

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety 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 closed medical record review, hospital record review, review of a facility investigation, review of the facility assessment, policy review, and interview, the facility failed to develop and implement an effective discharge planning process focusing on the safety and total care needs of Resident #23 to ensure the resident was discharged to a safe location with continuity of care post-discharge. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injury, and/or death beginning on 08/12/25 when Resident #23, who had been admitted to the facility with a known diagnosis of alcohol abuse, was discharged from the facility without evidence the resident had a safe location in which to go. Following the resident's discharge, on 08/13/25 the facility was notified by an unidentified bystander that Resident #23 wanted the facility contacted and Assistant Director of Nursing (ADON) #341 informed the unknown caller Resident #23 would have to go to the emergency room. The resident was subsequently admitted to the hospital with diagnoses of suicidal ideation and malnutrition. On 09/11/25 at 1:21 P.M., Regional Director of Operations (RDO) #261, Licensed Nursing Home Administrator (LNHA) #271, Regional Nurse #264, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 08/12/25 when Resident #23 was discharged from the facility without proper assessment, without evidence he had a safe location in which to discharge to and without evidence of coordination of care to ensure the resident's medical and psychosocial needs were met resulting in the resident being hospitalized for malnutrition and suicidal ideation. The Immediate Jeopardy was removed on 09/11/25 when the facility implemented the following corrective actions: Resident #23 exited the facility on 08/12/25 at 6:45 A.M. He did not return to the facility. On 09/11/25 at 9:00 A.M., LNHA #271 and the DON were educated on the facility's discharge against medical advice (AMA) and leave of absence (LOA) policies. On 09/11/25 at 12:00 P.M., an audit was completed by LNHA #271 of current residents with plans to discharge to the community. The audit identified five residents (Residents #16, #42, #101, #114, and #122). All five resident's records were audited to ensure discharge planning was in progress and discharge plans were accurately recorded in each resident's record. On 09/11/25 at 3:30 P.M., Social Services Director (SSD) #312 and LNHA #271 were educated by Regional Director of Clinical Services (RDCS) #263 on ensuring support for residents' psychosocial well-being and providing assistance with discharge needs and requests. Additional education included SSD #312 will complete new admission care conferences within 72 hours of admission which will include screening assessments such as the PHQ-9 depression screening tool. On 09/11/25, the DON provided education to the facility's interdisciplinary team (IDT) and licensed nurses on the facility's policies on discharge AMA and LOA policies. The IDT included LNHA #271, ADON #341, Unit Manager (UM) #347, UM #345, SSD #312, Business Office Manager (BOM) #267, Dietary Manager #269, Activity Director #270, Therapy Director #315, Housekeeping Supervisor #280, Maintenance Director #219, Central Supply Coordinator #205, and Medical Records Coordinator #273. Additionally, 20 Licensed Practical Nurses (LPN) and 11 Registered Nurses (RN) were educated. All education was completed on 09/11/25 by 4:30 P.M. The facility held a Quality Assurance Performance Improvement (QAPI) meeting on 09/11/25 which (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	included completion of a root cause analysis of the event and development of a plan of correction. Participants included Medical Director #450, LNHA #271, DON, RDO #261, RDOS #263, and Regional Nurse #264. The QAPI plan was approved by Medical Director #450 and the IDT on 09/11/25 at 4:30 P.M. On 09/11/25 at 4:45 P.M., Minimum Data Set (MDS) Nurse #343 completed an audit of in-house residents with the diagnosis or history of substance abuse or polysubstance abuse. The audit identified six in-house residents (Residents #3, #17, #58, #78, #89, and #120) with a substance abuse or polysubstance abuse history. On 09/11/25 at 5:00 P.M., the DON provided one-on-one education to Residents #3, #17, #58, #78, #89, and #120 on the facility's leave of absences policy. Ad hoc (not scheduled) education will be provided on an ongoing basis by RDOS #263 or Regional Nurse #264 for any staff member who is not correctly implementing the AMA and/or LOA policies on an as-needed basis. Beginning on 09/11/25, newly hired nurses will be trained on the facility's discharge AMA and LOA policies upon hire by the DON or designee. Beginning on 09/12/25, the DON or designee will provide education to agency staff nurses on the facility's discharge AMA and LOA procedures prior to the agency nurse being able to accept the assignment at the facility. Beginning the week of 09/15/25, LNHA #271 or designee will audit weekly discharges for a duration of four weeks to ensure documentation supports a safe discharge, including a discharge plan that meets the residents' behavioral and psychosocial needs. The results of ongoing audits will be reviewed by the facility's QAPI committee to determine if additional audits or education is needed. Beginning on 09/18/25 at regularly scheduled Utilization Review (UR) meetings, LNHA #271 or designee will discuss upcoming resident discharges and safe discharge planning. The weekly UR meetings will be attended by LNHA #271, DON, Therapy Director #315, BOM #770 (start date 09/15/25), and MDS Nurse #343. Although the Immediate Jeopardy was removed on 09/11/25, the deficiency remained at a Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #23 revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition, anemia, alcohol abuse, hypertensive heart disease, adult failure to thrive, chronic viral hepatitis C, osteoarthritis, cutaneous abscess of right lower limb, and multiple myeloma. Emergency contacts included a female friend and the resident's sister. The medical record revealed Resident #23 was discharged on 08/13/25. An admission note dated 05/22/25 at 6:19 P.M. authored by Licensed Practical Nurse (LPN) #221 revealed Resident #23 was admitted to the facility from the hospital via medical transport. Review of the physician orders revealed Resident #23's scheduled medications included amlodipine (antihypertensive) 10 milligram (mg) daily, Vitamin D3 (supplement) 125 micrograms daily, Folic Acid (supplement) one mg daily, magnesium oxide (supplement) 400 mg daily, multivitamin with minerals (supplement) one tablet daily, thiamine (supplement) 100 mg daily, Vitamin E (supplement) one tablet daily, zinc (supplement) 220 mg daily, Acyclovir (antiviral) 400 mg twice a day, ascorbic acid (supplement) 500 mg twice a day, Gabapentin (for nerve pain) 500 mg twice a day and 300 mg once a day, senna (laxative) 8.6 mg twice a day, and melatonin (for insomnia) three mg at bedtime. A plan of care dated 05/22/25 revealed Resident #23 was at risk for falls related to weakness, limited mobility, and COPD. Interventions included educating and encouraging Resident #23 to use the ramp when going off a curb, to call for assistance before transferring, and food/fluids and personal care items within reach. An order dated 05/22/25 at 8:47 A.M., given by Certified Nurse Practitioner (CNP) #425, revealed Resident #23 could go on leave of absence (LOA) without supervision. CNP #425 was aware the resident was not signing out when he went on LOA, but the resident was alert and oriented. No care plan was initiated at the time the order was received to ensure the residents' safety when leaving on LOA. The 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact, had no documented behavior and required supervision or touching assistance for ambulating. The MDS also revealed Resident #23 had a venous/arterial (continued on next page)		

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ulcer.A nursing note dated 06/06/25 at 7:42 A.M. authored by Nursing Supervisor #311 revealed Resident #23 was found outside in his wheelchair wheeling himself down the road in front of the facility. Resident #23 stated he was going to buy beer. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA.A nursing note dated 06/14/25 at 3:57 A.M. revealed around 3:30 A.M., Resident #23 called the facility and stated he was at a lady friend's house and would return in the morning. Resident #23 refused to give the address of where he was staying. The DON was notified of the phone call. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA.A nursing note dated 06/14/25 at 10:31 A.M. revealed the outgoing nurse gave report that Resident #23 went on a LOA the previous day and did not return. Resident #23 called on 06/14/25 around 10:15 A.M. and stated he was stalked on [NAME] Road (no clarification was provided regarding what the resident meant by stalked) at the bus stop and needed someone to pick him up. An activity person (unidentified) went to pick Resident #23 up. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA.A nursing note dated 06/22/25 at 10:30 A.M. revealed Resident #23 was not in his room during morning medication administration. The outgoing nurse did not give report on Resident #23 and stated she took over the shift at 4:00 A.M. The police arrived at the facility around 10:30 A.M. and stated Resident #23 was found sitting in his wheelchair in the street (location not identified). The Administrator sent someone to pick Resident #23 up. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA. A nursing note dated 07/02/25 at 11:57 P.M. revealed Resident #23 returned to the facility around 11:30 P.M. The note documented the nurse educated Resident #23 about signing out before leaving the facility. Resident #23 stated he would sign out next time. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA. A Preadmission Screening and Resident Review (PASRR) identification screen dated 07/07/25 revealed Resident #23 had no mental disorders or substance use related disorders. However, review of the resident's admission diagnoses revealed the resident had a diagnosis of alcohol abuse.A plan of care dated 07/19/25 revealed Resident #23 had the potential to be discharged . Resident #23 desired to be discharged to home. Interventions included discussing any special equipment needs and to facilitate obtaining the equipment needed prior to discharge, make referrals to other community agencies as needed, and to talk with Resident #23, allowing the resident to express feelings regarding discharge. A nursing note dated 07/22/25 at 6:42 P.M. authored by Agency LPN #900 revealed the DON notified the nurse Resident #23 had left the building without signing the LOA book. Agency LPN #900 had no knowledge of Resident #23 leaving the building without signing the LOA book. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA.A plan of care dated 07/23/25 revealed Resident #23 had a history of substance seeking behavior alcohol and had the potential for complications such as substance abuse, withdrawal symptoms, and mood and/or behavioral disturbances (not identified in the medical record). Resident #23 does sign himself out to go drink. Interventions include to discuss behavioral limits and expectations with Resident #23, if Resident #23 returned from leave of absence and appeared to be impaired, the doctor should be notified for directions regarding administration of regularly scheduled medications and observe for indications the resident may be storing drugs or alcohol in room or on person. The doctor should be notified if drugs or alcohol were found. A nursing note dated 08/09/25 at 6:41 A.M. authored by Agency LPN #901 revealed Resident #23 insisted on leaving the facility to go to the mall around 6:00 A.M. The nurse informed Resident #23 that the mall was usually closed at that time, but Resident #23 stated he was leaving anyway. Several staff attempted to redirect Resident #23 without success. The nursing supervisor on call was made aware of Resident #23 leaving the facility. Record review revealed no new interventions were initiated at this time to ensure the resident's safety when leaving on LOA.A social service note dated 08/11/25 at 2:50 P.M. authored by SSD #312 revealed the writer met with Resident #23 to discuss discharge (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	planning. The note included Resident #23 wanted to discharge on ce his therapy goals were met and he was safe to reside on his own. Resident #23 was unclear if he would be able to return to his previous apartment because he had been late on his rent prior to going to the hospital and had made no attempt to pay the rent. Record review revealed no evidence of any social service follow-up or information related to the resident's progress with therapy goals or ability to safely reside on his own.A nursing note dated 08/12/25 at 7:12 A.M. authored by LPN #902 revealed Resident #23 refused a shower after multiple attempts by the Certified Nursing Assistant (CNA). The note included Resident #23 left the building around 6:45 A.M. and failed to comply with signing the LOA book. There was no additional information related to the circumstances surrounding why Resident #23 left and/or what his condition was at the time he left. Record review revealed no evidence the resident's physician, CNP #425 or responsible party were notified the resident had left at this time.Review of the resident's medical record revealed there was no evidence the resident was offered or provided any type of mental health services. There was no evidence of counseling or behavioral health services while the resident resided in the facility.Review of hospital records revealed on 08/12/25 at 6:45 P.M. Resident #23 entered the emergency department at Ohio State University and then left. On 08/13/25 at 11:43 A.M. a follow up note revealed Ohio State University Hospital did not have a bed available for the resident.A nursing note dated 08/13/25 at 8:48 A.M. and authored by LPN #903 revealed Resident #23 was at the hospital (no additional information was provided in the note).A nursing note dated 08/14/25 at 8:18 A.M. authored by RN #235 revealed Resident #23 was at the hospital.The last nursing note in the medical record dated 08/15/25 at 8:00 A.M. authored by RN #235 revealed Resident #23 was hospitalized . Review of hospital records from (Hospital #1) revealed Resident #23 arrived on 08/13/25 at the emergency department on 08/13/25 at 1:32 P.M. Resident #23 had complaints of a headache and lack of housing. Resident #23 stated he had pressure at the top of his head and rated the pain an eight out of ten (on a 0-10 pain scale with zero meaning no pain and 10 being the worst pain the resident has experienced) and described the pain as crushing. The pressure was slow in onset and progressed throughout the day. Resident #23 stated he got headaches infrequently but had headaches like this before. Resident #23 stated he had been outside most of the day and was homeless. Resident #23 denied any trauma and was not sure if he had been under a lot of stress. Resident #23 was discharged (from Hospital #1) on 08/13/25 at 7:35 P.M. (location not identified).Review of hospital records revealed on 08/15/25 at 9:36 P.M. Resident #23 entered Mount Carmel emergency department. An emergency department note dated 08/15/25 from [NAME] Health/Mount Carmel revealed Resident #23 was found in the middle of the road in his wheelchair. Resident #23 admitted to drinking alcohol. Review of hospital records revealed on 08/19/25 at 2:19 P.M. Resident #23 entered Riverside emergency department. An emergency department provider note dated 08/19/25 at 3:44 P.M. revealed Resident #23 had come to the emergency department with concerns for left foot pain and swelling. Resident #23 reported he was ambulatory and walked around a lot. Resident #23 reported he drank some alcohol today and reported suicidal ideation. Resident #23 stated he could not disclose his plan for harming himself. Resident #23 appeared somewhat disheveled and intoxicated and had bilateral lower extremity pitting edema that was 2+ (indentation is three to four millimeters deep and rebounds in less than 15 seconds) with pain overlying erythema (redness) and some venous stasis (where blood flow in the veins slows down or stops) changes. Resident #23's lower extremities would be treated for cellulitis, suspect cellulitis versus venous stasis dermatitis. The first dose of Keflex (antibiotic) would be given. Hospital notes dated 08/19/25 revealed Resident #23 reported he was suicidal and had been since he was at the skilled nursing facility (Sapphire). When asked if Resident #23 had a plan, he stated there was not a building tall enough in Columbus. Resident #23 stated the building would need to be as tall as the Empire State building. Resident #23 reported he had been having suicidal thoughts for months and wanted to stop the misery. Resident #23 was not able to say when he left the skilled facility but stated it was the second time he had left the same facility (he had a prior admission in April 2025). Resident #23 (continued on next page)		

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported he had not really eaten much in the past two weeks. Resident #23 described his sleep as volatile and reported nightmares and used alcohol to mitigate these symptoms. Resident #23 struggled with homelessness and received an eviction notice prior to hospitalization in May 2025. Resident #23 reported sleeping wherever it was safe. Resident #23 had poor hygiene, and his hair was overly long and matted in the back. Further review of the hospital record revealed an emergency department social worker behavioral health initial assessment completed on 08/19/25 at 8:26 P.M. revealed Resident #23 was currently homeless and stayed wherever is safe. Resident #23 stated there was no one to call for a contact person. An emergency social worker behavioral health updated assessment dated [DATE] at 12:05 P.M. revealed Resident #23 had current severe episode of major depressive disorder with psychotic features. Resident #23 continued to endorse thoughts of suicide with a plan to jump from a building. Resident #23 felt he would be better off dead and knows he was not able to manage his medical needs and should have stayed at the skilled nursing facility where he was sent in May. When asked why he left, he admitted to leaving to get a beer. On 08/21/25 at 2:09 P.M., Resident #23 was discharged from Riverside (and transferred to another hospital). Review of hospital records from Hospital #3 revealed Resident #23 was admitted on [DATE] at 2:11 P.M. from another medical center. Resident #23's principal diagnosis included other specified depressive disorder (dysphoria in the context of alcohol use disorder, multiple medical co-morbidities, and psychosocial stressors). Resident #23 had other diagnoses listed that included alcohol use, tobacco use, cannabis use, recent failure to thrive, multiple myeloma, right groin lymphadenopathy, hypertension, coccyx wound, bilateral lower extremity edema (suspected cellulitis versus venous stasis dermatitis, hyponatremia, and limited mobility wheelchair bound). The note included Resident #23 presented to the emergency department at Hospital #3 on 08/19/25 via emergency medical services reporting foot pain/swelling, alcohol use, and suicidal ideation (SI) with thoughts to jump off a building but stated there was not a tall enough structure in Columbus. Resident #23 described SI for months and wanted to stop the misery. Resident #23 was medically stabilized and transferred to Hospital #2 on 08/21/25 for further care. Hospital records revealed Resident #23 was treated for failure to thrive in May of 2025 and then transferred to Sapphire Rehabilitation (Rehab) on 05/22/25. The note included Resident #23 left the facility in search of beer so the staff at Sapphire Rehab told him he could not return. Resident #23 reported he had not eaten in two weeks, had poor sleep and drank alcohol to cope with nightmares. Upon initial evaluation, Resident #23 shared he had been struggling with homelessness and physical health issues. Resident #23 stated he left Sapphire Rehab due to a desire for beer. Resident #23 was amenable to re-referral to skilled nursing facility and indicated he would remain until formally transferred or discharged. Resident #23 was agreeable with transfer to the medical surgical unit for ongoing physical health stabilization and referral to a skilled nursing facility. A nutrition care initial assessment dated [DATE] at 12:19 P.M. revealed Resident #23 had an unintentional weight loss of more than seven pounds in the last month. Resident #23 had a body mass index of less than 23 and was underweight. A behavioral medicine note dated 08/24/25 at 9:02 P.M. revealed Resident #23 stated his mood was not good. Resident #23 had a flat affect. When asked the reason for the resident's mood, Resident #23 stated I am a homeless man I have no idea what I'm going to do when I get out of here. Review of a facility investigation related to Resident #23's discharge, undated, revealed the investigation documented the resident had left the facility Against Medical Advice (AMA). The investigation included Resident #23's face sheet, care plan, progress notes, recent physician orders, and an AMA form signed by the DON and ADON #341 that was not included in the resident's medical record during the investigation. An AMA Informed Signature form that was privileged and confidential (not part of the medical record) dated 08/13/25 at 1:32 P.M. (this was the same time the resident was at Hospital #1) completed by ADON #341 under Nursing Description revealed Resident #23 returned to the facility after a LOA and refused to sign the LOA book. Resident #23 was asked to sign the LOA book. Resident #23 was educated again on signing the LOA book and Resident #23 stated he would not sign the book. Resident #23 was informed that if he (continued on next page)		

