STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366135	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mohun Health Care Center	2340 Airport Dr Columbus, OH 43219

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to ensure resident care plans included use of hospice services. This affected one (Resident #8) out of eight residents reviewed for care plans. The facility census 62. Findings include:Review of the medical record for Resident #8 revealed an admission date of 11/28/16 with diagnoses of Alzheimer's, Parkinson's, hypertensive heart disease, ischemic cardiomyopathy, and dysphagia.Review of the quarterly minimum data set (MDS) 3.0 assessment completed 09/05/25 revealed Resident #8 is severely cognitively impaired.Review of physician order dated 09/26/25 revealed admit to hospice for Alzheimer's disease, weight loss, Parkinson's disease, and failure to thrive.Review of level of care evaluation dated 09/26/25 for Resident #8 revealed a diagnosis of Alzheimer's disease with an election to receive hospice care.Review of Resident #8's care plan dated 03/24/26 revealed no mention of receiving hospice services.Interview on 03/24/26 at 11:01 A.M. with Minimum data set (MDS) Nurse #301 confirmed Resident #8's care plan does not include hospice services and hospice should be reflected in the resident's comprehensive care planReview of comprehensive care plan policy (undated) revealed the facility is to develop and implement a comprehensive person-centered care plan for each resident, which includes objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. A comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 ensure physician ordered medications were administered under specified parameters, physician was notified of administration and weight changes. This affected one (Resident #1) out of seven resident records reviewed. The facility census was 62. Findings include:Review of the medical record for Resident #1 revealed an admission date of 06/14/16 with diagnoses including paroxysmal atrial fibrillation, presence of a cardiac pacemaker, cardiomyopathy, heart failure, nonrheumatic aortic valve stenosis, and hypertensive heart and chronic kidney disease with heart failure.Review of a physician order dated 11/28/24 directed staff to weigh the resident daily at 6:30 A.M. and notify the heart failure clinic for a weight loss or gain of two pounds overnight.Review of physician order dated 07/15/25 directed staff to administer metolazone (diuretic) 2.5 milligrams (mg) by mouth as needed for weight gain over two pounds overnight or increased swelling.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact and was receiving a diuretic.Review of weight records for Resident #1 revealed multiple overnight weight increases meeting the twoˆpound parameter, including 137 pounds (lbs) to 139 lbs on 12/01/25 to 12/02/25, 137.2 lbs to 141.2 lbs on 12/05/25 to 12/06/25, 136.5 lbs to 139.0 lbs on 12/19/25 to 12/20/25, 141.0 lbs to 143.0 lbs on 12/2/25 to 12/26/25, 138.2 lbs to 143.8 lbs on 01/0/26 to 01/02/26, and 135.8 lbs to 140.0 lbs on 01/23/26 to 01/24/26.Review of the medication administration record revealed metolazone was not administered on 12/02/25, 12/06/25, 12/20/25, 12/26/25, 01/02/26 and 01/24/26. Review of progress notes showed no documentation that the physician was notified of the weight changes on 12/02/25, 12/06/25, 12/20/25, 12/26/25, 01/02/26 and 01/24/26.Interview on 03/24/26 at 10:22 P.M. with Licensed Practical Nurse (LPN) #201 revealed physician orders should be followed when parameters are met, and the physician should be notified when metolazone is administered. She confirmed completing weights on 12/06/25, 12/20/25, and 01/02/26. Attempted interview on 03/24/26 at 10:35 P.M. with LPN #172 who completed weights on 12/17/25, 12/18/25, 12/26/25 and 1/23/26.Attempted interview on 03/24/26 at 10:43 P.M. with Registered Nurse #114 who completed weights 12/01/25, 12/05/25, 12/19/25 and 01/24/26. Interview on 03/24/26 at 2:49 P.M. with the Director of Nursing confirmed weight changes at or above two pounds occurred on 12/02/25, 12/06/25, 12/20/25, 12/26/25, 01/02/26, and 01/24/26 without metolazone administration or physician notification.Interview on 03/24/26 at 3:09 P.M. with Physician #302 confirmed metolazone should be administered per order and the physician should be notified within two hours of administration.Review of the undated care plan revealed staff were to monitor, document, and report signs of heart failure including dependent edema, periorbital edema, shortness of breath on exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles or wheezes on auscultation, orthopnea, fatigue, tachycardia, lethargy, and disorientation. Review of the undated significant weight change policy revealed the physician was to be notified of all significant weight changes as well as concerning trends that may not yet meet defined thresholds.

