STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366155	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Albany Care Center	5691 Thompson Road Columbus, OH 43230

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to notify the physician and resident representative of a change in resident condition, in a timely manner. This affected one (Resident #62) of three residents reviewed for change in condition. Findings Include: Record review revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, constipation, disorder of muscle, cognitive communication deficit, dilated cardiomyopathy, pleural effusion, hyperkalemia, acute kidney failure, chronic kidney disease, atrial fibrillation, major depressive disorder, insomnia, hypo-osmolality and hyponatremia, atherosclerotic heart disease, hypertension, peripheral vascular disease, anemia, type II diabetes, and personal history of pulmonary embolism. Review of Resident #62's Minimum Data Set (MDS) assessment dated [DATE] revealed she had a mild cognitive impairment. Review of Resident #62's plan of care revealed she was at risk for respiratory complications related to her diagnoses of congestive heart failure, pleural effusion, and acute respiratory failure among other chronic health issues. Interventions for this care area included obtaining vital signs and notify physician as needed. Review of Resident #62's Fall Investigation form, dated 12/10/24, revealed she fell on [DATE] at 5:45 A.M. She was found on the floor, next to her bed, without her oxygen cannula. Her vital signs were taken and her oxygen saturation levels were between 88% and 90%. She had no injuries and was placed back into her bed. Because it was an unwitnessed fall, the facility started neurological checks. Evaluation statement of the fall revealed the following: resident was noted to have decreased oxygen saturation throughout the night and increased confusion. Staff reported to spend majority of the night in room with resident to ensure safety and keep oxygen on. Resident was impulsive at times. She was sent out to the hospital due to increased confusion and decreased oxygen saturation. There was no documentation to support the physician or resident representative were notified of the fall when it occurred, and were not notified of the decrease in oxygen saturation levels and increase confusion which were noted throughout the night of 12/10/24; prior to the fall. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62 progress notes, dated 12/09/24 to 12/10/24, revealed there was no documentation in the progress notes to support the physician and resident representative were notified of her decrease oxygen saturation levels and increased confusion during the night, and the fall that occurred on 12/10/24 at 5:45 A.M. Interview with the Director of Nursing (DON) on 12/17/24 at 1:15 P.M. confirmed there was no documentation to support the physician and resident representative were notified of the increased confusion and the decrease oxygen saturation levels, and there was no documentation the physician and resident representative were notified of the fall that occurred until she went to the hospital approximately 90 minutes after the fall and she had another change of condition. Interview with Licensed Practical Nurse (LPN) #103 on 12/17/24 at 1:30 P.M. confirmed she did not contact the physician about her decreased oxygen saturation levels and increased confusion until her oxygen saturation levels reached 64% at approximately 7:00 A.M., with was an hour and 15 minutes after her fall from bed. Review of facility Change in Condition policy, dated 08/09/23, revealed the nurse will notify the resident, the resident's physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and/or status. The nurse will notify when the following occur: an accident or incident involving the resident which results in an injury and has the potential for requiring physician/practitioner intervention. The nurse will document in the resident's medical record information relative to the resident's change in medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number OH00160665.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on closed medical record review, staff interview, and facility policy review, the facility failed to provide timely, adequate and necessary care, monitoring and treatment for Resident #62 who exhibited an acute change in condition. Actual harm occurred on 12/10/24 when Resident #62, who had an order for continuous use of oxygen, was noted to have an acute change in condition (decreased oxygen saturation levels and increased confusion) throughout the night that was not timely monitored or treated. In addition, there was no evidence the change in condition was reported timely to the physician. Per a facility fall investigation, on 12/10/24 at 5:45 A.M. the resident sustained an unwitnessed fall out of bed with low documented oxygen saturation levels. The resident was subsequently transported to the emergency room with a critically low oxygen saturation level of 64%. This affected one resident (#62) of three residents reviewed for change in condition. The census was 57. Findings Include: Review of Resident #62's closed medical record revealed an admitted [DATE]. Medical diagnoses included congestive heart failure, constipation, disorder of muscle, cognitive communication deficit, dilated cardiomyopathy, pleural effusion, hyperkalemia, acute kidney