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	refused to abide by facility policies he may not be permitted to return due to insurance authorization (insurance would not pay due to the resident going on LOA). Resident #23 stated he would just leave and refused to sign the LOA book or AMA form. Resident #23 stated Get the (expletive) out of my way. CNP #425 was notified. A note added at the end of the form revealed Resident #23 returned from LOA and stated he was leaving again. The DON and ADON #341 spoke with Resident #23 regarding the LOA and the need to sign out. Resident #23 refused. Resident #23 was educated on the need to sign out LOA for safety. Resident #23 became agitated and stated he would just leave. Resident #23 was alert and oriented. An attempt was made to educate Resident #23 on AMA. Resident #23 stated Get the (expletive) out of my way and refused to sign. Resident #23 left the facility in a wheelchair, and the AMA form was signed by two nurses (DON and ADON #341). ADON #341 was notified on 08/13/25 that Resident #23 had been found outside a hospital and he asked a bystander to call the facility (no clarification as to why the bystander called the facility). The nurse explained to the caller that Resident #23 had left the facility and would need to go to the emergency department for evaluation. Resident #23's girlfriend then came to the facility on [DATE] and stated she could not find Resident #23. The girlfriend was notified where Resident #23 had been taken (hospital information provided since that was near where the unidentified bystander called the facility) and Resident #23 had left. Resident #23's girlfriend/female friend declined to take Resident #23's belongings. The investigation revealed the facility was waiting for further information from the hospital regarding authorization for readmission. There were no staff or resident statements obtained as part of the investigation. During an interview on 08/25/25 at 12:36 P.M., Resident #23's female friend that was listed on the contact list revealed Resident #23 had mental health issues and the facility staff did not care. The friend stated she had located Resident #23, and he was currently at the hospital on a locked behavioral unit. Resident #23 had been living on the streets and was dirty. Resident #23's phone had been shut off and the friend stated she had filed a missing person report because no one knew where Resident #23 was after he left the facility. The friend stated Resident #23 left to get a beer. Resident #23 could not stop drinking and would leave the facility to get beer but always went back to the facility. Resident #23 could not walk very well and had a sore on his bottom when he went to the hospital. During an interview on 08/27/25 at 1:43 P.M., the DON stated Resident #23 liked to leave the facility and not sign the LOA book. The DON reported Resident #23 had left the facility and then come back on 08/13/25 and then wanted to leave again. The DON stated she assumed Resident #23 subsequently went to the hospital because someone called from the area near the hospital at the request of the resident. The DON stated central admissions for the facility was handled offsite, so the DON was not aware if Resident #23 had wanted to return to the facility or where Resident #23 had been discharged to (if discharged) from the hospital. During an interview on 09/02/25 at 3:24 P.M., the DON verified there was no notification to the police, adult protective services or a home healthcare agency when Resident #23 left the facility on [DATE]. The DON stated she considered Resident #23 an AMA discharge since he said he was leaving. The DON revealed Resident #23 made bad decisions but always knew to come back to the facility. When asked about the content and thoroughness of the facility investigation related to the incident, the DON revealed the facility did not complete much investigation into the incident because they didn't think it was an issue. During an interview on 09/03/25 at 9:25 A.M., the DON verified Resident #23 did not receive any type of services for substance abuse or mental health while residing at the facility. The DON stated she believed Resident #23 refused services but verified there was no documentation of Resident #23 being offered any services or refusing services. She also verified there was no discharge planning noted in the medical record such as contacting outside resources or looking into alternate places for the resident to live after the resident voiced, he had lost his apartment. The DON verified the resident did have a care plan for anticipated discharge to home but stated it was never followed. During an interview on 09/03/25 at 10:19 A.M., SSD #312 stated she was unsure what her responsibility was when Resident #23 left the facility on [DATE] because the resident had left on an LOA and never returned. SSD #312 (continued on next page)		

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 09/22/2025
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)		
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed she did contact the police about Resident #23 being missing after his female friend reported she was unable to locate Resident #23. SSD #312 stated she got report that following the resident leaving the facility he was at one hospital, discharged to the community and then was back at a different hospital. During an interview on 09/03/25 at 1:33 P.M., CNP #425 revealed she had not been notified immediately on 08/12/25 when Resident #23 left the facility. CNP #425 was later told Resident #23 had left the facility and would not be returning. During an interview on 09/08/25 at 12:39 P.M., the DON verified Resident #23 left the facility on [DATE] at 6:45 A.M. and did not return. She verified the resident's medical record contained no documentation supporting the resident verbalized he wanted to leave the facility against medical advice and there was no evidence the resident had any behaviors to support him wanting to leave against medical advice. The DON verified the facility considered the resident leaving the facility an AMA discharge because the resident did not return when he left. During an interview on 09/11/25 at 10:20 A.M., Regional Nurse #264 stated Resident #23 had lost his housing and the facility did not know where the resident went when he left the facility on [DATE]. During an interview on 09/11/25 at 10:20 A.M., LNHA #271, the DON, and Regional Nurse #264 revealed they were unable to provide information as to why the police, APS, Ombudsman and/or the resident's female friend were not notified when Resident #23 left the facility on [DATE]. Lastly, the DON and Regional Nurse #264 verified Resident #23 was alert and oriented but made unsafe decisions when he wanted alcohol. An attempt to reach the resident's physician (Physician #450) was made on 09/11/25 at 10:48 A.M. The attempt was unsuccessful. A message was left asking the physician to return the call; however, no return call was received. Further review of the medical record revealed no AMA form located within the medical record regarding the resident requesting to leave the facility AMA, no assessment of the resident's ability to safely leave the facility due to potential decision-making impairment related to alcohol use, no communication or attempts to contact the hospital regarding the resident's status and no behaviors documented. Facility staff continued to document through 08/15/25 the resident remained hospitalized (no hospital identified) with no mention the resident had refused to sign an AMA form and left the facility or make mention the resident had discharged from the facility. The facility policy titled Resident Leave of Absence, dated 12/2024, revealed that all residents leaving the facility must have orders for supervised or unsupervised leave of absence. Residents leaving the facility on leave of absence must sign out when leaving. Prior to opening the door to allow a resident to leave, the nurse would verify the leave of absence order and would communicate the leave of absence with the receptionist. Staff observing a resident leaving the premises and having doubts about the resident being properly signed out, should notify their supervisor at once. The nurse would document in a progress note the time the resident leaves the facility and if known, the purpose. Review of the Facility Assessment Tool dated 07/31/25 revealed the number/average or range of residents with behavioral health needs was four to five residents, and those with active or current substance use disorders were four to five residents. The assessment revealed the facility managed the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder, and other psychiatric diagnoses, intellectual or developmental disability. Emotional support and mental well-being and support with helpful coping mechanisms would be provided. The facility would identify hazards and risks for residents. Behavioral and mental health providers were available to provide services to residents. This deficiency represents noncompliance investigated under Complaint Number 2596080.		

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 09/22/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, policy review, review of an Ohio Department of Health (ODH) educational pamphlet, and facility policy review, the facility failed to ensure Resident #107 was adequately supervised while outside and had a way to summon staff assistance. Actual Harm occurred on 08/16/25 when Resident #107, who had been outside in 88 degree Fahrenheit (F) weather, had a change in condition and had a body temperature of 106 degrees F (normal body temperature 98.6 degrees F) and was subsequently hospitalized for heat exhaustion. An additional finding that did not rise to Actual Harm but had the potential for more than minimal harm occurred when the facility failed to ensure Resident #15's fall was thoroughly investigated and accurately documented. This affected two (Residents #107 and #15) of five residents reviewed for accidents. The facility census was 96. Findings include: 1. Review of Resident #107's medical record revealed an admission date of 07/20/17 with diagnoses including dysphagia, cognitive communication deficit, type two diabetes mellitus, cerebral infarction, vascular dementia, peripheral vascular disease, epilepsy, sickle-cell disease, contracture of left foot and hand, and flaccid hemiplegia affecting left nondominant side. Review of Resident #107's plan of care, revised 05/10/24, revealed the resident had an activity of daily living (ADL) self-care performance deficit related to decreased mobility, use of assistive devices, assist of staff, left side flaccid hemiplegia and contractures, diagnoses, impaired decision making and safety awareness. Interventions included varying ADL levels, hoyer for transfers, distant supervision for meals, assisting with ADL's as needed, assist with propelling around facility as needed, and therapy evaluation as needed. Review of Resident #107's Minimum Data Set (MDS) quarterly assessment, dated 06/14/25, revealed the resident had intact cognition. He was dependent on staff for wheelchair mobility. Review of Resident #107's progress note dated 08/16/25 at 12:53 P.M. revealed Resident #107 was outside by the door drinking water. Staff observed the resident display symptoms that included dizziness, fatigue, and flushed skin. The resident was immediately assisted indoors and positioned in a cool shaded area. Additional cool fluids were offered and damp cloths were applied to cool the resident. His vital signs showed an elevated temperature of 106 degrees F, a blood pressure of 109 over 56 millimeters of mercury (mmHg), oxygen saturation at 80 percent and heart rate of 123 beats per minute. Oxygen was administered at two liters. The resident was alert and oriented to person only. The physician and family were notified and the resident was sent to a local hospital for further evaluation. When emergency medical services arrived, Resident #107's temperature was 99.1 degrees F. Review of Resident #107's hospital paperwork from 08/16/25 to 08/18/25 revealed the resident presented to the hospital with dyspnea and hypotension. The resident was diagnosed with acute respiratory failure and newly required supplemental oxygen. The hospital records referenced the resident's body temperature had registered 106 degrees F at the facility and the resident's symptoms were likely an element of heat exhaustion and dehydration from being outside. Resident #107 received intravenous fluids and oral intake was encouraged. Resident #107 was discharged from the hospital and returned to the facility on [DATE]. (continued on next page)		

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 09/22/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the website www.timeanddate.com/weather/usa/columbus/historic revealed on 08/16/25 at 11:51 AM and 12:51 P.M., the temperature was 88 degrees F in Columbus, Ohio. Review of Resident #107's medical record and facility documents revealed no further documentation related to this incident. During an interview on 08/26/25 at 2:31 P.M., the Director of Nursing (DON) stated the facility had not conducted any further investigation into this incident as she felt the progress note covered it. During an interview on 08/26/25 at 2:51 P.M., Residents #3 and #96 stated Resident #107 was brought into the courtyard by staff and left unattended by staff on multiple occasions. They stated Resident #107 was unable to move his wheelchair on his own. Resident #3 and Resident #96 reported on 08/16/25, Resident #107 had been placed in the sun. Resident #96 stated he told staff that he thought Resident #107 was too hot and it took them 15 to 20 minutes to check on him. During an interview on 08/26/25 at 4:43 P.M. and on 08/27/25 at 12:06 P.M., Registered Nurse (RN) #253 initially stated Resident #107 was brought outside after breakfast and then clarified this to state the resident was taken outside around 11:00 A.M. Resident #107 was taken back inside around 12:00 P.M. RN #253 reported she had been checking on Resident #107 every twenty minutes while he was outside. He was in the shade and had fluids within reach. She reported it was very hot outside that day, and he was wearing a polo shirt, long pants, and had a top sheet on him. During one of her checks, she discovered his change in condition and brought him inside. RN #253 verified when he was outside, the resident had no way to get the staff's attention, and it was the staff's responsibility to check on him. Review of the Ohio Department of Health (ODH) pamphlet titled Heat-related illness in individuals using psychiatric medication, dated 2022, revealed risk for heat-related illness increase with age over 65 and diseases including heart disease, hypertension, and diabetes. Heat exhaustion was a moderate form of heat related illness. It occurs in high heat conditions when excessive sweating leads to fluid and salt loss and the body is unable to cool itself. Symptoms include heavy sweating, rapid and weak pulse, pale and clammy skin, muscle cramps, tiredness or weakness, dizziness or fainting, and nausea or vomiting. Heat stroke was a severe form of heat-related illness and a medical emergency. In this condition the body temperature can rise to temperature of 106 degrees F or higher, which can lead to permanent injury or death. Signs included very high body temperature, skin that is hot, red, dry or damp, rapid strong pulse, confusion or unconsciousness, dizziness or fainting, and nausea or vomiting. 2. Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses of unspecified psychosis, left side rib and right lower leg fracture, blindness, and delirium. The care plan for falls dated 02/20/25 revealed Resident #15 was at risk for falls due to history of falls, impaired balance/poor coordination, poor safety awareness, potential medication side effects, unsteady gait, and vision/hearing problems. Interventions dated 02/20/25 included to administer medications as ordered, do not leave on the toilet unattended, encourage non-skid footwear to be worn for transfers and ambulation, encourage resident to participate in activities, encourage to transfer and change positions slowly, evaluate medications if resident demonstrates changes in mental status, activities of daily living (ADL) function, appetite, and neurological status. Commonly used articles to kept within easy reach. Reinforce Resident #15 to call for assistance. The development of pain, bruises, change in mental status, ADL function, appetite, and neurological status (continued on next page)		

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 09/22/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	aft a fall. The care plan was updated on 04/24/25 for Resident #15's urinal to be in a designated place. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #15 had impaired cognition. Resident #15 used a wheelchair and required partial to moderate assistance for transfers. The care plan was updated on 06/05/25 for Resident #15 to be in the common area when out of bed. A nursing note dated 06/08/25 at 7:44 P.M. revealed Resident #15 was found on the floor with a head laceration. There was a moderate amount of blood noted on Resident #15's gown. Resident #15 was transported to the emergency department for evaluation. A fall risk evaluation dated 06/08/25 at 7:44 P.M. revealed Resident #15 had intermittent confusion, one to two falls in the past three months, was chair bound, was legally blind, and required assistive devices. The previous care plan was followed when the fall occurred (nothing identified what interventions were in place). A new intervention was put in place to offer Resident #15 toileting after dinner. The fall investigation dated 06/08/25 revealed Resident #15 was found in the bathroom. Resident #15 had been walking and had an unwitnessed fall. Resident #15's call light was within reach but was not on. Resident #15's room was well lit, and Resident #15 was wearing gripper socks. Resident #15 was alert and oriented to the situation. Resident #15 had a right-side head laceration and was sent to the hospital with seven out of ten pain on a scale of zero to ten with ten being the worst pain. There had been no recent medication changes or infections. Resident #15's care plan was not updated. Review of the fall investigation that was marked as privileged and confidential and not part of the medical record dated 06/08/25 revealed Resident #15 had gait imbalance, was ambulating without assistance, The care plan was updated on 06/08/25 with a new intervention to offer Resident #15 toileting after dinner. A nursing note dated 08/12/25 at 7:07 A.M. revealed Resident #15 was found on the edge of the floor mat scooting towards the door. Resident #15 stated he scooted off the bed but was unable to stand. An observation on 08/26/25 at 2:48 P.M. revealed Resident #15 was lying in a low bed with a regular sized mattress on the floor next to the bed. An observation on 09/02/25 at 10:26 A.M. revealed Resident #15 was lying in low bed, and a regular sized mattress was propped up against the wall. An interview on 09/02/25 at 10:27 A.M. with Registered Nurse #254 revealed the mattress was only to be used at night. An observation on 09/02/25 at 10:52 A.M. revealed Resident #15 was lying in a low bed, and the regular mattress was now on the floor next to Resident #15's bed. An interview on 09/03/25 at 3:54 P.M. DON stated Resident #15 was probably in bed and got out of bed when he fell on [DATE]. The DON stated she interviewed a staff member after the surveyor asked where Resident #15 had been prior to the fall, and they said Resident #15 had been in bed prior to ambulating to the bathroom by himself. The DON verified the documentation did not reveal if Resident #15 had been in bed prior to the fall and if Resident #15's urinal was in the designated spot. The DON also verified there was not an order or a fall intervention in place for the use of a mattress on the floor in Resident #15's room. DON verified a problem with the documentation and implementation of fall interventions for Resident #15. Review of the Fall Prevention Policy dated November 2024 revealed all residents will be assessed for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	fall risk on admission, readmission, and with any significant change in condition. Staff will take proactive measures to ensure resident safety and minimize fall risks.		

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 09/22/2025
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)		
F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, police report review, self-reported incident review, policy review, and facility assessment review, the facility failed to identify, address, and obtain appropriate services to meet the behavior health care needs of Resident #5 and failed to develop and implement an individualized comprehensive care plan to address and support the behavioral health care needs of Resident #5. Actual harm occurred on 08/03/25 when Resident #5, who had diagnoses of anxiety, intellectual disability, traumatic brain injury (TBI) and a history of self-injurious behavior of cutting, became agitated with staff during care and brandished a knife and threatened Certified Nursing Assistant (CNA) #350 that he was going to gut her. The police were contacted and Resident #5 was subsequently removed from the facility and placed in jail after a warrant was issued for his arrest. Prior to the incident, the facility failed to ensure comprehensive and individualized behavioral health interventions were in place to prevent the incident from occurring. This affected one (Resident #5) of three residents reviewed for mental health disorders. The facility census was 96. Findings include: Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including chronic pain, anxiety disorder, history of traumatic brain injury (TBI) in 2019, and paraplegia. A diagnosis of mood disorder was added on 08/12/25. The hospital exemption pre-admission screening notification dated 07/14/25 revealed Resident #5 had a mood disorder including depression and anxiety. Resident #5 also had a TBI and resided at an intermediate care facility (ICF) or intermediate care facility for individuals with intellectual disabilities (IID) before hospitalization. Review of employee list provided by Regional Director of Operations (RDO) #261 revealed Social Service #700 was employed from 06/06/24 to 07/18/25. Social Service #312 was hired on 07/31/25 and started working on 08/11/25. The facility did not have social services from 07/19/25 through 08/10/25. Review of physician orders revealed Resident #5 was ordered Cymbalta (antidepressant) 30 milligram (mg) in morning, Cymbalta 60 mg in the evening, Trazodone (antidepressant) 25 mg at bedtime, Depakote (used as a mood stabilizer) 500 mg every 12 hours, and hydroxyzine (used to treat anxiety) 25 mg three times a day. Review of hospital records (part of Resident #5's facility medical record) revealed Resident #5 was transferred to the hospital on [DATE] with intractable pain. Hospital records revealed Resident #5 had an inpatient consultation for behavioral health on 07/20/25. The record revealed Resident #5 was a [AGE] year-old male with a known intellectual disability and TBI, paraplegia, and chronic pain syndrome. Behavioral health services were consulted to evaluate Resident #5's episodes of agitation and labile (rapid and uncontrollable shifts in emotional states, often resulting in exaggerated emotional responses that may seem inappropriate to the situation) encounters with staff. Resident #5 has a history of depression and anxiety which were thought to be related to his TBI. This was complicated by poor frustration tolerance and maladaptive (inappropriate) coping strategies that often times involved him having episodes of agitation. Due to TBI, Resident #5 would always struggle with poor frustration and irritability. This was further limited by baseline intellectual disability and maladaptive coping skills. Resident #5 had past self-injurious behavior of cutting as recently as February 2025. A psychotropic medication consent dated 07/24/25 revealed Resident #5 took antianxiety, antidepressant, and sedative/hypnotic medication. Diagnoses or indications for use included anxiety, depression, and insomnia/sleep disorder with targeted behaviors of agitation, decreased socialization/withdrawal, and insomnia/sleep disturbance. An admission Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was cognitively intact and had no behaviors. An incident report from the police department dated 08/03/25 revealed at 6:15 P.M. the police were dispatched on a report of a resident with a knife. Upon arrival at 6:17 P.M., the resident was located and complied with officers' commands to drop the knife. The suspect (Resident #5) and victim (CNA #350) stated the incident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0740 Level of Harm - Actual harm Residents Affected - Few	arose from an argument regarding Resident #5's care. During the argument, Resident #5 began throwing food, feces, and miscellaneous items at CNA #350 causing minor injury to CNA #350's arm and hand. Resident #5 brandished a knife and drove CNA #350 out of his room. The knife used in the incident and another small knife were seized from Resident #5's room. Due to the patient's condition, officers were unable to remove Resident #5 from the facility. CNA #350 was provided with the report number and victim's rights information. The narrative notes from the police department revealed Resident #5 was located in the hallway outside of his room in possession of a multicolored butterfly knife (a folding pocketknife with two handles that rotate around a pivot to enclose the blade. When the handles are swung apart, the blade becomes exposed, and the handles can then be gripped to click it in an open position). A police officer commanded Resident #5 to drop the knife and Resident #5 complied. Once the scene was secured, Resident #5 and CNA #350 were interviewed. Resident #5 had a bowel movement on an incontinence pad and CNA #350 had entered the room to provide care. Resident #5 overheard CNA #350 discussing what had happened with another staff member and Resident #5 became frustrated. Resident #5 and CNA #350 engaged in a verbal argument about Resident #5's care, which quickly escalated verbally. Resident #5 then began to throw food, a water pitcher, and a soiled incontinence pad causing minor injury to CNA #350's forearm and hand. CNA #350 left Resident #5's room and entered the hallway. Resident #5 followed CNA #350 in his wheelchair, brandishing a multicolored butterfly knife. Resident #5 stated the knife was open while he was in his room, but he closed it when he went into the hallway. Resident #5 denied making any threatening statements related to the knife towards CNA #350. CNA #350 stated Resident #5 threatened to stab and gut her. While there were numerous caretakers and residents in the hallway that observed Resident #5 wielding the knife, there were none close enough to provide a statement on what words Resident #5 used nor the events leading up to Resident #5 leaving his room and entering the hallway. The butterfly knife and a [NAME] multitool (a versatile, portable device that packs multiple tools, such as pliers, knives, screwdrivers, and saws, into a single, compact design) were seized from Resident #5's room. Due to Resident #5's condition, he was unable to be transported to police headquarters or jail. The report revealed Resident #5 would remain at the facility to receive treatment until other arrangements could be made. As part of the facility investigation beginning 08/03/25, the following statements were obtained: A typed statement by the Director of Nursing (DON) about an incident on 08/03/25. The nurse was notified there had been an incident between a resident and a staff member. Resident #5 was being assisted by CNA #350 with incontinence care. CNA #350 cleaned up Resident #5 and placed the soiled linens in a trash bag. CNA #350 exited the room to speak with Resident #5's nurse regarding care when Resident #5 became agitated and started yelling. Resident #5 began throwing items at CNA #350. Resident #5 picked up a urinal to throw at CNA #350 and CNA #350 pushed the trash bag aside with her foot and closed the door. Resident #5 then came out of his room and yelled profanities and racial slurs at CNA #350. Resident #5 was brandishing a switchblade style knife and threatening CNA #350. The police were called, and the knife was removed from Resident #5 by the police. The police searched Resident #5's room for additional contraband. The police took statements from the staff and Resident #5 was placed on frequent observations until cleared by Certified Nurse Practitioner (CNP) #425 after a face-to-face visit. A handwritten, undated, statement by Unit Manager/Licensed Practical Nurse #347 revealed they received call from the weekend supervisor (unidentified) on 08/03/25 at 6:20 P.M. The supervisor stated that police were in the facility because Resident #5 pulled a knife on a staff member. This nurse asked to speak with the staff member (CNA #350). CNA #350 stated Resident #5 became upset with CNA #350 after care was completed. Resident #5 then grabbed a knife and followed CNA #350 out of the room into hallway. Resident #5 was yelling I will gut you (expletive). Resident #5 began throwing items, screaming and yelling. This nurse advised the supervisor to make sure all staff and residents were out of harm's way. This nurse then notified the DON and administrator. A statement by CNA #257 revealed the CNA was picking up trays and saw Resident #5 with a knife. CNA #257 stated Resident #5 wheeled out (continued on next page)		