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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 medical record review, staff interview, and facility policy review, the facility failed to ensure antibiotic stewardship protocol was followed for the use of an antibiotic medication. This affected one (Resident #35) of one residents reviewed for the use of antibiotics. The census was 62.Findings Include: Resident #35 was admitted to the facility on [DATE]. Her diagnoses were Type II Diabetes, functional urinary incontinence, blepharitis, hypothyroidism, hyperlipidemia, vitamin D deficiency, decreased white blood cell count, anemia, dysphagia, venous insufficiency, kyphosis, anxiety disease, muscle wasting and atrophy, cognitive communication deficit, muscle weakness, depression, dorsalgia, and osteoarthritis. Review of her minimum data set (MDS) assessment, dated 01/15/26, revealed she was cognitively intact. Review of Resident #35 care plan for antibiotic use, dated 04/23/25, revealed she could be at risk for adverse effects and/or side effects of antibiotic medication therapy. The only monitoring interventions for this care plan were to monitor for ongoing signs of infection, to monitor for signs and symptoms of a potential adverse drug reaction, and to report if evident: elevated liver or kidney function tests, elevated potassium, decrease in platelets, lethargy, hearing loss, seizures, ventricular arrhythmias, peripheral neuropathy, and hypoglycemia. Review of Resident #35 progress notes, dated 08/13/25, revealed Resident #35 was expressing pain in her jaw with redness noted. She was prescribed Amoxicillin 500 mg, three times daily, for five days. Review of Resident #35 physician orders, dated 08/19/25, revealed Amoxicillin 500 mg once daily was ordered for prophylaxis of osteonecrosis of jaw. There is no end date provided for this medication and has been administered each day. Review of Resident #35 care plan, physician orders, pharmacy recommendations, and progress notes, dated 04/23/25 to current, revealed no specific documentation or plan to assess or monitor the use of long term antibiotics. Interview with Assistant Director of Nursing (ADON) #199 on 03/24/26 at 12:01 P.M. and 12:25 P.M. stated the antibiotic ordered for Resident #35 is being monitored by the physician and/or nurse practitioner on a monthly basis with all other medications during routine visits. Also, she confirmed that floor staff will report if there are signs/symptoms of change to the nursing staff. She confirmed Resident #35 is scheduled to see the dentist on an annual basis; not more often due to her diagnosis of osteonecrosis. The last appointment with the dentist was in August 2025, and then she saw the oral surgeon in September 2025. There has not been any dental or oral surgeon appointments or review of her condition/treatment by these specialists since. She confirmed there are no future appointments schedule until the annual appointments next August. She confirmed the nurse practitioner is the provider who had ordered the antibiotic; not the oral surgeon or dentist. She confirmed they do not have any plan or method of monitoring the effectiveness and necessity of the antibiotic on a periodic basis; it will continue with no end date until the physician or nurse practitioner determined the need is no longer there for the antibiotic. She also confirmed this antibiotic for Resident #35 is not listed on the infection control logs, because it is deemed to be a prophylactic antibiotic. Review of facility Antibiotic Stewardship Program, dated September 2025, revealed it is the policy of the facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. The facility will monitor response to anti-biotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g. antibiotic timeout). At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Documentation related to the program maintained by the Infection Preventionist, including, but not limited to: action plans and/or work plans associated with the program, assessment forms, antibiotic use protocol/algorithms, data collection forms from antibiotic use, process, and outcome measures, feedback reports, records related to education of physicians, staff, residents, and families, and annual reports.