failure, chronic kidney disease, atrial fibrillation, major depressive disorder, insomnia, hypo-osmolality and hyponatremia, atherosclerotic heart disease, hypertension, peripheral vascular disease, anemia, type II diabetes, and personal history of pulmonary embolism. Review of Resident #62's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a mild cognitive impairment. Review of Resident #62's plan of care revealed she was at risk for respiratory complications related to her diagnosis of congestive heart failure, pleural effusion, and acute respiratory failure among other chronic health issues. Interventions for this care area included to administer oxygen as ordered by the physician, monitor and report to the physician any signs or symptoms of cardiovascular and/or respiratory complications such as shortness of breath, and obtain vital signs and notify physician as needed. Review of Resident #62's Fall Investigation form, dated 12/10/24, revealed the resident sustained a fall on 12/10/24 at 5:45 A.M. The resident was found on the floor, next to her bed, without her oxygen cannula. Her vital signs were taken, and her oxygen saturation levels were between 88% and 90%. The resident had no injuries and was placed back into her bed. Due to the fall being unwitnessed, the facility started neurological checks. An evaluation statement of the fall revealed the following: resident was noted to have decreased oxygen saturations throughout the night and increased confusion. Staff reported to spend majority of the night in the resident's room with the resident to ensure safety and to ensure the resident kept her oxygen nasal cannula on. Resident was documented as impulsive at times. Resident #62 was sent out to the hospital due to increased confusion and decreased oxygen saturations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #62's Neurological Evaluation Flowsheet, dated 12/10/24, revealed the following vital signs and checks were completed: level of consciousness, eye response, motor movement, communication/verbal responses, blood pressure, temperature, and respiration rate. Her oxygen saturation levels were not documented. Also, the documentation on the form confirmed the resident was confused at every monitoring time after the fall, until she was sent to the hospital. Review of Resident #62's progress note, dated 12/10/24, revealed the nurse entered her room at 7:00 A.M. Resident was noted to have labored breathing and pulse oxygen level was at 62%. Her lungs were moist in all fields. The physician was notified and the resident was transferred to the emergency room . Review of Resident #62's vital sign records, dated 12/09/24 to 12/10/24, revealed on 12/09/24 at 11:37 A.M. the resident's oxygen saturation was documented to be 94%, on 12/10/24 at 5:09 P.M. 94%, and 12/10/24 at 12:30 P.M. 64%. Further documentation provided by the facility revealed the oxygen saturation (pulse oximetry) level documented on 12/10/24 at 12:30 P.M. was actually obtained on 12/10/24 at 7:00 A.M. but documented as a late entry. Record review no evidence the resident's oxygen level was documented between 12/09/24 at 11:37 A.M. and 12/10/24 at 5:09 A.M. to show the resident was assessed/monitored and/or that her oxygen saturation levels were checked, even though there was documentation to indicate the resident had decreased oxygen saturation levels throughout the night of 12/10/24. Interviews with Certified Nursing Aide (CNA) #101 and Registered Nurse (RN) #102 on 12/17/24 at 12:45 P. M. and 1:00 P.M. revealed if a resident removed their oxygen cannula, and they appeared to be short of breath or their vital signs decrease, they would replace the oxygen cannula and then monitor the resident's oxygen saturation levels until they became appropriate and stable. Both staff during interview revealed they would check on the resident every 15 to 30 minutes until the resident's vital signs became stable. They also confirmed they would document the vital signs, including the oxygen saturation levels, in the resident's medical records to confirm they were monitoring the change in condition. Interview with the Director of Nursing (DON) on 12/17/24 at 1:15 P.M. revealed low oxygen saturation levels that would need to be addressed immediately would be any level below 90%. The DON confirmed Resident #62's oxygen saturation levels when she fell on [DATE] at 5:45 A.M. were between 88% and 90%, which she confirmed was deemed to be low. She confirmed there was no documentation during the overnight shift of 12/10/24 about Resident #62's oxygen saturation levels even though there was documentation within the fall investigation document from 12/10/24 that reflected Resident #62's oxygen saturation levels were decreased overnight, and her confusion was increased. The DON confirmed there was no documentation to support the physician was notified when the change in Resident #62's condition was first noted during the overnight shift of 12/10/24 (prior to the resident's fall). The DON also confirmed there was no documented evidence to indicate Resident #62 had a behavior of removing her oxygen cannula. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #103 on 12/17/24 at 1:30 P.M. revealed Resident #62 had continued to take her oxygen cannula off during the night shift of 12/10/24. She confirmed she did not document these behaviors during that time. The LPN also indicated she reported Resident #62 was having decreased oxygen saturation levels and increased confusing during the night, which she thought was primarily because the resident was removing her oxygen cannula. The LPN confirmed she did not document or report what the resident's oxygen saturation levels were, only that she was short of breath and naturally confused because she took her oxygen cannula off. The LPN revealed she increased her observations of Resident #62 that night and checked on her about once an hour. However, she confirmed she did not contact the physician about the resident's change in condition/decreased oxygen saturation levels and increased confusion until her oxygen saturation levels reached 64% at approximately 7:00 A.M., with was an hour and 15 minutes after the resident sustained a from bed. Interview with the DON on 12/17/24 at approximately 2:00 P.M. revealed Resident #62 was admitted to the hospital with a diagnosis of SARS CoV-2 (COVID-19) pneumonia. Review of facility Change in Condition policy, dated 08/09/23, revealed the nurse would notify the resident, the resident's physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and/or status. The nurse would notify when the following occur: an accident or incident involving the resident which results in an injury and has the potential for requiring physician/practitioner intervention. The nurse will document in the resident's medical record information relative to the resident's change in medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number OH00160665.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to maintain a complete medical record regarding resident changes of condition that occurred. This affected one (Resident #62) of three residents reviewed for change in condition. Findings Include: Record review revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, constipation, disorder of muscle, cognitive communication deficit, dilated cardiomyopathy, pleural effusion, hyperkalemia, acute kidney failure, chronic kidney disease, atrial fibrillation, major depressive disorder, insomnia, hypo-osmolality and hyponatremia, atherosclerotic heart disease, hypertension, peripheral vascular disease, anemia, type II diabetes, and personal history of pulmonary embolism. Review of Resident #62's Minimum Data Set (MDS) assessment dated [DATE] revealed she had a mild cognitive impairment. Review of Resident #62's Fall Investigation form, dated 12/10/24, revealed she fell on [DATE] at 5:45 A.M. She was found on the floor, next to her bed, without her oxygen cannula. Her vital signs were taken and her oxygen saturation levels were between 88% and 90%. She had no injuries and was placed back into her bed. Because it was an unwitnessed fall, the facility started neurological checks. Evaluation statement of the fall revealed the following: resident was noted to have decreased oxygen saturation throughout the night and increased confusion. Staff reported to spend majority of the night in room with resident to ensure safety and keep oxygen on. Resident was impulsive at times. She was sent out to the hospital due to increased confusion and decreased oxygen saturation. There was no documentation to support the physician or resident representative were notified of the fall when it occurred, and no documentation the physician and resident representative were not notified of the decrease in oxygen saturation levels and increase confusion which were noted throughout the night of 12/10/24; prior to the fall. Review of Resident #62's progress notes, dated 12/09/24 to 12/10/24, revealed there was no documentation of Resident #62's fall in the medical records; the only documentation of the fall was listed in the facility's incident report record. Also, there was no documentation to support monitoring of Resident #62's decrease in oxygen saturation levels and increased confusion were completed. Review of Resident #62's vital signs documentation, dated 12/09/24 to 12/10/24, revealed there was no documentation of oxygen saturation levels between 12/09/24 at 11:37 A.M. and 12/10/24 at 5:09 A.M. There should have been documentation of those vital signs due to the nurse documenting in the fall incident report that Resident #62 was having decreased oxygen saturation levels and increased confusion throughout the night of 12/10/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 12/17/24 at 1:15 P.M. confirmed there was no documentation to support the physician and resident representative were notified of the increased confusion and the decrease oxygen saturation levels. She confirmed when there are changes in condition, there should be documentation in the resident's medical record to support that. Also, she confirmed there was no documentation to support the alleged on-going monitoring of Resident #62 decreased oxygen saturation levels and increase confusion. Finally, she confirmed there was nothing in Resident #62's medical records regarding her fall and post fall evaluations; the incident report was not readily available to anyone who wanted to review her medical records. Interview with Licensed Practical Nurse (LPN) #103 on 12/17/24 at 1:30 P.M. confirmed she did not document the oxygen saturation levels or monitoring of increased confusion for Resident #62. She also confirmed she did not complete a progress note for her fall, that occurred on 12/10/24 at 5:45 A.M. This deficiency represents non-compliance investigated under Complaint Number OH00160665.