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 09/22/2025
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)		
F 0740 Level of Harm - Actual harm Residents Affected - Few	fast toward CNA #350 yelling and saying Resident #5 would wound CNA #350. CNA #257 quickly walked past Resident #5's door and alerted all staff and residents who were around to run. As everyone was running Resident #5 took the soiled linen out of the bag and put feces on top of the medication cart and on the floor. CNA #257 only knew what happened when Resident #5 came out with a knife. A handwritten statement by Unit Manager (UM) #345 revealed CNA #350 called about the incident which involved Resident #5 and a knife. CNA #350 stated after completing incontinence care for Resident #5, she suggested Resident #5 use disposable incontinence pads. CNA #350 left the room to notify the nurse that the dressing to Resident #5's bottom was soiled. Resident #5 began yelling and CNA #350 went to see what was wrong. Resident #5 began throwing items at CNA #350. Resident #5 was cursing and using racial slurs. Resident #5 reached for his urinal with urine in it. CNA #350 shut Resident #5's door to prevent Resident #5 from hitting CNA #350 and others with objects that were being thrown. Moments later, Resident #5 came out of his room in his wheelchair holding a knife and wheeled toward CNA #350 stating he was going to gut CNA #350. The police were called. The medical record revealed a form completed with 15-minute checks for Resident #5 from 08/03/25 at 5:45 P.M. until 08/04/25 at 11:15 A.M. A care plan dated 08/04/25 (following the incident) revealed Resident #5 had alteration in behavior with abusive attacks on staff and/or other residents. Resident #5 was physically abusive and pulled a knife on a staff member. Interventions included to approach Resident #5 in a low, calm voice, document the behavior as to type, duration, and precipitating causes, encourage Resident #5 to discuss and vent angry feelings, inform the doctor/nurse practitioner of worsening behavior, intervene as needed to protect the rights and safety of others, approach/speak to Resident #5 in a calm manner, divert attention, remove from situation and take to another location as needed, and set limits on aggressive behavior and communicate expectations to resident to prevent injury to Resident #5 and others. A note dated 08/04/25 by Certified Nurse Practitioner (CNP) #425 revealed Resident #5 was seen for an alleged altercation. Resident #5 allegedly pulled a knife on a CNA. Resident #5 reported different circumstances and stated CNA #350 threw trash at Resident #5. The weapons had been removed from Resident #5, and it was okay to remove Resident #5 from one-on-one monitoring. No concerns were found during the exam and there were no concerns about safety. Resident #5 had a mood disorder versus personality disorder versus manipulative behaviors with increasing agitation. A note dated 08/05/25 by Physician #450 revealed Resident #5 became aggressive and threatening towards staff over the weekend. The police were called and de-escalated the situation and confiscated his knife. Resident #5's overall demeanor since that episode had been improved and Resident #5 was no longer irritable and no longer threatening staff. Physician #450 was unclear about the details about what started the incident as Resident #5 stated he did not like something the staff member did. The incident report from the police department revealed on 08/05/25 at 2:00 P.M. a detective returned to the facility to request information regarding Resident #5's ability to leave the facility to attend court. It was confirmed there were no witnesses to this incident and facility cameras in the hallway were not working. The facility staff stated they were starting the process to have Resident #5 relocated to another facility and CNA #350 would be kept from working the unit Resident #5 resided on. The incident report from the police department revealed on 08/07/25 at 11:41 A.M. a detective returned to Mirandize Resident #5. Resident #5 refused to answer questions or provide a statement. Resident #5 was served with two charges and given summons to appear in court on 08/22/25 at 9:00 A.M. The detective spoke with someone in the manager's office and notified them that Resident #5 had been served. The male in the manager's office (not identified) stated the process had been started to transfer Resident #5 to another facility. A preadmission screening and resident review (PASRR) dated 08/12/25 was completed because Resident #5's hospital exemption notification ([NAME]) was expiring. A mental disorder of panic or other severe anxiety disorder was checked. A mood disorder was not checked. Indications of intellectual and developmental disability revealed Resident #5 had a TBI. A referral had been made for Level II evaluation. The typed statement/timeline completed by the DON revealed on 08/22/25 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0740 Level of Harm - Actual harm Residents Affected - Few	Resident #5 was scheduled to attend his arraignment at [NAME] County Municipal Court. Transportation was arranged by the facility, but Resident #5 refused to attend. A progress note dated 08/27/25 at 4:05 P.M. revealed two officers arrived to arrest Resident #5. Resident #5 had an active warrant for Aggravated Menacing and Assault. Resident #5 was transported to jail via an ambulance due to his health conditions. An interview on 08/27/25 at 1:56 P.M. with the DON revealed she was told the police arrived within a few minutes of being called and Resident #5 was in the hallway in front of his room when the police arrived (the date of the incident). Resident #5 was put on 15-minute checks after the police left. The DON thought Resident #5 would be put on a 72-hour psychological hold but he was not. The CNP talked with Resident #5 the next day, and felt Resident #5 was no longer a threat and Resident #5 was taken off the 15-minute checks. An interview on 08/28/25 at 10:19 A.M. CNA #350 revealed on 08/03/25 Resident #5 had removed his incontinence brief to defecate on a cloth pad in the bed. CNA #350 cleaned up the feces and placed the soiled linens in a trash bag. While cleaning Resident #5, CNA #350 noticed the bandage to Resident #5's bottom was soiled. CNA #350 stated the nurse was outside Resident #5's room. CNA #350 sat the trash bag down inside the doorway of Resident #5's room and started telling the nurse about the bandage being soiled. Resident #5 became upset and started yelling not to talk about him. CNA #350 went back into Resident #5's room to explain why she was talking to the nurse. Resident #5 threw a Styrofoam food container and then his tray. CNA #350 put her arms up to block the tray, and her arms had become bruised. Resident #5 then picked up his urinal with urine in it. CNA #350 used her foot to kick the trash bag with soiled linen out of the way and went out into the hallway and shut Resident #5's door so she and anyone else would not be hit with the urinal. Resident #5 must have transferred himself to his wheelchair and opened the door leading into the hallway. Resident #5 opened the trash bag and threw the soiled linens. Feces from the soiled lines went onto the floor and medication cart. Resident #5 had a knife and started towards CNA #350 stating he was going to gut her. CNA #350 verified there were residents in the hallway and CNA #350 was afraid that Resident #5 would focus his anger on other residents if she ran away. CNA #350 called the police on her cellphone but stood still in the hallway. CNA #350 stated she talked with a Unit Manager and gave a report to the police. CNA #350 stated the facility did not ask her to write a statement about what happened. CNA #350 verified there was no information provided to staff, verbally or in the medical record, about Resident #5 becoming easily agitated or upset or there being any concerns with inappropriate behavior or coping skills. An interview on 08/28/25 at 10:41 A.M. CNA #257 verified there were residents in the hallway when Resident #5 had a knife. CNA #257 stated everyone ran away and the staff waited for the police to arrive. CNA #257 stated she had not provided any care for Resident #5 that day or any time prior. CNA #257 ended the interview stating she should not say any more. An interview on 08/28/25 at 10:44 A.M. DON verified there was not an individualized or comprehensive plan of care in place to address Resident #5's behavioral/mental health needs including his poor frustration tolerance, intellectual disabilities, and maladaptive coping strategies that could involve him in having episodes of agitation, irritability. The facility filed self-reported incident tracking number 264663 on 08/29/25 related to an allegation of emotional/verbal abuse by staff towards Resident #5. Resident #5's relevant conditions included mood disorder, anxiety disorder, TBI, and paraplegia. An interview on 09/02/25 at 9:09 A.M. with the DON revealed the facility received a police report regarding the incident (on 08/03/25) with Resident #5 and CNA #350. Verbiage in the police report included verbal altercation so Licensed Nursing Home Administrator #271 felt out of abundance of caution a self-reported incident should be filed with the State agency. The DON stated CNA #350 refused to write a statement stating she had given a statement to the police. The DON verified Resident #5 was taken to jail for failure to appear in court and was still in jail as of this date. An interview on 09/03/25 at 9:25 A.M. with the DON revealed she believed Resident #5 had declined any psychological services. However, the DON was unable to provide any documentation of services being offered and Resident #5 refusing any such mental health services. In addition, the DON revealed the facility had had six different social service workers since (continued on next page)		

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 09/22/2025
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)		
F 0740 Level of Harm - Actual harm Residents Affected - Few	02/22/24 (social service staff were responsible for overseeing mental health services for residents in the facility). An interview on 09/03/25 at 1:33 P.M. with CNP #425 revealed she thought Resident #5 did receive services from psychiatric services but was unsure where the documentation was to determine why. CNP #425 also revealed she was not aware Resident #5 had a history of cutting himself. An interview on 09/03/25 at 3:56 P.M. with the DON verified she was not aware Resident #5 had a history of cutting himself and problems with agitation. The DON stated admissions were done off-site and the facility had to admit the residents that the central admissions department sent them. An interview on 09/04/25 at 10:06 A.M. with Social Services (SS) #312 revealed the PASSAR for Resident #5 was completed by the listed diagnoses. SS #312 verified diagnoses of an intellectual disability, and a mood disorder were not added for Resident #5 until 08/12/25 even though the [NAME] assessment dated [DATE] indicated Resident #5 had a mood disorder including depression, anxiety, and TBI. The [NAME] also revealed Resident #5 had resided in an ICF/IID prior to hospital admission. SS #312 verified Resident #5 had been discharged from the facility with an anticipated return to the facility because Resident #5 was in jail. SS #312 verified a Level II referral had been made on 08/12/25 when the new PASSAR was completed. An interview on 09/04/25 at 10:13 A.M. with MDS Nurse # 343 revealed previous diagnoses such as self-harm or intellectual disabilities could not be used unless the doctor ordered the diagnoses. An interview on 09/04/25 at 2:14 P.M. with the DON verified Resident #5 was still in jail as of this date. The DON verified the facility did not send a medication list, list of diagnoses, or medical history to the jail. The DON stated the police officers thought Resident #5 would be returning to the facility the same day. The DON stated the jail could contact the facility if they needed any information about Resident #5. Review of the Facility Assessment Tool dated 07/31/25 revealed the number/average or range of residents with behavioral health needs was four to five residents, and those with active or current substance use disorders were four to five residents. The assessment revealed the facility managed the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder, and other psychiatric diagnoses, intellectual or developmental disability. Emotional support and mental well-being and support with helpful coping mechanisms would be provided. The facility would identify hazards and risks for residents. Behavioral and mental health providers were available to provide services to residents.		

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 09/22/2025
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)		
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, review of staff time punches, and review of facility policy, the facility failed to have sufficient staffing in the kitchen to maintain a clean kitchen and to serve residents on appropriate dishware. This had the potential to affect all 96 residents residing in the facility who consumed food by mouth from the facility kitchen. Findings include: 1. Observation on 08/25/25 from 9:10 A.M. to 9:28 A.M. revealed the following concerns in the kitchen: a. The wall behind the handwashing sink was covered in food splatter. b. Boxes of food were on the floor, not six inches off the ground. There were 11 boxes piled up in the freezer, over 13 boxes piled up in the walk-in refrigerator, and 17 boxes in dry storage. c. Shelves on all food prep tables, the shelf in the dishwashing area, and the table that had a griddle on it, had a large buildup of food debris and stains. d. The ice machine had a black or gray build up in the back. e. Nine ceiling tiles surrounding a vent were covered in a thick black dust, this went down the wall, which was peeling. f. There were two open containers of sugar that were undated and unlabeled, one container had a scoop in it. g. In the freezer there was a large orange spill that had frozen and was not cleaned up. h. In the refrigerator there were multiple open unlabeled and undated foods including three containers of shredded cheese, two containers of sliced ham, and one container of what was likely deli chicken or turkey. i. There were three drawers containing serving utensils such as scoops, tongs, and spoons. Each drawer was lined with soiled aluminum foil. The drawers had a large amount of food debris and splatters. Interview on 08/25/25 from 9:10 A.M. to 9:28 A.M. with [NAME] #211 and Licensed Nursing Home Administrator (LNHA) #200 revealed the facility's dietary manager had quit last week and they were short staffed, so cleaning had not been a priority. [NAME] #211 reported they had received a food delivery on Friday, and they had not put away the delivered items. [NAME] #211 reported a little while ago, the freezer had been down and something orange had melted in the freezer and had not been cleaned up prior to the freezer re-freezing. [NAME] #211 and LNHA #200 verified all observations. 2. Observation on 08/25/25 from 9:10 A.M. to 9:28 A.M. revealed Dietary Aide #207 cleaning the breakfast trays. All trays had Styrofoam containers and plastic silverware. Interview on 08/25/25 from 9:10 A.M. to 9:28 A.M. with Dietary Aide #207 verified they had used Styrofoam containers for breakfast that day. She reported this was due to there only being her and [NAME] #211 working in the kitchen that morning. She said they would not have been able to get the dishes clean for lunch with just the two of them. Review of time punches for 08/25/25 revealed from 5:44 A.M. to 10:50 A.M. there were only two staff (Cook #211 and Dietary Aide #207) in the kitchen. Review of the facility policy 'Sanitization' revised October 2008, revealed the kitchen area was to be kept clean. All utensils, counters, shelves and equipment were to be kept clean. Food preparation equipment and utensils were to be allowed to air dry whenever practical. The ice machines were to be drained, cleaned, and sanitized per manufacturer's instructions.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy revealed the facility failed to maintain a clean and sanitary kitchen and serve beverages in clean cups for the B Unit. This had the potential to affect all 96 residents who consumed food from the kitchen and the 47 residents residing on the B unit (#4, #5, #7, #8, #9, #11, #12, #14, #17, #19, #22, #24, #26, #28, #30, #31, #33, #35, #36, #37, #38, #40, #41, #47, #54, #59, #61, #65, #70, #75, #76, #80, #81, #85, #86, #87, #89, #93, #96, #98, #99, #101, #102, #103, #105, #106, #107). The facility identified all residents received meals/beverages from the kitchen. Findings include: 1. Observation on 08/25/25 from 9:10 A.M. to 9:28 A.M. revealed the following concerns in the kitchen: a. The wall behind the handwashing sink was covered in food splatter. b. Boxes of food were on the floor, not six inches off the ground. There were 11 boxes piled up in the freezer, over 13 boxes piled up in the walk-in refrigerator, and 17 boxes in dry storage. c. Shelves on all food prep tables, the shelf in the dishwashing area, and the table that had a griddle on it, had a large buildup of food debris and stains. d. The ice machine had a black or gray build up in the back. e. Nine ceiling tiles surrounding a vent were covered in a thick black dust, this went down the wall, which was peeling. f. There were two open containers of sugar that were undated and unlabeled, one container had a scoop in it. g. In the freezer there was a large orange spill that had frozen and was not cleaned up. h. In the refrigerator there were multiple open unlabeled and undated foods including three containers of shredded cheese, two containers of sliced ham, and one container of what was likely deli chicken or turkey. i. There were three drawers containing serving utensils such as scoops, tongs, and spoons. Each drawer was lined with soiled aluminum foil. The drawers had a large amount of food debris and splatters. Interview on 08/25/25 from 9:10 A.M. to 9:28 A.M. with [NAME] #211 and Licensed Nursing Home Administrator (LNHA) #200 revealed the facility's dietary manager had quit last week and they were short staffed, so cleaning had not been a priority. [NAME] #211 reported they had received a food delivery on Friday, and they had not put away the delivered items. [NAME] #211 reported a little while ago the freezer had been down and something orange had melted in the freezer and had not been cleaned up prior to the freezer re-freezing. [NAME] #211 and LNHA #200 verified all observations. 2. Observation on 08/26/25 at 8:25 A.M. and 8:40 A.M. revealed Medical Records #273 cleaning the cups on unit B with a rag. These cups were used to provide beverages to residents on the B Unit. At 8:40 A.M. an observation revealed more than half the unit had been served and Medical Records #273 was still wiping out the cups. The cups were not wet, and they had a buildup of a white residue inside them. Interview on 08/26/25 at 8:40 A.M. with Medical Records #273 verified the cups were not appropriately cleaned, but she had been trying to wipe them out. Medical Records #273 reported she would return them to the kitchen. Review of the facility policy 'Sanitization' revised October 2008, revealed the kitchen area was to be kept clean. All utensils, counters, shelves and equipment were to be kept clean. Food preparation equipment and utensils were to be allowed to air dry whenever practical. The ice machines were to be drained, cleaned, and sanitized per manufacturer's instructions.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and facility policy review, the facility failed to ensure kitchen trash cans were appropriately contained. This had the potential to affect all residents residing in the facility. The facility census was 96. Findings include: Observation on 09/03/25 at 8:30 A.M. and 11:14 A.M. revealed two large, approximately 20 gallon, trash containers filled with trash. One container was near the handwashing station, and the other one was near the dishwashing area. Both containers were filled with trash and open with no lids or coverings on them. Interview on 09/03/25 at 11:20 A.M. with Dietary Manager (DM) #269 confirmed that the two containers were uncovered and needed lids or covering. DM #269 obtained lids for the trash containers at time of discovery. Review of the policy Sanitization dated October 2008, revealed kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent, tightly closed containers and shall be disposed of daily.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on staff interview, review of the surety bond, and review of facility resident financial account balances, the facility failed to ensure that their surety bond was sufficient to cover the highest resident daily funds balance. This had the potential to affect 45 resident accounts that were managed by the facility. The facility census was 96. Findings include: Review of the facility surety bond dated 12/27/24 revealed that the facility had a surety bond in the amount of \$50,000.00 dollars. Review of the facility's Resident Fund Management Service (RFMS) resident balance sheet, dated 09/03/25, revealed that the total current balance of all resident accounts was \$59,786.08 which was \$9,786.08 higher than the surety bond amount. Interview on 09/03/25 at 4:10 P.M. with Regional Business Office Manager (RBOM) #267 confirmed that the amount of the surety bond was not enough to cover the 09/03/25 current resident funds balance.		

