didn't stay all the time due work. Resident #99 stated he was not eating because he cannot stand up to make food. DSW #800 stated Resident #99 lost three pounds in the five days (06/03/26 to 06/08/26) and it was unheard for dialysis patients unless they were not eating. DSW #800 stated they called and spoke to a nurse (unknown name) on 06/03/26 when they heard Resident #99 was being discharged to home that day (06/03/26) and the nurse verified Resident #99 was being discharged that day. The nurse took down DSW #800's name and telephone number for social services to call back to understand the discharge plan for Resident #99. The facility's social worker never returned DSW #800's call.Interview on 06/15/26 at 2:09 P.M. and on 06/16/26 at 9:10 A.M. with Social Services Designee (SSD) #220 stated a care conference was completed on 05/29/26 with Resident #99 and their daughter. At the time of the care conference, Resident #99 and daughter were agreeable to a discharge date of 06/03/26 and voiced no concerns. The daughter stated at the care conference that she would be in [NAME] at the time of the discharge, but other family members would be at home to help with care for Resident #99. SSD #220 stated Resident #99 was discharged because they were ready to go home and did not want to pay out of pocket to stay at the facility. SSD #220 stated PT and OT services were set up for Resident #99 through HHS #500. Resident #99 stated he would use his family or the bus as (continued on next page)

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