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 09/22/2025
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure Minimum Data Set (MDS) assessments were filled out accurately and timely. This affected four residents (#4, #10, #19 and #64) of 40 sampled for the annual survey. The facility census was 96. Findings include: 1. Review of Resident #10's medical record revealed an admission date of 04/18/25 and diagnoses including, but were not limited to, diabetes, dementia, major depressive, hypertension, asthma, and other sequelae of cerebral infarction Review of resident #10's physicians orders revealed an order dated 04/19/25 for aspirin 81 milligrams daily by mouth. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment, dated 06/11/25, revealed a Brief Interview for Mental Status (BIMS) could not be completed because the resident was rarely/never understood. The resident required set-up assistance for eating, was independent for bed mobility, and required supervision for transfers and ambulation. Resident #10's MDS indicated he was occasionally incontinent of bladder and frequently incontinent of bowel and was working with physical therapy at the time of the assessment. Further review of Resident #10's MDS revealed the MDS was not marked that the resident was receiving antiplatelet medications and was not signed as complete until 07/12/25. In an interview on 09/02/25 at 4:15 P.M., MDS Nurse #343 confirmed Resident #10's MDS was incorrectly marked that the resident was not receiving antiplatelet medication and that the quarterly assessment was completed more than 14 days after the Assessment Reference Date (ARD). 2. Review of Resident #64's medical record revealed an admission date of 11/25/24 and diagnoses including, but were not limited to, depression, anxiety disorder, Vitamin D deficiency, hypertension, diabetes, and unspecified dementia. Review of Resident #64's quarterly MDS assessment, dated 06/02/25, revealed a BIMS score of two indicating the resident had severely impaired cognition. The resident required set-up assistance for eating and partial/moderate assistance for bed mobility and transfers. Further review of the MDS revealed Resident #64's MDS was signed as complete on 07/08/25. In an interview on 09/02/25 at 4:15 P.M., MDS Nurse #343 confirmed Resident #10's quarterly MDS assessment was completed more than 14 days after the ARD. 3. Review of Resident #4's medical record revealed an admission date of 08/16/24 with diagnoses including gastrostomy, severe protein-calorie malnutrition, multiple sclerosis, stage four pressure ulcer of sacral region, epilepsy, unspecified convulsions, cognitive communication deficit, and major depressive disorder. Review of Resident #4's physician order dated 05/09/25 revealed the resident received Osmolyte 1.2 (a tube feed formula) continuously at 65 milliliters (ml) per hour. Review of Resident #4's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. The resident was not marked as receiving tube feeding. The ARD was 06/30/25, however, the assessment was not completed and submitted until 07/24/25. (continued on next page)		

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 09/22/2025
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's plan of care revised 07/24/25 revealed the resident required tube feeding related to her diagnoses, altered intakes, and dysphagia. Interventions included checking for placement and gastric contents per facility protocol, elevating the head of bed 30 to 45 degrees during and 30 minutes after tube feeding, monitoring for signs of aspiration, providing feedings and flushes as ordered, providing care to the feeding tube site as ordered, dietitian to evaluate quarterly and as needed, and speech therapy evaluation as ordered. Interview on 09/02/25 at 4:15 P.M. with MDS Nurse #343 verified Resident #4's tube feeding were not marked on Resident #4's MDS assessment and her assessment was completed and submitted late, past the 14-day time frame. 4. Review of Resident #19's medical record revealed an admission date of 11/01/24 with diagnoses including major depressive disorder, peripheral vascular disease, chronic obstructive pulmonary disease, cognitive communication deficit, repeated falls, vascular dementia, mood disorder, and alcohol dependence. Review of Resident #19's progress notes revealed a note dated 06/30/25 which revealed the nurse was summoned to the resident's room. It appeared the resident had gotten up from the bed and walked to the bathroom by himself and fell on the floor in front of the toilet. Review of Resident #19's quarterly MDS 3.0 assessment dated [DATE] revealed he had impaired cognition. The MDS assessment did not list any indication the resident had a prior fall. Interview on 09/02/25 at 4:15 P.M. with MDS Nurse #343 verified Resident #19's assessment did not indicate he had a fall. Review of the Resident Assessment Instrument (RAI) manual version 1.19.1 dated October 2024, revealed the MDS assessment should be marked yes for antiplatelet medication use if the resident was receiving aspirin therapy. Further review of the RAI manual revealed a MDS quarterly assessment should be completed and signed as complete no later than 14 days after the ARD. Additionally, the RAI manual provided instructions for coding fall instances and stated to review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. All relevant records should be reviewed for evidence of one or more falls.		

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 09/22/2025
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to have comprehensive care plans were in place for Residents #5, #14, and #23. This affected three residents (#5, #14, and #23) out of 40 residents reviewed for care planning. The facility census was 96. Findings include: 1. Review of the medical review revealed Resident #5 was admitted on [DATE] with diagnoses that included mood disorder, anxiety disorder, history of traumatic brain injury (TBI), and paraplegia. Review of hospital record dated 07/22/25 revealed an inpatient consult to behavioral health on 07/20/25 for Resident #5. Resident #5 was a [AGE] year-old male with a known intellectual disability and TBI (2019), paraplegia, with chronic pain syndrome. Behavioral health services were consulted to evaluate episodes of agitation and labile encounters with staff. Resident #5 had a history of depression and anxiety which were thought to be related to his TBI. This was complicated by poor frustration tolerance and maladaptive (inappropriate) coping strategies that often times involve him having episodes of agitation. Due to TBI, Resident #5 will always struggle with poor frustration and irritability. This was further limited by baseline intellectual disability and maladaptive coping skills. Resident #5 had past self-injurious behavior of cutting as recently as February 2025. A care plan dated 07/26/25 revealed Resident #5 was at risk for adverse effects related to psychotropic medication use. Resident #5 took antianxiety and antidepressant medications. Interventions included to monitor for antianxiety and antidepressant medication side effects. The admission Medicare 5-day Minimum Data Set, dated [DATE] revealed Resident #5 was cognitively intact. A care plan dated 08/26/25 revealed Resident #5 had an alteration in behavior as evidence as abusive attacks on staff and/or other residents. Resident #5 pulled knife on staff member. Interventions include to approach Resident #5 in a low, calm voice, document behavior as to type, duration, and precipitating causes, encourage Resident #5 to discuss and vent angry feelings, inform the physician or nurse practitioner of worsening behavior, intervene as needed to protect the rights and safety of others, approach/speak in calm manner, divert attention, remove from situation and take to another location as needed, and set limits on aggressive behavior and communicate expectations to resident to prevent injury to resident and others. An interview on 08/28/25 at 10:44 A.M. Director of Nursing (DON) verified there were not a care plan in place to address Resident #5's by poor frustration tolerance, intellectual disabilities, and maladaptive coping strategies that could cause him to have episodes of agitation, and irritability. DON also verified there was not a care plan in place to address Resident #5 self-injurious behavior of cutting or a TBI. 2. Resident #23 was admitted on [DATE], readmitted on [DATE], and discharged [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition, anemia, alcohol abuse, hypertensive heart disease, adult failure to thrive, chronic viral hepatitis C, osteoarthritis, cutaneous abscess of right lower limb, and multiple myeloma. A nursing note dated 06/06/25 at 7:42 A.M. revealed Resident #23 was found outside in his wheelchair wheeling himself down the road in front of the facility. Resident #23 stated he was going (continued on next page)		

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 09/22/2025
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to buy beer. Resident #23 did not sign the leave of absence (LOA) book before leaving the building and was educated to sign the LOA book before leaving. The DON was notified Resident #23 had left the facility without signing the LOA book. A nursing note dated 06/14/25 at 3:57 A.M. revealed around 3:30 A.M. Resident #23 called the facility and stated he was at a lady friend's house and would return in the morning. Resident #23 refused to give the address of where he was staying. The DON was notified of the phone call. A nursing note dated 06/14/25 at 10:31 A.M. revealed the outgoing nurse gave report that Resident #23 went on a LOA the previous day and did not return. Resident #23 called on 06/14/25 around 10:15 A.M. and stated he was stalked on [NAME] Road at the bus stop and needed someone to pick him up. An activity person went to pick Resident #23 up. A nursing note dated 06/14/25 at 12:30 P.M. revealed Resident #23 returned to the facility. A nursing note dated 06/22/25 at 10:30 A.M. revealed Resident #23 was not in his room during morning medication administration. Resident #23 was permitted to leave the facility on his own. The outgoing nurse did not give report on Resident #23 and stated she took over the shift at 4:00 A.M. The police arrived at the facility around 10:30 A.M. and stated Resident #23 was found sitting in his wheelchair in the street. The administrator sent someone to pick Resident #23 up. The DON was notified of the incident. On 06/22/25 at 11:14 A.M. Resident #23 returned to the facility around 10:56 A.M. by the person sent to get Resident #23. Resident #23 stated he left the facility around 12:00 A.M. A nursing note dated 07/02/25 at 10:42 P.M. revealed Resident #23 left the building without signing out. Resident #23 was known for leaving without signing out. A nursing note dated 07/02/25 at 11:57 P.M. revealed Resident #23 returned to the facility around 11:30 P.M. The nurse educated Resident #23 about signing out before leaving the facility. Resident #23 stated he would sign out next time. A nursing note dated 07/22/25 at 6:42 P.M. revealed the DON notified the nurse that Resident #23 had left the building without signing the LOA book. A plan of care dated 07/23/25 revealed Resident #23 had a history of substance seeking behavior alcohol and had the potential for complications such as substance abuse, withdrawal symptoms, and mood and/or behavioral disturbances. Resident #23 will sign himself out to go out to drink. Interventions include to discuss behavioral limits and expectations with resident, if returns from leave of absence and appeared to be impaired, notify the doctor for directions regarding administration of regularly scheduled medications, and observe for indications the resident may be storing drugs or alcohol in room or on person. Notify the doctor if drugs or alcohol found. A nursing note dated 08/09/25 at 6:41 A.M. revealed Resident #23 insisted on leaving the facility to go to the mall around 6:00 A.M. The nurse informed Resident #23 that the mall was usually closed at that time, but Resident #23 stated he was leaving anyway. Several staff attempted to redirect Resident #23 without success. Resident #23 refused to sign the LOA book. A nursing note dated 08/12/25 at 7:12 A.M. revealed Resident #23 left the building around 6:45 A.M. and refused to sign the LOA book. An interview on 08/27/25 at 1:43 P.M. DON verified Resident #23 liked to leave the facility and not sign the LOA book. DON stated Resident #23 left the facility to buy alcohol. DON verified there was not a care plan in place with interventions to address Resident #23 leaving the facility without signing out and providing the required information when LOA. 3. Review of Resident #14's medical record revealed an admission date of 11/12/24 with diagnoses including Alzheimer's disease, major depressive disorder, unspecified mood disorder, anxiety disorder, and other chronic pain. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood and she required assistance with eating. Review of Resident #14's plan of care revealed it did not address her hydration status, risk, or interventions in place to ensure adequate hydration. Interview on 09/02/25 at 3:54 P.M. with the Director of Nursing (DON) verified Resident #14's care plan did not address the residents hydration status.		

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 09/22/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure Residents #38 and #93 received medications timely and as ordered, failed to ensure Resident #15's laceration was monitored, and failed to apply Resident #11's ace wraps per physician orders. This affected four residents (#11, #15, #38, and #93) out of 40 residents sampled for quality of care and treatment. The facility census was 96. Findings include: 1. Review of Resident #38's medical record revealed an admission date of 04/17/25 with diagnoses including migraine, mild-protein calorie malnutrition, cognitive communication deficit, chronic pain syndrome, major depressive disorder, unspecified dementia, open angle glaucoma bilateral and severe, and retinal neovascularization of the right eye. Review of Resident #38's plan of care dated 09/18/23 revealed the resident was at risk for impaired comfort related to chronic arthritis, wedge compression fracture, chronic pain, and migraines. Interventions included administering pain medications as ordered, assessing for verbal and nonverbal signs of pain and treating accordingly, encouraging to report pain as soon as it starts, monitoring and recording pain characteristics, monitoring and reporting to nurse any complaints of pain or requests for pain treatment, positioning for comfort as needed, and therapy evaluation as needed. Review of Resident #38's physician order dated 01/28/25 to 02/01/25 revealed an order for Aimovig subcutaneous solution 70 milligrams (mg) to be injected every thirty days for migraine. Review of Resident #38's physician order dated 02/26/25 to 04/14/25 revealed an order for Aimovig subcutaneous solution 70 mg to be injected every thirty days for migraine. Review of Resident #38's Medication Administration Record (MAR) for February 2025 revealed Aimovig was not administered. Review of Resident #38's progress note dated 02/04/25 revealed Aimovig was not available. Review of Resident #38's progress notes for 02/04/25 to 02/28/25 revealed no evidence there was follow up on the missing medication. Continued review of Resident #38's physician orders revealed an order dated 04/17/25 for routine medications of Depakote (a mood stabilizing medication), orders dated 04/18/25 for memantine (used to treat dementia), brimonidine eye drops (used to treat glaucoma), apixaban (a blood thinning medication), famotidine (an acid-reducing medication), refresh eye ointments (eye drops), dorzolamide eye drops (used to treat glaucoma), latanoprost eye drops (used to treat glaucoma), Rhopressa eye drops (used to treat glaucoma), and oxcarbazepine (used to control and prevent seizures). Resident #38 additionally had an order dated 04/28/25 for gabapentin and an order dated 05/02/25 for mometasone furoate (an inhaled medication used to treat inflammatory respiratory conditions). Resident #38 additionally had an order dated 05/02/25 (discontinued on 07/02/25) for Aimovig subcutaneous solution 70 mg to be injected every thirty days for migraine, an order dated 06/11/25 for Timolol eye drop (used to treat glaucoma), and an order dated 06/30/25 for Zyrtec (an allergy medication). Review of Resident #38's MAR for July 2025 revealed Refresh ointment was not given on 07/13/25, 07/14/25, 07/15/25, 07/16/25, and 07/25/25. Rhopressa Ophthalmic solution was not administered on 07/27/25. Timolol Maleate Ophthalmic solution was not administered on 07/23/25. Dorzolamide was not administered once on 07/25/25 and famotidine was not administered once on 07/30/25. (continued on next page)		

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 09/22/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #38's progress notes from 07/01/25 to 07/30/25 revealed on 07/15/25 Refresh ointment was not in the cart and was reordered. On 07/16/25 Refresh ointment was not in the cart but the pharmacy indicated it was in the building. On 07/27/25 Rhopressa was not in the cart. There was no further documentation related to the missing medications. Review of Resident #38's physician order dated 08/20/25 revealed an order for Augmentin (an antibiotic) 125 mg one tablet by mouth every morning and at bedtime for seven days. Review of Resident #38's MAR for August 2025 revealed Latanoprost Ophthalmic solution was not administered on 08/24/25. Famotidine was not administered once on 08/24/25. Gabapentin 100 mg was not administered once on 08/25/25. Review of Resident #38's medication administration audit report revealed on 08/23/25 the following medications were scheduled for administration between 8:00 P.M. and 10:00 P.M. and were administered at 2:55 A.M.: Oxcarbazepine, Latanoprost Ophthalmic Solution, Refresh P.M. ophthalmic ointment, mometasone furoate, Augmentin, Zyrtec, Brimonidine Tartrate Ophthalmic solution, famotidine, apixaban, dorzolamide, divalproex, memantine, and gabapentin. Review of Resident #38's progress notes for 08/01/25 through 08/25/25 revealed they did not address any rationale for the missing or late medications. Interview on 08/25/25 at 11:56 A.M. with Resident #38 revealed she has missed her migraine shot (Aimovig) multiple times due to it not being in the facility. Rather than administering it when it arrives the facility waits for the next month when it is scheduled. Resident #38 additionally reported on the night of 08/23/25, she did not receive her medications until after 1:30 A.M. She reported she usually goes to bed at midnight and had to stay up to make sure she got her medications. Resident #38 additionally reported they frequently could not find her eye treatments. Some staff would claim it was not in the facility, and others would say it was. She was worried about missing her eye treatment due to her severe eye problems and fear her eye conditions would worsen. Interview on 08/27/25 at 4:08 P.M., on 09/02/25 at 3:49 P.M., and on 09/04/25 at 10:40 A.M. with the Director of Nursing (DON) verified the missing medications. The Aimovig may have been unavailable at the time, however, the refresh eye ointment was always in house. She was unsure why the additional medications were not administered. The DON verified medications should be administered on time, there had been sufficient staffing on 08/23/25, and there was no reason they should not have been administered on time. 2. Review of Resident #93's medical record revealed an admission date of 04/26/24 with diagnoses including end stage renal disease with dependence on renal dialysis, type two diabetes mellitus, and personal history of transient ischemic attack. Review of Resident #93's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #93's physician note dated 07/18/25 revealed the resident had excessive cerumen (ear wax) in ear canal with right ear hearing impairment. Debrox for three days was ordered. Review of Resident #93's physician order dated 07/18/25 to 07/21/25 revealed an order for Debrox otic (referring to drops to be administered directly into the ear) solution one drop in both ears two (continued on next page)		

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 09/22/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times a day for ear wax for 3 days. Review of Resident #93's MAR from 07/18/25 revealed the resident missed doses of the Debrox solution on 07/19/25 and 07/21/25. Review of Resident #93's physician order dated 07/24/25 to 07/25/25 revealed an order for Debrox otic solution one drop in both ears two times a day for ear wax for 31 days. Review of Resident #93's physician order dated 07/25/25 to 08/01/25 revealed an order for Debrox otic solution one drop in both ears two times a day for ear wax for seven days. Review of Resident #93's Medication Administration Record (MAR) for July and August 2025 revealed Debrox solution was not administered once on 07/27/25, 07/29/25, 07/30/25, and 08/01/25, and twice on 07/20/25 and 07/25/25. Review of the progress notes from 07/18/25 to 08/01/25 revealed on 07/20/25, 07/21/25, 07/25/25, 07/26/25, 07/27/25, and 08/01/25 it was indicated that Debrox was not available in house. Interview on 09/02/25 at 9:26 A.M. with the Director of Nursing (DON) revealed they always had Debrox drops in house. She was unsure why the nurses did not go to the stockroom to get them and verified the missing doses. 3. Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses of unspecified psychosis, blindness, and delirium. Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 had a cognitive impairment. Review of a nursing note dated 06/08/25 at 7:40 P.M. revealed Resident #15 was found on the floor with a head laceration. A moderate amount of blood was noted on Resident #15's gown. The nurse continuously held pressure to decrease bleeding. Emergency medical technicians (EMTs) were called 7:40 P.M. and arrived at 7:42 P.M. An admission assessment dated [DATE] revealed Resident #15 had a laceration to the back of the head measuring 1.4 centimeter (cm) long and 0.5 cm wide with two staples intact. A nursing note at 06/19/25 at 11:54 A.M. revealed therapy reported two staples to the back of the head. The nurse contacted the certified nurse practitioner about removing staples. A nursing note dated 06/19/25 at 1:26 P.M. revealed a new order to remove Resident #15's staples present on the back of the head. Review of the Treatment Administration Record (TAR) for June 2025 revealed no evidence of monitoring of the lacerated area nor orders for site care until 06/19/25. An interview on 09/03/25 at 11:05 A.M. DON verified there was no monitoring or orders for care for the laceration and staples to Resident #15's head between 06/12/25 and 06/19/25. 4. Record review for Resident #11 revealed the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, Alzheimer's disease, asthma, and high blood pressure. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 01/06/25 revealed the Resident #11 has altered cardiovascular status. Interventions included monitoring for edema. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 07. This resident was assessed to require assistance with self-care activities. Review of Resident #11's physician orders revealed an order dated 07/13/25 for ace wraps to be applied to both legs and feet every morning and removed at night. Review of Resident #11's TAR for August 2025 and September 2025 through the morning of 09/03/25 revealed the order for the ace wrap application had been signed-off as completed as ordered. Observations of Resident #11 on 08/27/25, 08/28/25, 09/01/25, 09/02/25 and 09/03/25 between 08:00 A.M. and 5:00 P.M. revealed the ace wraps were not present on either of the resident's legs as ordered. During an interview with DON on 09/03/25 at 4:49 P.M. she confirmed Resident #11 was not wearing the ace wraps on either legs as ordered by the physician.		

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 09/22/2025
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were dated and expired medication was discarded. This affected five (Resident #2, #50, #55, #57, and #116) residents but had the potential to affect newly admitted residents. The facility census was 96. Findings include: 1.An observation on [DATE] at 11:49 A.M. revealed two Glargine (long-acting insulin) pens were open and undated for Resident #57. Registered Nurse (RN) #850 verified the insulin pens for Resident #57 were open and undated. 2.An observation on [DATE] at 11:56 A.M. revealed two vials of Admelog (fast acting insulin) were opened and undated for Resident #2. 3.Aspart (fast acting insulin) was open and undated for Resident #50. Resident #50 was admitted on [DATE] and discharged on [DATE]. 4.Lispro (fast acting insulin) and Glargine were open and undated for Resident #55 that was discharged on [DATE]. An unopened box of Cathflo (alfeplase) for Resident #55 was in the medication cart. The Cathflo for Resident #55 had a sticker that revealed the powder must be stored in the refrigerator. 5.Lantus (long-acting insulin) for Resident #116 was dated as opened on [DATE]. Resident #116 was admitted on [DATE] and discharged on [DATE]. An interview on [DATE] at 12:05 P.M. with the Assistant Director of Nursing (ADON) verified medications were open and undated for Resident #2, #50, and #55. The ADON verified Cathflo for Resident #55 was stored improperly and was to be refrigerated. The ADON also verified the medications for Resident #50, #55, and #116 should have been removed from the medication carts when Residents #55, #116, and #50 were discharged . 6.An observation on [DATE] at 12:13 P.M. revealed an open Tubersol (purified protein derivative used to detect tuberculosis infection) vial with an opened date of [DATE], stored in a medication refrigerator. On [DATE] at 12:13 P.M. Licensed Practical Nurse #345 verified the vial of Tubersol should have been discarded 30 days after being opened.		

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 09/22/2025
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to ensure the floor and air conditioning units were maintained on the B unit, failed to ensure the floor in Resident #4's room was clean, and failed to ensure the floor and walls of Resident #103 room were clean. This had the potential to affect 47 residents residing on the B unit (#4, #5, #7, #8, #9, #11, #12, #14, #17, #19, #22, #24, #26, #28, #30, #31, #33, #35, #36, #37, #38, #40, #41, #47, #54, #59, #61, #65, #70, #75, #76, #80, #81, #85, #86, #87, #89, #93, #96, #98, #99, #101, #102, #103, #105, #106, and #107). The facility census was 96. Findings include: Observation on 08/25/25 at 11:01 A.M. and 4:09 P.M. of Resident #4's room revealed the floor around her tube feeding had brown splatters. The hallway floor on the B unit was observed to have a black, sticky residue throughout the hallway. Observation on 09/04/25 at 10:00 A.M. and 1:20 P.M. revealed Resident #4 had brown splatters on her floor around her tube feeding pole and had black sticky appearing residue under her wheelchair, which was in the same spot as 08/25/25. Observation of Resident #103's room revealed he had brown splatters on the wall around an outlet and a variety of stains on his floor. Observation of the floor on the unit revealed multiple locations with a thick sticky residue, causing shoes to stick to the floor on multiple areas of the hallway. Additionally, there were two air conditioning units in the common areas of the B unit with a build up of dust and a black mold-like substance visible around the vents. Interview on 09/04/25 at 1:20 P.M. Housekeeping Aide #280 verified the observations. She reported they were waiting on a part for the floor scrubber which made it difficult to thoroughly clean the hallway floors. Housekeeping Aide # 282 reported the floor scrubber had been down for about a month.		

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 09/22/2025
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to honor Resident #57's and Resident #68's bathing preferences and failed to ensure Resident #12's call light was within reach. This affected three residents (#12, #57, and #68) out of six residents reviewed for accommodations of needs and preferences. The facility census was 96. Findings include: 1. Review of the medical record revealed Resident #57 was admitted on [DATE] with diagnoses that included type one diabetes, rheumatoid arthritis, peripheral vascular disease, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side. A care plan dated 08/13/25 and revised on 08/28/25 revealed Resident #57 had a self-care performance deficit related to activities of daily living (ADL) abilities. Interventions included one to two persons to assist with bathing, and two persons to assist with transfers. The 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively intact. An interview on 08/26/25 at 2:04 P.M. with Resident #57 revealed she was not always getting bathed, and she preferred a shower. The undated recreational therapy referral form revealed it was very important to Resident #57 to choose a tub bath, shower, bed bath, or sponge bath. The shower option was circled indicating a preference for bathing. Review of the bathing documentation revealed Resident #57 received a bed bath on 08/15/25, 08/17/25, 08/20/25, and 08/26/25. Resident #57 was scheduled to be bathed on Mondays and Thursdays on the night shift. An interview on 09/03/25 at 9:27 A.M. with the Director of Nursing (DON) verified Resident #57 was not receiving showers per Resident #57's preference. 2. Review of the medical record revealed Resident #68 was admitted on [DATE] with diagnoses that included dysphagia, anxiety, malignant neoplasm of male breast, and type two diabetes. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed it was very important to choose between a tub bath, shower, and bed bath. The quarterly MDS dated [DATE] revealed Resident #68 had cognitive impairment and was independent with bathing. Review of the care plan dated 06/30/25 for activities of daily living (ADL) self-care performance revealed Resident #68 required one person assistance for bathing. Review of the undated recreational therapy referral form revealed it was very important for Resident #68 to choose a tub bath, shower, bed bath, or sponge bath. The shower option was circled indicating a preference for bathing. Review of the bathing documentation revealed Resident #68 received a shower on 08/02/25, a bed bath on 08/04/25, an unknown type of bathing on 08/06/25, a shower on 08/09/25, and a bed bath on 08/20/25. (continued on next page)		

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 09/22/2025
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/25/25 at 2:02 P.M. with Resident #68 verified he preferred showers. On 09/03/25 at 9:27 A.M. an interview with the Director of Nursing (DON) verified Resident #68 received only two showers out of the five times Resident #68 was bathed and Resident #68 was not getting showers per Resident #68's preference. 3. Review of Resident #12's medical records revealed an admission date of 11/13/23 and diagnoses including dysphagia, pain, personal history of traumatic brain injury, spinal stenosis cervical region, unspecified osteoarthritis, anxiety disorder, hypertension, asthma, depression, diabetes, and other spondylosis of the cervical region. Review of Resident #12's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating the resident was moderately cognitively impaired. Further review of the MDS revealed Resident #12 was dependent for toileting hygiene tasks, needed partial/moderate assistance with bed mobility, and was always incontinent of bladder and bowel. An observation 08/25/25 at 11:09 A.M. revealed Resident #12's call light was not within the resident's reach. The call light was draped across the bedside stand situated at the head of the bed and to the right of the resident's bed. Resident #12 was seated in bed with the head of the bed elevated at a 45 degree angle which placed the call light behind the resident. An observation and interview on 09/02/25 at 8:55 A.M. revealed Resident #12's call light was not with in the resident's reach. The call light was draped across the bedside stand situated at the head of the bed and to the right of the resident's bed. Resident #12 was seated in bed with the head of the bed elevated at a 45 degree angle which placed the call light behind the resident. Resident #12 stated, at the time of the observation, that she used her call light to get help when she needed the staff. In an interview on 09/02/25 at 8:55 A.M. with Unit Manager Licensed Practical Nurse (LPN) #345 confirmed Resident #12's call light was not with in the resident's reach.		

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 09/22/2025
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)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to maintain resident privacy during a routine dressing change. This affected one resident (#25) of one resident observed for wound care. The facility census was 96. Findings include: Review of Resident #25's medical record revealed an admission date of 06/23/21 and diagnoses including but not limited to major depressive disorder, generalized anxiety disorder, constipation, vitamin d deficiency, and unspecified dementia. Review of Resident #25's annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was unable to be completed for Resident #25 because the resident was rarely/never understood. Further review of the MDS revealed Resident #25 required supervision for eating, substantial/maximal assistance for bathing, bed mobility, and transfers and was dependent for toileting hygiene, was always incontinent of bowel and bladder, and had a stage two pressure area. An observation on 09/02/2025 at 12:00 P.M. of a dressing change to Resident #25's left ischium revealed that upon entering the room Resident #25's bed was on the left against the wall with the head of the bed toward the window and the foot of the bed was toward the door. Resident #25's roommate's bed was on the right against the wall with the head of the bed toward the window and the foot of the bed was toward the door. The bathroom was immediately to the left upon entering the room. There were privacy curtains in the room the first of which was horseshoe shaped, positioned directly past the bathroom with open end of the horse shoe to the right and when pulled closed was at the foot of Resident #25's roommate's bed. The second privacy curtain was in the center of the room and divided the room in half from right to left. When closed the second curtain was just past the foot of both of the residents' beds, toward the head of the bed, by about 12 inches. Resident #25's roommate was in her bed throughout the dressing change and was lying on her right side facing the center of the room and Resident #25's bed. In an interview on 09/02/2025 at 12:00 P.M., Assistant Director of Nursing (ADON) #341 confirmed Resident #25's room was set up so the privacy curtains could not be pulled between the beds to provide privacy and Resident #25's roommate could see the dressing change and any other care the resident received.		

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 09/22/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility self-reported incidents, and review of facility policy the facility failed to ensure Resident #107's injury of unknown origin and an altercation between Resident #5 and a Certified Nursing Assistant (CNA) were reported to the State Agency in a timely manner. This affected one resident (#107) of seven reviewed for accidents and one resident (#5) of one resident reviewed for abuse. The facility census was 96. Findings include: 1. Review of Resident #107's medical record revealed an admission date of 07/20/17 with diagnoses including dysphagia, cognitive communication deficit, type two diabetes mellitus, cerebral infarction, vascular dementia, epilepsy, contracture of left foot and hand, and flaccid hemiplegia affecting left nondominant side. Review of Resident #107's occupational evaluation and plan of treatment dated 06/09/25 revealed he had left upper extremity paralysis with contractures. Review of Resident #107's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. He had a range of motion impairment to both upper and lower extremity on one side and he was dependent for rolling in bed. Review of Resident #107's progress note dated 05/29/25 revealed the resident was noted to have several liquid filled blister like areas on the back of his hand. Two of the areas were seeping and two were completely opened. There was a yellowish drainage with a mild odor and the resident had pitting edema to his hand. The physician was notified, and they received orders to send the resident to the hospital. Review of Resident #107's facility investigation dated 05/29/25 revealed the nurse noted blisters to the back of his hand, this included five blisters, two of which were connected on his index finger. The resident said he had not noticed they were there, he denied slipping or doing anything to cause an injury. The resident was sent to the emergency room. There were no predisposing environmental or situation factors, diabetes and hyperglycemia were listed as predisposing physiological factors. There was no further investigation or witness statements related to the injury. Review of Resident #107's hospital notes dated 05/31/25 revealed the resident had bullae (fluid filled blisters larger than five millimeters) and yellow crusting of his left hand with a strong suspicion of bullous impetigo (bacterial skin infection) with bacteria collections between fingers. There was a noted buildup of organic debris within his partially contracted hand. The physician recommended daily cleaning of his contracted hand with mupirocin ointment to the hand twice a day. In addition to the blisters, the backside of his left hand was noted to have shallow ulceration and swelling with an unknown start date. The resident reported his left hand was painful and he thought it had been present for over two weeks. The daughter reported care concerns related to the nursing facility and stated it seemed as though his hand had been pressed against his hoyer pad. His hospital notes contained an image of his left hand which revealed two large blisters on the back of his hand, and one large blister where his hand met his fingers. This blister was almost split in two with half of it open exposing the skin beneath. Underneath the blisters on the back of his hand was an imprinted pattern of symmetrical rows of circles. (continued on next page)		

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 09/22/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's self-reported incidents on 08/28/25 revealed Resident #107's injury had not been reported. Interview on 08/28/25 at 2:04 P.M. with the Director of Nursing (DON) revealed this had not been treated as an injury of unknown origin, however, they had not been able to determine the cause of the injury. Review of the policy 'Abuse, mistreatment, neglect, exploitation and misappropriation of resident property' dated October 2022, an injury of unknown source is classified when the following conditions were met, the source of the injury was not observed by any person, the source could not be explained by the resident, and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point, or the incidence of injuries over time. Allegations that do not involve serious bodily injury were to be reported to the Ohio Department of Health but no later than 24 hours from the incident was made known. 2. Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included but not limited to chronic pain, anxiety disorder, history of traumatic brain injury (TBI) in 2019, and paraplegia. A diagnosis of mood disorder was created on 08/12/25. Review of hospital records (part of Resident #5's facility medical record) revealed Resident #5 was transferred to the hospital on [DATE] with intractable pain. Hospital records revealed Resident #5 had an inpatient consultation for behavioral health on 07/20/25. The record revealed Resident #5 was a [AGE] year-old male with a known intellectual disability and TBI, paraplegia, and chronic pain syndrome. Behavioral health services were consulted to evaluate Resident #5's episodes of agitation and labile (rapid and uncontrollable shifts in emotional states, often resulting in exaggerated emotional responses that may seem inappropriate to the situation) encounters with staff. Resident #5 has a history of depression and anxiety which were thought to be related to his TBI. This was complicated by poor frustration tolerance and maladaptive (inappropriate) coping strategies that often times involved him having episodes of agitation. Due to TBI, Resident #5 would always struggle with poor frustration and irritability. This was further limited by baseline intellectual disability and maladaptive coping skills. Resident #5 had past self-injurious behavior of cutting as recently as February 2025. An admission Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was cognitively intact and had no behaviors. As part of the facility investigation beginning 08/03/25, the following statements were obtained: A typed statement by the Director of Nursing (DON) about an incident on 08/03/25. The nurse was notified there had been an incident between a resident and a staff member. Resident #5 was being assisted by CNA #350 with incontinence care. CNA #350 cleaned up Resident #5 and placed the soiled linens in a trash bag. CNA #350 exited the room to speak with Resident #5's nurse regarding care when Resident #5 became agitated and started yelling. Resident #5 began throwing items at CNA #350. Resident #5 picked up a urinal to throw at CNA #350 and CNA #350 pushed the trash bag aside with her foot and closed the door. Resident #5 then came out of his room and yelled profanities and racial slurs at CNA #350. Resident #5 was brandishing a switchblade style knife and threatening CNA #350. The police were called, and the knife was removed from Resident #5 by the police. The police searched Resident #5's room for additional contraband. The police took statements from the staff and Resident #5 was placed on frequent observations until cleared by Certified Nurse Practitioner (CNP) (continued on next page)		

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 09/22/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#425 after a face-to-face visit. A handwritten, undated, statement by Unit Manager/Licensed Practical Nurse #347 revealed they received call from the weekend supervisor (unidentified) on 08/03/25 at 6:20 P.M. The supervisor stated that police were in the facility because Resident #5 pulled a knife on a staff member. This nurse asked to speak with the staff member (CNA #350). CNA #350 stated Resident #5 became upset with CNA #350 after care was completed. Resident #5 then grabbed a knife and followed CNA #350 out of the room into hallway. Resident #5 was yelling I will gut you (expletive). Resident #5 began throwing items, screaming and yelling. This nurse advised the supervisor to make sure all staff and residents were out of harm's way. This nurse then notified the DON and administrator. A statement by CNA #257 revealed the CNA was picking up trays and saw Resident #5 with a knife. CNA #257 stated Resident #5 wheeled out fast toward CNA #350 yelling and saying Resident #5 would wound CNA #350. CNA #257 quickly walked past Resident #5's door and alerted all staff and residents who were around to run. As everyone was running Resident #5 took the soiled linen out of the bag and put feces on top of the medication cart and on the floor. CNA #257 only knew what happened when Resident #5 came out with a knife. A handwritten statement by Unit Manager (UM) #345 revealed CNA #350 called about the incident which involved Resident #5 and a knife. CNA #350 stated after completing incontinence care for Resident #5, she suggested Resident #5 use disposable incontinence pads. CNA #350 left the room to notify the nurse that the dressing to Resident #5's bottom was soiled. Resident #5 began yelling and CNA #350 went to see what was wrong. Resident #5 began throwing items at CNA #350. Resident #5 was cursing and using racial slurs. Resident #5 reached for his urinal with urine in it. CNA #350 shut Resident #5's door to prevent Resident #5 from hitting CNA #350 and others with objects that were being thrown. Moments later, Resident #5 came out of his room in his wheelchair holding a knife and wheeled toward CNA #350 stating he was going to gut CNA #350. The police were called. An incident report from the police department dated 08/03/25 (not requested by the facility until 08/29/25 when the state survey agency inquired about the incident with Resident #5 and facility staff) revealed at 6:15 P.M. the police were dispatched on a report of a resident with a knife. Upon arrival at 6:17 P.M., the resident was located and complied with officers' commands to drop the knife. The suspect (Resident #5) and victim (CNA #350) stated the incident arose from an argument regarding Resident #5's care. During the argument, Resident #5 began throwing food, feces, and miscellaneous items at CNA #350 causing minor injury to CNA #350's arm and hand. Resident #5 brandished a knife and drove CNA #350 out of his room. The knife used in the incident and another small knife were seized from Resident #5's room. Due to the patient's condition, officers were unable to remove Resident #5 from the facility. CNA #350 was provided with the report number and victim's rights information. The narrative notes from the police department revealed Resident #5 was located in the hallway outside of his room in possession of a multicolored butterfly knife (a folding pocketknife with two handles that rotate around a pivot to enclose the blade. When the handles are swung apart, the blade becomes exposed, and the handles can then be gripped to click it in an open position). A police officer commanded Resident #5 to drop the knife and Resident #5 complied. Once the scene was secured, Resident #5 and CNA #350 were interviewed. Resident #5 had a bowel movement on an incontinence pad and CNA #350 had entered the room to provide care. Resident #5 overheard CNA #350 discussing what had happened with another staff member and Resident #5 became frustrated. Resident #5 and CNA #350 engaged in a verbal argument about Resident #5's care, which quickly escalated verbally. Resident #5 then began to throw food, a water pitcher, and a soiled incontinence pad causing minor injury to CNA #350's forearm and hand. CNA #350 left Resident #5's (continued on next page)		

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 09/22/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and entered the hallway. Resident #5 followed CNA #350 in his wheelchair, brandishing a multicolored butterfly knife. Resident #5 stated the knife was open while he was in his room, but he closed it when he went into the hallway. Resident #5 denied making any threatening statements related to the knife towards CNA #350. CNA #350 stated Resident #5 threatened to stab and gut her. While there were numerous caretakers and residents in the hallway that observed Resident #5 wielding the knife, there were none close enough to provide a statement on what words Resident #5 used nor the events leading up to Resident #5 leaving his room and entering the hallway. The butterfly knife and a [NAME] multitool (a versatile, portable device that packs multiple tools, such as pliers, knives, screwdrivers, and saws, into a single, compact design) were seized from Resident #5's room. Due to Resident #5's condition, he was unable to be transported to police headquarters or jail. The report revealed Resident #5 would remain at the facility to receive treatment until other arrangements could be made. A care plan dated 08/04/25 revealed Resident #5 had alteration in behavior with abusive attacks on staff and/or other residents. Resident #5 was physically abusive and pulled a knife on a staff member. Interventions include to approach Resident #5 in a low, calm voice, document the behavior as to type, duration, and precipitating causes, encourage Resident #5 to discuss and vent angry feelings, inform the doctor/nurse practitioner of worsening behavior, intervene as needed to protect the rights and safety of others, approach/speak to Resident #5 in a calm manner, divert attention, remove from situation and take to another location as needed, and set limits on aggressive behavior and communicate expectations to resident to prevent injury to Resident #5 and others. An interview on 08/27/25 at 1:56 P.M. DON revealed the police arrived quickly and Resident #5 was in the hallway in front of his room when the police arrived. Resident #5 was put on 15-minute checks and DON thought Resident #5 would be put on a 72-hour psychological hold but was not. The CNP talked with Resident #5 the next day, and felt Resident #5 was no longer a threat and was taken off the 15-minute checks. An interview on 08/28/25 at 10:19 A.M. CNA #350 stated Resident #5 had removed his incontinence brief to defecate on a cloth pad in the bed. CNA #350 cleaned up the feces and placed the soiled linens in a trash bag. While cleaning Resident #5, CNA #350 noticed the bandage to Resident #5's bottom was soiled. CNA #350 stated the nurse was outside Resident #5's room. CNA #350 sat the trash bag down inside the doorway of Resident #5's room and started telling the nurse about the bandage being soiled. Resident #5 became upset and started yelling not to talk about him. CNA #350 went back into Resident #5's room to explain why she was talking to the nurse. Resident #5 threw a Styrofoam food container and then his tray. CNA #350 put her arms up to block the tray, and her arms had become bruised. Resident #5 then picked up his urinal with urine in it. CNA #350 used her foot to kick the trash bag with soiled linen out of the way and went out into the hallway and shut Resident #5's door so she and anyone else would not be hit with the urinal. Resident #5 must have transferred himself to his wheelchair and opened the door leading into the hallway. Resident #5 opened the trash bag and threw the soiled linen, and feces went on the floor and nurse's cart. Resident #5 had a knife and started towards her stating Resident #5 was going to gut her. CNA #350 verified there were residents in the hallway and CNA #350 was afraid that Resident #5 would focus his anger on other residents if she ran away. CNA #350 called the police on her cellphone. CNA #350 stated she talked with a Unit Manager and gave a report to the police. An interview on 08/28/25 at 10:41 A.M. CNA #257 verified there were residents in the hallway when Resident #5 had a knife. CNA #257 stated everyone ran away and the staff waited for the police to arrive. CNA #257 stated she had not provided any care for Resident #5 that day or any time prior. CNA (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#257 ended the interview stating she should not say any more. The facility filed self-reported incident #264663 on 08/29/25 for allegation of emotional/verbal abuse by staff towards Resident #5. Resident #5's relevant conditions included mood disorder, anxiety disorder, TBI, and paraplegia. An interview on 09/02/25 at 9:09 A.M. with the DON revealed the facility picked up the police report on 08/29/25 regarding the incident with Resident #5 and CNA #350. Because of the verbiage in the police report of a verbal altercation, a self-reported incident was filed with the state agency on 08/29/25 and not on 08/03/25 when the incident occurred. Review of the Abuse, Mistreatment, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 03/2024 revealed all incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property and all injuries of unknown source must be reported immediately to the Administrator or designee. If any form of abuse is alleged, the administrator or his/her designee will notify Ohio Department of Health immediately, but not later than two hours after the allegation is made.		

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 09/22/2025
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility self-reported incidents, facility investigation review and review of facility policy the facility failed to ensure Resident #107's injury of unknown origin and an altercation between Resident #5 and a Certified Nursing Assistant CNA) were thoroughly investigated. This affected one resident (#107) of seven reviewed for accidents and one resident (#5) of one resident reviewed for abuse. The facility census was 96. Findings include: 1. Review of Resident #107's medical record revealed an admission date of 07/20/17 with diagnoses including dysphagia, cognitive communication deficit, type two diabetes mellitus, cerebral infarction, vascular dementia, epilepsy, contracture of left foot and hand, and flaccid hemiplegia affecting left nondominant side. Review of Resident #107's occupational evaluation and plan of treatment dated 06/09/25 revealed he had left upper extremity paralysis with contractures. Review of Resident #107's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. He had a range of motion impairment to both upper and lower extremity on one side and he was dependent for rolling in bed. Review of Resident #107's progress note dated 05/29/25 revealed the resident was noted to have several liquid filled blister like areas on the back of his hand. Two of the areas were seeping and two were completely opened. There was a yellowish drainage with a mild odor and the resident had pitting edema to his hand. The physician was notified, and they received orders to send the resident to the hospital. Review of Resident #107's facility investigation dated 05/29/25 revealed the nurse noted blisters to the back of his hand, this included five blisters two of which were connected on his index finger. The resident said he had not noticed they were there, he denied slipping or doing anything to cause an injury. The resident was sent to the emergency room. There were no predisposing environmental or situation factors, diabetes and hyperglycemia were listed as a predisposing physiological factors. There was no further investigation or witness statements related to the injury. Review of Resident #107's hospital notes dated 05/31/25 revealed the resident had bullae (fluid filled blisters larger than five millimeters) and yellow crusting of his left hand with a strong suspicion of bullous impetigo (bacterial skin infection) with bacteria collections between fingers. There was a noted buildup of organic debris within his partially contracted hand. The physician recommended daily cleaning of his contracted hand with mupirocin ointment to the hand twice a day. In addition to the blisters, the backside of his left hand was noted to have shallow ulceration and swelling with an unknown start date. The resident reported his left hand was painful and he thought it had been present for over two weeks. The daughter reported care concerns related to the nursing facility and stated it seemed as though his hand had been pressed against his hoyer pad. His hospital notes contained an image of his left hand which revealed two large blisters on the back of his hand, and one large blister where his hand met his fingers. This blister was almost split in two with half of it open exposing the skin beneath. Underneath the blisters on the back of his hand was an imprinted pattern of symmetrical rows of circles. Review of the facility's self-reported incidents on 08/28/25 revealed Resident #107's injury had not (continued on next page)		

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 09/22/2025
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been reported. Interview on 08/28/25 at 2:04 P.M. with the Director of Nursing (DON) revealed this had not been treated as an injury of unknown origin, however, they had not been able to determine the cause of the injury. Review of the policy 'Abuse, mistreatment, neglect, exploitation and misappropriation of resident property' dated October 2022, an injury of unknown source is classified when the following conditions were met, the source of the injury was not observed by any person, the source could not be explained by the resident, and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point, or the incidence of injuries over time. Investigation into allegations must be completed within five working days. All witnesses should be interviewed, this includes anyone who came in close contact with the resident the day of the incident and employees who worked closely with the alleged victim. If there were no direct witnesses the interviews may be expanded. For injuries of unknown source, the investigation generally involves talking with staff working on both the shift on duty when the injury was discovered and prior shifts as well. 2. Review of the medical record revealed Resident #5 was admitted on [DATE] with diagnoses that included but not limited to chronic pain, anxiety disorder, history of TBI in 2019, and paraplegia. A diagnosis of mood disorder was created on 08/12/25. Review of hospital records (part of Resident #5's facility medical record) revealed Resident #5 was transferred to the hospital on [DATE] with intractable pain. Hospital records revealed Resident #5 had an inpatient consultation for behavioral health on 07/20/25. The record revealed Resident #5 was a [AGE] year-old male with a known intellectual disability and TBI, paraplegia, and chronic pain syndrome. Behavioral health services were consulted to evaluate Resident #5's episodes of agitation and labile (rapid and uncontrollable shifts in emotional states, often resulting in exaggerated emotional responses that may seem inappropriate to the situation) encounters with staff. Resident #5 has a history of depression and anxiety which were thought to be related to his TBI. This was complicated by poor frustration tolerance and maladaptive (inappropriate) coping strategies that often times involved him having episodes of agitation. Due to TBI, Resident #5 would always struggle with poor frustration and irritability. This was further limited by baseline intellectual disability and maladaptive coping skills. Resident #5 had past self-injurious behavior of cutting as recently as February 2025. An admission Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was cognitively intact and had no behaviors. As part of the facility investigation beginning 08/03/25, the following statements were obtained: A typed statement by the Director of Nursing (DON) about an incident on 08/03/25. The nurse was notified there had been an incident between a resident and a staff member. Resident #5 was being assisted by CNA #350 with incontinence care. CNA #350 cleaned up Resident #5 and placed the soiled linens in a trash bag. CNA #350 exited the room to speak with Resident #5's nurse regarding care when Resident #5 became agitated and started yelling. Resident #5 began throwing items at CNA #350. Resident #5 picked up a urinal to throw at CNA #350 and CNA #350 pushed the trash bag aside with her foot and closed the door. Resident #5 then came out of his room and yelled profanities and racial slurs at CNA #350. Resident #5 was brandishing a switchblade style knife and threatening CNA (continued on next page)		

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 09/22/2025
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#350. The police were called, and the knife was removed from Resident #5 by the police. The police searched Resident #5's room for additional contraband. The police took statements from the staff and Resident #5 was placed on frequent observations until cleared by Certified Nurse Practitioner (CNP) #425 after a face-to-face visit. A handwritten, undated, statement by Unit Manager/Licensed Practical Nurse #347 revealed they received call from the weekend supervisor (unidentified) on 08/03/25 at 6:20 P.M. The supervisor stated that police were in the facility because Resident #5 pulled a knife on a staff member. This nurse asked to speak with the staff member (CNA #350). CNA #350 stated Resident #5 became upset with CNA #350 after care was completed. Resident #5 then grabbed a knife and followed CNA #350 out of the room into hallway. Resident #5 was yelling I will gut you (expletive). Resident #5 began throwing items, screaming and yelling. This nurse advised the supervisor to make sure all staff and residents were out of harm's way. This nurse then notified the DON and administrator. A statement by CNA #257 revealed the CNA was picking up trays and saw Resident #5 with a knife. CNA #257 stated Resident #5 wheeled out fast toward CNA #350 yelling and saying Resident #5 would wound CNA #350. CNA #257 quickly walked past Resident #5's door and alerted all staff and residents who were around to run. As everyone was running Resident #5 took the soiled linen out of the bag and put feces on top of the medication cart and on the floor. CNA #257 only knew what happened when Resident #5 came out with a knife. A handwritten statement by Unit Manager (UM) #345 revealed CNA #350 called about the incident which involved Resident #5 and a knife. CNA #350 stated after completing incontinence care for Resident #5, she suggested Resident #5 use disposable incontinence pads. CNA #350 left the room to notify the nurse that the dressing to Resident #5's bottom was soiled. Resident #5 began yelling and CNA #350 went to see what was wrong. Resident #5 began throwing items at CNA #350. Resident #5 was cursing and using racial slurs. Resident #5 reached for his urinal with urine in it. CNA #350 shut Resident #5's door to prevent Resident #5 from hitting CNA #350 and others with objects that were being thrown. Moments later, Resident #5 came out of his room in his wheelchair holding a knife and wheeled toward CNA #350 stating he was going to gut CNA #350. The police were called. An incident report from the police department dated 08/03/25 (not requested by the facility until 08/29/25 when the state survey agency inquired about the incident with Resident #5 and facility staff) revealed at 6:15 P.M. the police were dispatched on a report of a resident with a knife. Upon arrival at 6:17 P.M., the resident was located and complied with officers' commands to drop the knife. The suspect (Resident #5) and victim (CNA #350) stated the incident arose from an argument regarding Resident #5's care. During the argument, Resident #5 began throwing food, feces, and miscellaneous items at CNA #350 causing minor injury to CNA #350's arm and hand. Resident #5 brandished a knife and drove CNA #350 out of his room. The knife used in the incident and another small knife were seized from Resident #5's room. Due to the patient's condition, officers were unable to remove Resident #5 from the facility. CNA #350 was provided with the report number and victim's rights information. The narrative notes from the police department revealed Resident #5 was located in the hallway outside of his room in possession of a multicolored butterfly knife (a folding pocketknife with two handles that rotate around a pivot to enclose the blade. When the handles are swung apart, the blade becomes exposed, and the handles can then be gripped to click it in an open position). A police officer commanded Resident #5 to drop the knife and Resident #5 complied. Once the scene was secured, Resident #5 and CNA #350 were interviewed. Resident #5 had a bowel movement on an incontinence pad and CNA #350 had entered the room to provide care. Resident #5 overheard CNA #350 discussing what had happened with another staff member and Resident #5 (continued on next page)		

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 09/22/2025
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	became frustrated. Resident #5 and CNA #350 engaged in a verbal argument about Resident #5's care, which quickly escalated verbally. Resident #5 then began to throw food, a water pitcher, and a soiled incontinence pad causing minor injury to CNA #350's forearm and hand. CNA #350 left Resident #5's room and entered the hallway. Resident #5 followed CNA #350 in his wheelchair, brandishing a multicolored butterfly knife. Resident #5 stated the knife was open while he was in his room, but he closed it when he went into the hallway. Resident #5 denied making any threatening statements related to the knife towards CNA #350. CNA #350 stated Resident #5 threatened to stab and gut her. While there were numerous caretakers and residents in the hallway that observed Resident #5 wielding the knife, there were none close enough to provide a statement on what words Resident #5 used nor the events leading up to Resident #5 leaving his room and entering the hallway. The butterfly knife and a [NAME] multitool (a versatile, portable device that packs multiple tools, such as pliers, knives, screwdrivers, and saws, into a single, compact design) were seized from Resident #5's room. Due to Resident #5's condition, he was unable to be transported to police headquarters or jail. The report revealed Resident #5 would remain at the facility to receive treatment until other arrangements could be made. An interview on 08/28/25 at 10:19 A.M. CNA #350 stated Resident #5 had removed his incontinence brief to defecate on a cloth pad in the bed. CNA #350 cleaned up the feces and placed the soiled linens in a trash bag. While cleaning Resident #5, CNA #350 noticed the bandage to Resident #5's bottom was soiled. CNA #350 stated the nurse was outside Resident #5's room. CNA #350 sat the trash bag down inside the doorway of Resident #5's room and started telling the nurse about the bandage being soiled. Resident #5 became upset and started yelling not to talk about him. CNA #350 went back into Resident #5's room to explain why she was talking to the nurse. Resident #5 threw a Styrofoam food container and then his tray. CNA #350 put her arms up to block the tray, and her arms had become bruised. Resident #5 then picked up his urinal with urine in it. CNA #350 used her foot to kick the trash bag with soiled linen out of the way and went out into the hallway and shut Resident #5's door so she and anyone else would not be hit with the urinal. Resident #5 must have transferred himself to his wheelchair and opened the door leading into the hallway. Resident #5 opened the trash bag and threw the soiled linen, and feces went on the floor and nurse's cart. Resident #5 had a knife and started towards her stating Resident #5 was going to gut her. CNA #350 verified there were residents in the hallway and CNA #350 was afraid that Resident #5 would focus his anger on other residents if she ran away. CNA #350 called the police on her cellphone. CNA #350 stated she talked with a Unit Manager and gave a report to the police. CNA #350 stated the facility did not ask her to write a statement. An interview on 08/28/25 at 10:41 A.M. CNA #257 verified there were residents in the hallway when Resident #5 had a knife. CNA #257 stated everyone ran away and the staff waited for the police to arrive. CNA #257 stated she had not provided any care for Resident #5 that day or any time prior. CNA #257 ended the interview stating she should not say any more. The facility filed self-reported incident #264663 on 08/29/25 (after the facility requested the police report from the incident) for an allegation of emotional/verbal abuse by staff towards Resident #5. Resident #5's relevant conditions included mood disorder, anxiety disorder, TBI, and paraplegia. An interview on 09/02/25 at 9:09 A.M. with the DON revealed the facility picked up the police report on 08/29/25 regarding the incident with Resident #5 and CNA #350. Verbiage in the police report included verbal altercation so a self-reported incident was filed with the state agency. The DON stated CNA #350 refused to write a statement stating she had already given a statement to the police. The DON also verified the nurse providing care for Resident #5 was an agency nurse and a statement (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not obtained from that nurse. The DON verified there was no evidence of what residents were in the hallway when the incident occurred and no residents had been interviewed about the incident. The DON verified there was not a statement given by Resident #5 as part of the facility's investigation. The Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 3/2024 revealed abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes verbal abuse. The person investigating the incident should generally take the following actions. Interviews include the resident, accused, and all witnesses, Witnesses generally include anyone who witness or heard the incident (including other residents, family members) and employees who worked closely with the accused employee and/or alleged victim the day of the incident. If the allegation involves abuse/neglect, interview other residents, as appropriate, to determine if they may have been affected by the accused staff member or resident.		

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 09/22/2025
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)		
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to timely complete a Preadmission Screening and Resident Review (PASARR) for Resident #9 and failed to ensure an accurate PASARR was completed for Resident #23. This affected two residents (#9 and #23) out of six residents reviewed for PASARR assessments. The facility census was 96. Findings include: 1. Resident #23 was admitted on [DATE], readmitted on [DATE], and discharged [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition, anemia, alcohol abuse, hypertensive heart disease, adult failure to thrive, chronic viral hepatitis C, osteoarthritis, cutaneous abscess of right lower limb, and multiple myeloma. Review of the 5-day Medicare Minimum Data Set (MDS) dated [DATE] Revealed Resident #23 was cognitively intact. Review of the Preadmission Screening and Resident Review (PASARR) identification screen dated 07/07/25 revealed Resident #23 had no mental disorders or substance use related disorders. An interview on 09/03/25 at 10:19 A.M. Social Services (SS) #312 verified the PASARR for Resident #23 dated 07/07/25 was incorrect due to Resident #23 had substance use disorder and Resident #23 had a diagnosis of alcohol abuse. 2. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder, chronic obstructive pulmonary disease, hypertension, and acute kidney failure. Review of Resident #9's MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated she was mildly cognitively impaired. Review of Resident #9's medical records revealed no evidence that an initial PASARR application/form was submitted to the state mental health agency to make a determination of her eligibility of additional services. During an interview on 09/02/25 at 12:05 P.M., SS #312 confirmed she filed a new PASSAR on this day because she noticed that one had not previously been filed when it should have been.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update the preadmission screening and resident review (PASARR) when Resident #15 received a new diagnosis. This affected one (Resident #15) out of six residents reviewed for PASARR assessments. The facility census was 96. Findings include: Review of the medical record revealed the Hospital Exemption from Preadmission Screening Notification dated 02/06/25 revealed Resident #15 had a mood disorder and paranoia. A disability of blindness was not marked. Review of the medical record for Resident #15 revealed he was admitted to the facility on [DATE] with diagnosis of unspecified psychosis, blindness, and delirium. A pharmacy recommendation dated 05/27/25 revealed a new diagnosis for Risperdal (an antipsychotic medication) was needed. A new diagnosis of delirium due to a known physiological condition was added on 06/06/25. A Preadmission Screening and Resident Review (PASARR) dated 08/28/25 was completed due to the Hospital Exemption from Preadmission Screening expiring. The PASARR was marked that Resident #15 had serious mental illnesses that included mood disorder and delirium due to know physiological condition. Resident #15 was prescribed antipsychotic and mood stabilizing medications. Resident #15 also had a related disability of blindness. A referral for Level II evaluation was made. An interview on 09/02/25 at 9:49 A.M. with Social Service #312 verified a PASARR should have been completed within 30 days of Resident #15 being admitted to the facility. Social Service #312 also verified a new PASARR should have been completed when a new diagnosis was added in June.		

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 09/22/2025
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)		
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 record review, interviews, and policy review, the facility failed to provide nail care for Resident #62 and failed to provide bathing as scheduled for Resident #68. This affected two (Resident #62 and #68) of nine residents reviewed for activities of daily living (ADL). The facility census was 96. Findings include: 1. Review of the medical record revealed Resident #62 was admitted on [DATE] with diagnoses that included dementia, type 2 diabetes, and chronic kidney disease. A care plan dated 08/13/25 revealed Resident #62 had an ADL self-care performance deficit with interventions to check nail length and trim and clean (nails) on bath day and as necessary. An admission Functional abilities and goals form dated 08/14/25 revealed Resident #62 was dependent on staff for bathing. An observation and interview on 08/26/25 at 8:27 A.M. with Resident #62 revealed Resident #62 had long fingernails with a dark substance under the nails. Resident #62 verified he would like his fingernails trimmed and cleaned. An additional observation and interview on 09/02/25 at 10:33 A.M. revealed Resident #62 still had long fingernails with a dark substance under the nails. Resident #62 stated he was not a girl, and he wanted his fingernails trimmed and cleaned. An interview on 09/02/25 at 10:34 A.M. with Unit Manager #347 verified Resident #62 had long, dirty fingernails. Resident #62 asked Unit Manager #347 if his fingernails could be trimmed that day. Unit Manager #347 obtained items to trim Resident #62's fingernails. 2. Review of the medical record revealed Resident #68 was admitted on [DATE] with diagnoses that included dysphagia, anxiety, malignant neoplasm of male breast, and type 2 diabetes. The annual Minimum Data Set (MDS) dated [DATE] revealed it was very important to Resident #68 to choose between a tub bath, shower, and bed bath. The quarterly MDS dated [DATE] revealed Resident #68 had cognitive impairment and was independent with bathing. A care plan dated 06/30/25 for ADL self-care performance revealed Resident #68 required one person assistance for bathing. Review of the bathing documentation revealed Resident #68 received a shower on 08/02/25, a bed bath on 08/04/25, unknown type of bathing on 08/06/25, and a shower on 08/09/25. Resident #68 was not bathed again for ten days. The resident received a bed bath on 08/20/25. Resident #68 was scheduled to be bathed on day shift every Wednesday and Saturday. An interview on 08/25/25 at 2:02 P.M. with Resident #68 stated he did not get bathed because the staff do not like to bathe residents. Resident #68 verified he preferred showers. An interview on 09/03/25 at 9:27 A.M. with the Director of Nursing (DON) verified Resident #68 was not bathed twice a week as scheduled and he required staff assistance to be showered. The ADL Supporting policy revised 03/2018 revealed appropriate care and services will be provided for residents who are unable to carry out ADL's independently including appropriate support and assistance with hygiene which includes bathing and grooming.		

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 09/22/2025
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Resident #11 and #38 were offered activities and had activity plans of care in place. This affected two residents (#11 and #38) of three residents reviewed for activities. The facility census was 96. Findings include: 1. Review of Resident #38's medical record revealed an admission date of 04/17/25 with diagnoses including cognitive communication deficit, chronic pain syndrome, major depressive disorder, unspecified dementia, open angle glaucoma bilateral and severe, and retinal neovascularization of the right eye. Review of Resident #38's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #38's recreational therapy assessment dated [DATE] revealed the resident had interest in jazz, reading, and watching television and movies. Review of Resident #38's plan of care on 08/25/25 revealed it did not address her activities preferences. Review of Resident #38's medical record revealed no evidence she had been offered or attended activities from 07/01/25 to 08/25/25. Review of August 2025 activity calendar revealed morning activities every day included exercise with hydration and the daily chronicle. There were no activities scheduled after 3:30 P.M. Interview on 08/25/25 at 11:56 A.M. with Resident #38 revealed the activities department was short staffed. They no longer followed the activity schedule. Resident #38 reported she would attend activities if they had them. Without the scheduled activities she felt she no longer had any reason to leave her room. Interview on 09/02/25 at 1:04 P.M and 1:39 P.M. with Activities Aide #403 revealed she was the only full-time activity staff, the activities director was providing transportation as well. She verified they were not always doing activities according to the schedule. In the morning, she was in the memory care unit and in the afternoon she did activities for the rest of the facility. She reported activities stopped at four due to her schedule. Activities Aide #403 verified there was no evidence Resident #38 had been offered to attend activities. She reported she had pretty much only had time to introduce herself to Resident #38. 2. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including muscle weakness, Alzheimer's disease, depression, high blood pressure and asthma. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 07. This resident was assessed to require assistance with self-care activities. Review of the care plan dated 01/06/25 revealed a focus on Resident #11's psychosocial well-being (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to her dementia and schizoaffective disorder. Interventions included monitoring the resident for feelings of isolation. Continued review of Resident #11's care plan revealed there was no activity related focus areas, goals, or interventions. Observations of Resident #11 on 08/27/25, 08/28/25, 09/01/25, 09/02/25 and 09/03/25 between 08:00 A.M. and 5:00 P.M. revealed the resident alone in her room, lying in her bed. During an interview with Resident #11 on 08/26/25 at 8:35 A.M. Resident #11 said she didn't know of any activities happening in the facility, but if there were any, she would like to participate in them. During an interview with Activities Specialist #300 on 09/02/25 at 1:05 P.M. confirmed she had not introduced herself to Resident #11, discussed her activities interests, or invited her to any activities. Activities Specialist #300 additionally confirmed Resident #11 did not have an activity plan of care. Review of the policy 'Activity programs' dated July 2024, revealed the activities program was to support the well-being of residents and to encourage both independence and community interaction. Activities offered should be based on the comprehensive resident-centered assessment and the preferences of each resident. Activities were to be documented in the residents medical record. Scheduled activities were to be posted on the resident bulletin board.		

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 09/22/2025
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility policy review, the facility failed to implement interventions to prevent pressure ulcer development for Resident #21 and failed to ensure Resident #85's pressure ulcer was treated as ordered. This affected two residents (#21 and #85) of four residents reviewed for pressure ulcers. The facility census was 96. Findings include:1. Review of Resident #21's medical record revealed an admission date of 07/29/25 with diagnoses including obstructive and reflux uropathy, spinal stenosis, severe protein-calorie malnutrition, colostomy status, pressure ulcer of sacral region, heart failure, and anal abscess. Review of the Braden scale for Predicting Pressure ulcer risk for Resident #21, dated 07/29/25, revealed the resident was at moderate risk for developing pressure ulcers. This was related to a very limited sensory perception, very limited mobility, and friction and shearing risk. Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #21, dated 08/05/25, revealed he had intact cognition. The resident was at risk of developing pressure ulcers. Resident #21 needed staff assistance with bed mobility. Review of Resident #21's plan of care, dated 08/11/25, revealed he had actual pressure injury with risk for delayed wound healing secondary to progressing comorbidities, debility and generalized weakness with decreased physical mobility and bowel and bladder incontinence. Interventions included frequent turning and repositioning, weekly skin evaluation, wound care as ordered, providing and encouraging nutritional supplements per dietary recommendation, preventative skin scare post incontinence, and obtaining and monitoring labs as ordered. Review of Resident #21's activity of daily living (ADL) documentation from 08/01/25 to 08/18/25 revealed turning and repositioning was not recorded as having been provided. There was no evidence turning and repositioning had been refused by or offered to the resident. They don't necessarily have to document it. Review of Resident #21's progress note written by Certified Nurse Practitioner (CNP) #400 and dated 08/11/25 documented Resident #21 was seen for assessment of his non-pressure surgical wound. Preventative measures in place to prevent the development of further wounds included turning and repositioning and incontinence care according to the facility protocol. Review of Resident #21's functional assessment dated [DATE] revealed the resident was dependent on staff for rolling from side to side in the bed. Review of the pressure skin grid for Resident #21, dated 08/18/25, documented he had a new area to his mid-back. This was an unstageable pressure ulcer measuring four cm by two cm by two cm. The area had moderate drainage with 100 percent slough. Review of Resident #21's physician order dated 08/20/25 to 08/25/25 revealed an order to cleanse the area to his middle back with normal saline, pat dry, apply silver alginate, and cover with foam dressing daily. Review of Resident #21's Treatment Administration Record (TAR) from 08/20/25 to 08/25/25 revealed treatment to his back was not completed on 08/22/25 and 08/23/25. There was no (continued on next page)		

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 09/22/2025
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	additional corresponding documentation to reflect why the treatments were not completed on 08/22/25 and 08/23/25. Review of Resident #21's physician order dated 08/26/25 revealed an order to cleanse the area to his middle back with normal saline, pat dry, apply silver alginate, and cover with foam dressing daily and as needed. Review of Resident #21's Treatment Administration Record (TAR) from 08/26/25 to 08/31/25 revealed treatment to his back was not completed on 08/29/25. There was no additional corresponding documentation to reflect why the treatment was not completed on 08/29/25. During an interview on 09/02/25 at 3:49 P.M. and on 09/03/25 at 9:08 A.M., the Director of Nursing (DON) verified there was no evidence the facility was turning and repositioning Resident #21 as care planned or recommended by the CNP prior to the development of his pressure ulcer on 08/18/25. The only preventative measure in place was a low air-loss mattress. 2. Review of the medical record for Resident #85 revealed an admission date of 05/10/19. Diagnoses included paraplegia, pressure ulcer of the sacral region stage four, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/19/25, revealed Resident #85 had intact cognition. The resident was dependent on staff for bed mobility, transfers, ambulation. Review of Resident #85's orders in the electronic medical record revealed an order dated 07/10/25 to cleanse the sacral wound with Dakin's solution and pat dry. Apply Dakin's wet-to-dry gauze dressing and cover with a foam dressing daily and as needed. Review of an outside wound practitioner progress note dated 08/04/25 revealed Resident #85's sacral wound was to be cleansed with normal saline and covered with a bordered foam dressing daily. Continued review of Resident #85's electronic medical record revealed no evidence the wound practitioner's order for the resident's sacral wound to be cleansed with normal saline and covered with a bordered foam dressing daily had been transcribed into the medical record or implemented by nursing staff. Review of Resident #85's Treatment Administration Record (TAR) for August 2052 revealed it contained the sacral dressing ordered on 07/10/25 for the wound to be cleansed with Dakin's solution, a Dakin's wet-to-dry gauze dressing to be applied covered with a foam dressing daily and as needed. The treatment was the only treatment ordered for Resident #85's sacral wound and was recorded as administered as ordered. Interview on 08/29/2025 at 9:44 AM with Licensed Practical Nurse (LPN) #221 verified the current wound treatment being done for Resident #85's sacral wound is cleansing the wound with Dakin's solution, patting it dry, and applying a Dakin's wet-to-dry gauze and covering the wound with bordered foam. During an interview on 09/03/2025 at 9:25 AM, the DON verified the last provider to see Resident #85 was the nurse practitioner on 08/04/25 because he has refused to be seen since then, so the treatment orders from that date are the ones that the staff should be following. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's skin and wound management policy dated October 2024 revealed nurses will ensure treatments for skin and wounds are implemented as ordered.		

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 09/22/2025
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure documented evidence of Resident #15's bowel movements and failed to ensure documented evidence of Resident #21's catheter care. This affected two (Residents #15 and #21) out of four residents reviewed for bowel and bladder. The facility census was 96. Findings include: 1. Review of the medical record revealed Resident #15 was admitted [DATE] with diagnoses that included unspecified psychosis, left side rib and right lower leg fracture, blindness, and delirium. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had cognitive impairment. The MDS also revealed Resident #15 was always continent of bowel and bladder. Review of the bowel documentation revealed Resident #15 did not have documentation of a bowel movement from 08/07/25 until 08/16/25. An interview on 09/03/25 at 9:17 A.M. with the Director of Nursing (DON) verified the facility did not have a bowel protocol, but stated a residents' name would show up on the dashboard of the electronic medication record if a bowel movement was not recorded for several days. The DON verified there was no documentation of Resident #15 having a bowel movement on 08/07/25 through 08/15/25. 2. Review of Resident #21's medical record revealed an admission date of 07/29/25 with diagnoses including obstructive and reflux uropathy, hypertension, spinal stenosis, severe protein-calorie malnutrition, systolic heart failure, colostomy status, pressure ulcer of sacral region, heart failure, and anal abscess. Review of Resident #21's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition and an indwelling catheter. Review of Resident #21's plan of care dated 08/11/25 revealed he had a need for an indwelling foley catheter related to benign prostatic hypertrophy. Interventions included catheter care every shift, monitoring for signs and symptoms of urinary tract infection, documenting output, providing perineal care prior to application and removal of catheter, irrigating foley catheter as needed, keeping tubing free of kinks and twists, maintaining the drainage bag below bladder, and privacy cover to drainage bag. Review of Resident #21's Certified Nurse Practitioner (CNP) note dated 08/03/25 revealed the resident had a chronic foley catheter since September of 2024. Review of Resident #21's physician order dated 08/19/25 revealed an order to maintain a 16 French urinary catheter and replace as needed for obstructive uropathy. Review of Resident #21's physician order dated 08/25/25 revealed an order for catheter care every shift and as needed. Review of Resident #21's medical record revealed no evidence catheter care was performed prior to 08/25/25. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/03/25 at 9:08 A.M. with the Director of Nursing (DON) verified there was no documented evidence that catheter care had been performed prior to 08/25/25.		

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 09/22/2025
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)		
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide documented evidence that Resident #9's ileostomy/urostomy bag was routinely changed. This affected one (Residents #9) out of four residents reviewed for bowel and bladder. The facility census was 96. Findings include: Review of the medical record for Resident #9 revealed an admission date of 03/03/25. Diagnoses included acute kidney failure, hypertension, colostomy, and ileostomy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/24/25, revealed the resident had slightly impaired cognition. It also noted the resident required staff assistance with managing her colostomy and ileostomy, including changing of the bags. Review of Resident #9's physician orders for March 2025 revealed no orders for ensuring the resident's ileostomy or urostomy bag was changed. Review of Resident #9's medical record revealed no documented ileostomy or urostomy bag changes from her admission [DATE] until she was hospitalized on [DATE]. Review of Resident #9's hospital documentation confirmed she was hospitalized from [DATE] to 04/25/25. During her stay, she was diagnosed and treated for a urinary tract infection. The hospital notes also stated Resident #9 had a [NAME] operation (ileal conduit urinary diversion, creating a new way for urine to exit the body) in 2001. The verbiage urostomy and ileostomy were utilized interchangeably through the medical record. Review of Resident #9's physician orders revealed on 04/28/25 the resident was ordered a urostomy wafer and pouch change every three days. During an interview with the Director of Nursing (DON) on 09/03/25 at 9:29 A.M. she confirmed there was not an order or documented evidence that Resident #9's ileostomy or urostomy bag was changed routinely.		

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 09/22/2025
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to appropriately supervise and position Resident #107 during meals, and timely implement dietitian recommendations for Resident #4 and #21. This affected three residents (#4, #21, and #107) of seven residents reviewed for nutrition. The facility census was 96. Findings include: 1. Review of Resident #107's medical record revealed an admission date of 07/20/17 with diagnoses including dysphagia, cognitive communication deficit, type two diabetes mellitus, cerebral infarction, vascular dementia, peripheral vascular disease, epilepsy, sickle-cell disease, contracture of left foot and hand, and flaccid hemiplegia affecting left nondominant side. Review of Resident #107's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. He required substantial to maximal assistance with eating. Review of Resident #107's occupational evaluation and plan of treatment dated 06/09/25 revealed he had left upper extremity paralysis with contractures. Review of Resident #107's diet order dated 08/19/25 revealed an order for a cardiac or diabetic diet, mechanical soft texture, with nectar thick consistency. He was to receive a divided plate for all meals and receive close supervision. Observation on 08/28/25 at 8:35 A.M. revealed Resident #107 eating breakfast in his room without staff present. His food was on the bedside table which was to the left side of the bed, it was not over him. He was leaning over the perimeter mattress bringing the spoon to his mouth with his right hand. There was food observed all over the tray and the resident and no fluids were present. Interview on 08/28/25 at 8:38 A.M. with Certified Nursing Assistant (CNA) #310 verified the observation. He verified Resident #107 was supposed to be supervised during meals and he was not positioned appropriately. 2. Review of Resident #4's medical record revealed an admission date of 08/16/24 with diagnoses including gastrostomy, severe protein-calorie malnutrition, multiple sclerosis, stage four pressure ulcer of sacral region, epilepsy, unspecified convulsions, cognitive communication deficit, and major depressive disorder. Review of Resident #4's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #4's plan of care revised 07/24/25 revealed the resident received both oral and enteral nutrition with a history of poor oral intake. Interventions included addressing any nutritional concerns, administering flushes as ordered, checking tube for placement and patency before feeding, elevating the head of bed, adjusting tube feeding with any changes, and monitoring weight as ordered. Review of Resident #4's physician order dated 05/09/25 revealed an order for Osmolyte 1.2 Calorie continuously at 65 milliliters (ml) per hour. Review of Resident #4's progress note dated 08/08/25 revealed the dietitian recommended increasing the tube feeding rate to 70 ml an hour due to a worsening wound. Review of Resident #4's medical record revealed no evidence this recommendation was addressed. Interview on 09/02/25 at 3:49 P.M. with the Director of Nursing (DON) verified Resident #4's tube feeding was not increased as recommended. 3. Review of Resident #21's medical record revealed an admission date of 07/29/25 with diagnoses including obstructive and reflux uropathy, hypertension, spinal stenosis, severe protein-calorie malnutrition, systolic heart failure, colostomy status, pressure ulcer of sacral region, heart failure, and anal abscess. Review of Resident #21's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. Review of Resident #21's diet order dated 07/29/25 revealed an order for a regular diet with regular texture. Review of Resident #21's plan of care revised 08/01/25 revealed the resident was at risk for malnutrition related to recent admission, chronic conditions, a wound increasing metabolic needs, and his advanced age. Interventions included following the diet as ordered, providing supplements as ordered, obtaining weight as ordered, reporting significant weight changes, monitoring labs, and assessing diet tolerance. Review of Resident #21's nutrition risk assessment dated [DATE] revealed the dietitian recommended double protein portions for dietary support. Review of Resident #21's diet order dated 08/13/25 revealed an order for regular diet with (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	double protein portions. Interview on 09/02/25 at 12:54 P.M. and 1:36 P.M. with Dietitian #402 revealed she wrote her recommendations on a form her company designed and sent it to nursing at every visit. Dietician #402 verified Resident #21's double portion recommendation was not completed timely, however, she was unsure of the cause.		

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 09/22/2025
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to administer a fentanyl patch as ordered for Resident #38 and failed to ensure parameters were in place for Resident #105's pain medications to administer them appropriately. This affected one resident (#105) of five reviewed for unnecessary medications and one resident (#38) of four people reviewed for pain. The facility census was 96. Findings include: 1. Review of Resident #38's medical record revealed an admission date of 04/17/25 with diagnoses including migraine, osteoarthritis, cognitive communication deficit, chronic pain syndrome, major depressive disorder, unspecified dementia, open angle glaucoma bilateral and severe, and retinal neovascularization of the right eye. Review of Resident #38's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition, almost constantly had pain that occasionally affected day to day activities and the worst pain over the last five days was an eight out of ten. Review of Resident #38's plan of care dated 09/18/23 revealed the resident was at risk for impaired comfort related to chronic arthritis, wedge compression fracture, chronic pain, and migraines. Interventions included administering pain medications as ordered, assessing for verbal and nonverbal signs of pain and treating accordingly, encouraging to report pain as soon as it starts, monitoring and recording pain characteristics, monitoring and reporting to the nurse any complaints of pain or requests for pain treatment, nonpharmacological interventions, positioning for comfort as needed, and therapy evaluation as needed. Review of Resident #38's physician order dated 04/20/25 revealed an order for a Fentanyl Patch 12 micrograms (mcg) per hour to be applied once every 72 hours and removed per schedule. Review of Resident #38's Medication Administration Record (MAR) for July 2025 and August 2025 revealed the Fentanyl Patch was not given on 07/10/25, 08/03/25, or 08/12/25. Review of Resident #38's progress notes for July 2025 and August 2025 revealed on 07/10/25 and 08/12/25 the Fentanyl Patch was unavailable. There was no documented reason for the lack of administration on 08/03/25. Review of Resident #38's Narcotic count sheets verified the Fentanyl Patches were not administered on 07/10/25, 08/03/25, 08/12/25. However, the Fentanyl Patch should have been in house on 08/03/25. Interview on 08/25/25 at 11:56 A.M. with Resident #38 revealed they had missed administering her Fentanyl Patch on a few occasions. She reported even when it came in, they normally waited until the next scheduled day to put it on her. She reported she now made them keep the old patch on her until the new one came in. Interview on 08/28/25 at 12:00 P.M. and 2:04 P.M. with the Director of Nursing (DON) verified Resident #38 had not received her Fentanyl Patch as ordered. 2. Review of Resident #105's medical record revealed an admission date of 02/20/22 with diagnoses including anxiety disorder, paraplegia, moderate protein-calorie malnutrition, neuromuscular dysfunction of bladder, claustrophobia, social phobia, gout, and radiculopathy. Review of Resident #105's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. Review of Resident #105's plan of care, revised 05/13/24, revealed the resident was at risk for impaired comfort related to diagnoses, decreased mobility, use of assistive devices, and effects of medication. Interventions included administering pain medication as ordered, ace wraps to legs, assessing for pain every shift, encouraging to report pain as soon as it started, monitor for constipation, monitoring and recording pain characteristics, and ice pack to right earlobe as needed. Review of Resident #105's physician orders dated 05/02/23 revealed an order for Oxycodone five milligrams with instructions to administer two tablets by mouth every eight hours as needed (PRN) for pain. Review of Resident #105's physician order dated 05/08/23 revealed an order for Acetaminophen 325 milligrams (mg) two tablets by mouth every six hours as needed for pain. Review of Resident #105's Medication Administration Record (MAR) for August 2025 revealed there were no parameters in place for pain medication administration. Oxycodone was given on 08/10/25 for a pain of zero, on 08/23/25 for a pain of three, on 08/24/25 for a pain of five, and on 08/29/25 for a pain of three. Acetaminophen was (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given on 08/13/25 for a pain of three. Review of Resident #105's progress notes dated 08/10/25 to 08/29/25 revealed there was no description of Resident #105's pain on 08/23/25, 08/24/25, or 08/29/25. Interview on 09/02/25 at 3:49 P.M. with the Director of Nursing (DON) verified there were no parameters in place for pain medication. She additionally verified a pain of zero was not appropriate for the administration of Oxycodone. The DON verified nursing should be documenting the description of Resident #105's pain when administering PRN medication. Review of the policy titled 'Pain-Clinical Protocol' dated March 2018, revealed the staff were to identify characteristics of pain such as location, intensity, frequency, pattern, and severity.		

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 09/22/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to appropriately document the disposal of fentanyl patches for Resident #38. This affected one resident (#38) of five residents reviewed for pain. The facility census was 96. Findings include: Review of Resident #38's medical record revealed an admission date of 04/17/25 with diagnoses including migraine, osteoarthritis, cognitive communication deficit, chronic pain syndrome, unspecified dementia, open angle glaucoma bilateral and severe, and retinal neovascularization of the right eye. Review of Resident #38's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. almost constantly had pain that occasionally affected day to day activities. The worst pain over the last five days was an eight. Review of Resident #38's plan of care dated 09/18/23 revealed the resident was at risk for impaired comfort related to chronic arthritis, wedge compression fracture, chronic pain, and migraines. Interventions included administering pain medications as ordered, assessing for verbal and nonverbal signs of pain and treating accordingly, encouraging to report pain as soon as it starts, monitoring and recording pain characteristics, monitoring and reporting to the nurse any complaints of pain or requests for pain treatment, nonpharmacological interventions, positioning for comfort as needed, and therapy evaluation as needed. Review of Resident #38's physician order dated 04/20/25 revealed an order for a Fentanyl Patch 12 micrograms per hour to be applied once every 72 hours and removed per schedule. Review of Resident #38's Narcotic Count sheets from 05/29/25 to 08/24/25 revealed nursing staff was not appropriately documenting the disposal of Resident #38's Fentanyl Patch. Disposal was not documented on 06/01/25, 06/04/25, 06/07/25, 06/10/25, 06/13/25, 06/19/25, 06/22/25, 06/25/25, 06/28/25, 07/01/25, 07/04/25, 07/07/25, 07/19/25, 07/22/25, 07/25/25, 07/28/25, 07/31/25, 08/06/25, and 08/09/25. The disposal was signed but unwitnessed on 05/29/25, 07/12/25, 07/13/25, and 07/16/25. Interview on 08/28/25 at 2:04 P.M. with the Director of Nursing (DON) verified the nurses were not appropriately documenting the disposal of Fentanyl Patches for Resident #38. She stated the disposal of Fentanyl Patches should be witnessed and signed on the narcotic sheet by two nurses.		

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 09/22/2025
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #15's medication was ordered with the proper diagnosis. This affected one (Resident #15) of five residents reviewed for appropriate diagnosis for medications. The facility census was 96. Findings include: Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses of unspecified psychosis, left side rib and right lower leg fracture, blindness bilateral category 3, delirium, and acute embolism and thrombosis of deep veins of right lower extremity. Review of physician orders revealed from 04/17/25 until 09/03/25 Resident #15 was ordered Clonidine (to treat high blood pressure) 0.1 milligram transdermal patch weekly for deep vein thrombosis. Review of the medication administration record revealed the resident received the medication as ordered. An interview on 09/03/25 at 9:17 A.M. with the Director of Nursing (DON) verified a diagnosis of deep vein thrombosis was an incorrect diagnosis for Clonidine and there was no documentation to support the use of the medication.		

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 09/22/2025
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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent Resident #8 from experiencing a significant medication error when he missed his immunosuppressant medication related to a kidney transplant. This affected one resident (#8) of seven residents reviewed for accidents. The facility census was 96. Findings include: Review of Resident #8's medical record revealed an admission date of 06/06/19 with diagnoses including brief psychotic disorder, bipolar disorder, schizoaffective disorder, kidney transplant status, unspecified mood disorder, chronic kidney disease stage three, and immunodeficiency. Review of Resident #8's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #8's plan of care, revised 06/08/23, revealed the resident had renal insufficiency related to stage three kidney disease and immunodeficiency due to a kidney transplant. Interventions included monitoring and reporting changes in mental status, monitoring for signs of hypovolemia, monitoring for signs of acute renal failure, and monitoring and reporting signs including edema, weight gain of over two pounds a day, neck vein distension, difficulty breathing, increased heart rate or blood pressure, skin temperature, loss of consciousness, and crackles in breath sounds. Review of Resident #8's physician order dated 03/18/24 revealed an order for Mycophenolate Sodium Tablet Delayed Release (an immunosuppressant used to prevent organ rejection after a transplant) 360 milligrams (mg) one tablet by mouth twice a day for kidney transplant. Review of Resident #8's Medication Administration Record (MAR) for August 2025 revealed Mycophenolate was not given in the evening on 08/08/25, 08/14/25, 08/19/25, 08/24/25, and 08/25/25 or in the morning on 08/15/25, 08/21/25, 08/22/25, and 08/25/25. Review of Resident #8's progress notes dated 08/01/25 to 08/25/25 revealed the Mycophenolate medication was unavailable on 08/08/25, 08/15/25, 08/19/25, 08/21/25, 08/22/25, 08/24/25, 08/25/25. Interview on 09/02/25 at 3:22 P.M. with the Director of Nursing (DON) verified Resident #8 was missing doses of his medication. She reported at times the pharmacy did not have it and at times they were working with insurance to get approval.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, the facility failed to ensure Resident #10's physician-ordered laboratory testing was completed as ordered. This affected one resident (#10) of five residents reviewed for unnecessary medications. The facility census was 96. Findings include: Review of Resident #10's medical record revealed an admission date of 04/18/25 and diagnoses including, but not limited to, diabetes, dementia, major depressive, hypertension, asthma, and other sequelae of cerebral infarction. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment, dated 06/11/25, revealed a Brief Interview for Mental Status (BIMS) could not be completed because the resident was rarely/never understood. The resident required set up assistance for eating, was independent for bed mobility, and required supervision for transfers and ambulation. Resident #10's MDS indicated he was occasionally incontinent of bladder and frequently incontinent of bowel and was working with physical therapy at the time of the assessment. Review of Resident #10's physicians orders revealed an order dated 07/30/25 for laboratory testing for a complete blood count, comprehensive metabolic panel, hemoglobin A1C, thyroid-stimulating hormone, vitamin B12 level and a vitamin D level to be completed. Review of Resident #10's nursing progress notes revealed a note dated 08/01/25 that stated laboratory testing for a complete blood count, comprehensive metabolic panel, hemoglobin A1C, thyroid-stimulating hormone, vitamin B12 and vitamin D level was ordered and the laboratory orders were entered into the laboratory system to be drawn on 07/30/25, but were not collected. The laboratory orders were re-entered on 08/01/25 to be collected. Review of Resident #10's medical record revealed no laboratory testing results nor any evidence the laboratory testing had been obtained. In an interview on 09/03/2025 at 9:01 A.M. the Director of Nursing (DON) confirmed Resident #10's laboratory testing ordered on 07/30/25 was not completed.		

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 09/22/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure enhanced barrier precautions were in place as ordered for Resident #4, failed to appropriately sanitize a blood pressure cuff for the B Hall, and failed to maintain infection control procedures by changing Resident #64's incontinence brief in Residents #71's bed. This affected three residents (#4, #64, and #71) out of 10 residents reviewed for infection control, and had the potential to affect 47 residents residing on the B hall, that utilized the facility blood pressure cuff, at the time of the survey. The facility census was 96. Findings Include: 1. Review of Resident #64's medical record revealed an admission date of 11/25/24 and diagnoses including, but not limited to, depression, anxiety disorder, Vitamin D deficiency, hypertension, diabetes, and unspecified dementia. Review of Resident #64's quarterly Minimum Data Set (MDS) assessment, dated 06/02/25, revealed a Brief Interview for Mental Status (BIMS) score of 02 indicating the resident was severely cognitively impaired. The resident required set up assistance for eating, partial/moderate assistance for bed mobility and transfers, and was dependent for toileting hygiene. Further review of the MDS revealed Resident #64 was always incontinent of bladder and bowel. The assessment indicated Resident #64 was a male. An observation made on 08/25/25 at 11:45 A.M. revealed Certified Nursing Assistant (CNA) #304 assisting Resident #64 down the hall in a wheelchair and into a room. Further observation of the room CNA #304 and Resident #64 entered revealed the nameplate on the door indicated the room belonged to two female residents, #83 and #71. CNA #304 was observed to assist Resident #64 into the bed on the far side of the room (Resident #71's bed). CNA #304 then proceeded to close the door to the room. In an interview on 08/25/25 at 11:50 A.M. the Assistant Director of Nursing (ADON) confirmed Resident #64 was given incontinence care in Resident #71's bed. Resident #71's bed was stripped of the contaminated linens after the confirmation. 2. An observation and interview on 08/26/25 at 7:57 A.M. revealed Registered Nurse (RN) #253 came out of Resident #87's room with a blood pressure cuff. RN #253 pulled a facial tissue out of a box on the medication cart and applied hand sanitizer to it. RN #253 then used the facial tissue, with hand sanitizer on it, to wipe the blood pressure cuff. RN #253 verified she did not have any sanitation wipes to clean the blood pressure cuff. RN #253 opened the medication cart (for Hall B) and verified there were no sanitation wipes available in the medication cart. At 8:18 A.M. Regional Nurse #264 provided RN #253 with sanitation wipes. The Cleaning and Sanitizing Nursing Equipment policy dated June 2024 revealed only facility-approved environmental protection agency-registered disinfectants were to be used and to ensure the appropriate contact time for the disinfectant was followed. Non-critical equipment such as blood pressure cuffs, were to be wiped down with disinfectant wipes or solution. Shared equipment was to be cleaned and disinfected thoroughly after each resident use. 3. Review of Resident #4's medical record revealed an admission date of 08/16/24 with diagnoses including gastrostomy, severe protein-calorie malnutrition, multiple sclerosis, stage four pressure ulcer of sacral region, epilepsy, unspecified convulsions, cognitive communication deficit, and major depressive disorder. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #4's physician order dated 02/13/25 revealed an order for enhanced barrier precautions (EBP) related to her gastrostomy tube and wound. Review of Resident #4's plan of care revised 07/24/25 revealed the resident required enhanced barrier precautions related to her wound and peg tube site. Interventions included enhanced barrier precautions until resolution of the wound, resident and or responsible party educated, staff to wear a gown and gloves during high contact activities. Observation on 08/25/25 at 11:01 A.M. and 08/26/25 at 4:49 P.M. revealed Resident #4 did not have enhanced barrier precautions in place. There was no sign and no personal protective equipment (PPE) around her room. Interview on 08/26/25 at 4:49 P.M. with the Director of Nursing (DON) verified enhanced barrier precautions were not in place and should have been.		

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 09/22/2025
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)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure Resident #107's topical antibiotic cream was not provided antibiotic cream past its physician-ordered end date. This affected one resident (#107) of seven residents reviewed for accidents. The facility census was 96. Findings include: Review of Resident #107's medical record revealed an admission date of 07/20/17 with diagnoses including dysphagia, cognitive communication deficit, type two diabetes mellitus, cerebral infarction, vascular dementia, epilepsy, contracture of left foot and hand, and flaccid hemiplegia affecting left nondominant side. Review of Resident #107's progress note dated 05/29/25 revealed the resident was noted to have several liquid filled blister like areas on the back of his hand. Two of the areas were seeping and two were completely opened. There was a yellowish drainage with a mild odor and the resident had pitting edema to his hand. The physician was notified, and they received orders to send the resident to the hospital. Review of Resident #107's after visit summary dated 05/31/25 revealed the changes in his medication included Mupirocin, a topical antibiotic to be applied to his hand. This was to be applied every day through 06/03/25. Review of Resident #107's physician order dated 06/02/25 revealed the resident had an order for Mupirocin External ointment 2% to be applied to the left hand wound topically every day shift. Review of Resident #107's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #107's Medication Administration Record for June 2025, July 2025, and August 2025 revealed Mupirocin had been administered from 06/02/25 to 08/25/25. Interview on 09/02/25 at 9:26 A.M. with the Director of Nursing (DON) verified Resident #107's antibiotic ointment was continued past when it should have been. Review of the policy Administering Medications revised December 2012 revealed medications must be administered in accordance with the orders, including any required time frame.		

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 09/22/2025
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)		
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide bed hold notices, and transfer/discharge notices to residents being sent to the hospital and to notify the ombudsman monthly of facility discharges. This affected three residents (#3, #55, and #109) of three reviewed for hospitalization. Findings Include: 1. Review of Resident #109's medical record revealed an admission date of 06/18/25, a discharge date of 06/30/25 and diagnoses including, but not limited to, diabetes, chronic kidney disease stage three, Alzheimer's disease, anxiety, hypertension and metabolic encephalopathy. Review of the admission Minimum Data Set (MDS) assessment, dated 06/24/25 revealed a Brief Interview for Mental Status (BIMS) score of six indicating the resident had severely impaired cognition. The resident required set up assistance for eating and substantial/maximal assist for bathing, toileting hygiene, bed mobility and transfers. Further review revealed Resident #109 was frequently incontinent of bladder and bowel, was receiving antidepressant, diuretic and hypoglycemic medications and was working with speech, occupational, and physical therapy. Review of Resident #109's medical record revealed no documentation the resident or resident's representative had been given a bed hold notice or a transfer/discharge notice. Further review of Resident #109's medical record revealed no documentation the ombudsman had been notified of the resident's transfer to the hospital. In an interview on 08/27/2025 at 3:23 P.M. the Director of Nursing (DON) stated the facility was not able to provide documentation that Resident #109 or her representative had received a bed hold notice or transfer/discharge notice. The DON further stated the facility was unable to provide documentation of the ombudsman being notified of Resident #109's transfer. 2. Review of Resident #55's medical record revealed an admission date of 07/29/25, a discharge date of 08/24/25 and diagnoses including, but not limited to, peripheral vascular disease, diabetes, chronic obstructive pulmonary disease, hypertension, and other acute osteomyelitis of the left ankle and foot. Review of Resident #55's admission Minimum Data Set (MDS) assessment, dated 08/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact. The resident required set up assistance for eating, partial/moderate assist with bathing and dressing and substantial/maximal with transfers. Further review revealed Resident #109 was continent of bladder and bowel, was receiving insulin, antidepressant, antidepressant, antibiotic, opioid, antiplatelet, hypoglycemic and anticonvulsant medications and was working with occupational and physical therapy. Review of Resident #55's medical record revealed no documentation the resident or resident's representative had been given a bed hold notice or a transfer/discharge notice. In an interview on 09/04/2025 at 3:45 P.M. the Director of Nursing (DON) stated the facility was not able to provide documentation that Resident #55 or his representative had received a bed hold notice or transfer/discharge notice. (continued on next page)		

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 09/22/2025
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)		
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	3. Review of the medical record revealed Resident #3 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included osteomyelitis, asthma, type 2 diabetes, and methicillin resistant staphylococcus aureus. A nursing note dated 04/23/25 at 7:22 P.M. revealed Resident #3 went to an appointment and had not returned. A nursing note dated 05/14/25 at 4:38 P.M. revealed Resident #3 was readmitted to the facility from the hospital. Review of the census revealed Resident #3 was out to the hospital on [DATE] and returned to the facility on [DATE]. An interview on 08/28/25 at 2:13 P.M. Director of Nursing (DON) verified Resident #3 had not been provided with a bed hold notification when Resident #3 went to the hospital on [DATE] and 05/25/25. An interview on 09/02/25 at 10:49 A.M. Resident #3 stated she was told once that she had only nine days for her room to be held. Resident #3 verified she was not given a formal bed hold notification. Review of the policy titled Bed-Holds and Returns, revised March 2017, revealed that prior to transfers residents or resident representatives would be informed in writing of the bed-hold and return policy. Review of the policy titled Facility Initiated Transfers and Discharge Notice, dated December 2024, revealed that in emergencies the resident and their representative would be notified as soon as possible.		