

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  New Albany Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50536</p> <p>Based on medical record review, resident interview, staff interview and review of the facility the facility failed to arrange transportation for scheduled medical appointments. This affected one (Resident #112) of 25 sampled residents. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #112 revealed an admitted [DATE] with diagnoses including cerebral infarction, atrial fibrillation, chronic kidney disease stage four, type two diabetes mellitus, morbid obesity, hypertension, and depression.</p> <p>Review of the after-visit summary for Resident #112 dated 01/27/25 revealed discharge instructions that included a scheduled appointment at the wound care center on 01/28/25 at 8:00 A.M.</p> <p>Interview on 02/06/25 at 9:42 A.M. with Resident #112 confirmed he was upset he missed his follow up appointment with the wound care center scheduled for 01/28/25 because the facility did not provide him with transportation to the appointment.</p> <p>Interview on 02/06/25 at 10:50 A.M. with the Administrator confirmed the facility had a transport van and a driver but the facility did not provide transportation to Resident #112 for his appointment at the wound care center on 01/28/25.</p> <p>Review of the facility policy titled Offsite Diagnostic Services Transportation dated 08/08/13 revealed the facility would assist residents in arranging transportation to and from diagnostic appointments, and that the facility's designee was responsible to arrange the transportation if necessary or requested by the resident and/or the resident representative.</p>

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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>41266</p> <p>Based on review of resident funds accounts, staff interview, and review of the facility policy, the facility failed to obtain written authorizations to manage resident funds accounts. (Residents #123 and #124). This affected two (Residents #123 and #124) of five residents reviewed for resident funds accounts. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the banking records dated 02/06/25 revealed Resident #123 had a balance of \$50.04 and Resident #124 had a balance of \$67.03 in the resident trust accounts. Further review of the banking records for Resident #123 and #124 revealed they did not include written authorizations for the facility to manage the residents' funds.</p> <p>Interview on 02/06/24 at 5:15 P.M. with the Administrator confirmed the facility had not obtained written authorizations to manage resident fund accounts for Resident #123 or Resident #124.</p> <p>Review of the facility policy titled Resident Trust Account-Personal Needs Allowance dated 06/28/21 revealed the facility staff would ensure all resident fund accounts would have a written authorization per the resident and/or the resident's representative allowing the facility to manage the residents' funds.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>41266</p> <p>Based on review of resident funds accounts, staff interview, and review of the facility policy, the facility failed to provide written notification for the need to spend down resident funds to residents and/or resident representatives. This affected one (Resident #22) of five residents reviewed for resident fund accounts. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the banking records dated 02/06/25 revealed Resident #22 had a balance of \$2,482.60 in the resident fund account. Further review of the account for Resident #22 revealed there was no notification to the resident and/or resident's representative the account balance had exceeded the asset limit set by Medicaid.</p> <p>Interview on 02/06/25 at 5:15 P.M. with the Administrator confirmed the asset limit for Medicaid recipients was \$2000 and residents and/or resident representatives should be notified in writing when the balance in the resident fund account was within \$200 of the asset limit. The Administrator further confirmed the facility had not notified Resident #22 of the need to spend down the resident fund account to remain eligible for Medicaid assistance.</p> <p>Review of the document titled Ohio Medicaid Long-Term Care Eligibility for Seniors dated 2025 revealed the asset limit was \$2,000 for a single applicant.</p> <p>Review of the facility policy titled Resident Trust Account-Personal Needs Allowance dated 06/28/21 revealed the facility staff were responsible for notifying the resident and/or the resident's representative via certified mail if the resident fund account balance reached within \$200.00 of the state limit. A written notice would be provided to any resident who received Medicaid benefits and whose funds reached within \$200 of the state limit. A copy of the notice should be retained in the resident's banking records.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49039</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide assistance with bathing and shaving to dependent residents. This affected one (Resident #2) of 41 facility-identified residents (#2, #4, #6, #11, #14, #20, #21, #22, #23, #24, #26, #27, #28, #29, #31, #32, #33, #34, #36, #41, #42, #43, #44, #45, #47, #48, #50, #53, #57, #61, #112, #114, #116, #119, #161, #165, #168, #170, #171, #174, #175) who required assistance with shaving. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, acute kidney failure, chronic diastolic heart failure, hypertension, chronic obstructive pulmonary disease, chronic pain syndrome, insomnia, polyosteoarthritis and major depressive disorder.</p> <p>Review of Minimum Data Set (MDS) assessment for Resident #2 dated 11/11/24 revealed the resident had moderate cognitive impairment and required partial/moderate staff assistance with personal hygiene.</p> <p>Review of the care plan for Resident #2 dated 04/25/25 revealed the resident had an activities of daily living (ADL) self-care performance deficit related to activity intolerance, impaired balance, limited mobility, pain, and shortness of breath. Interventions included one-person assistance with personal hygiene/oral care.</p> <p>Observation on 02/03/25 at 1:24 P.M. revealed Resident #2 had long facial hair and dark shadowing to her upper lip.</p> <p>Observation on 02/05/25 at 3:02 P.M. revealed Resident #2 had long facial hair and dark shadowing to her upper lip.</p> <p>Interview on 02/05/24 at 3:02 P.M. with Resident #2 confirmed she would like her facial hair removed when it was visible.</p> <p>Interview on 02/05/25 at 3:09 P.M. with Certified Nurse Assistant (CNA) #197 confirmed Resident #2 had long facial hair. CNA #197 confirmed Resident #2 had a bath on 02/04/25, but they did not shave her face. CNA #197 confirmed staff should always ask residents if they would like their face shaved.</p> <p>Observation on 02/06/25 at 9:01 A.M. revealed Resident #2 had long facial hair and dark shadowing at her upper lip.</p> <p>Interview on 02/06/25 at 9:58 A.M. with the Director of Nursing (DON) and Administrator confirmed staff should ask all residents if they would like their face shaved when needed or residents could request to be shaved. The DON and the Administrator confirmed the facility had no records indicating that Resident #2 had been shaved recently.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Activities of Daily Living (ADL) dated 12/07/23 revealed residents would be provided with care, treatment, and services as appropriate. Daily personal needs included bathing, dressing, grooming, toileting, and oral care.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50536</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility staff failed to ensure residents received the proper treatment and assistive devices to maintain hearing. This affected two (Residents #15 and #48) of two residents reviewed for hearing. The facility census was 61 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including depression, endometrial hyperplasia, anxiety disorder, dysphagia, anemia, pulmonary embolism, type two diabetes mellitus, disorders of the pituitary gland, and unspecified hearing loss.</p> <p>Observation on 02/03/25 at 12:57 P.M. revealed Resident #15 was unable to adequately hear conversations unless parties who were speaking spoke close to her ears.</p> <p>Interview on 02/03/25 at 12:57 P.M. with Resident #15 confirmed her hearing aids had been lost from her bedside table approximately two years ago. The facility staff was notified, but the hearing aids were never found.</p> <p>Observation on 02/03/25 at 1:26 P.M. revealed Registered Nurse (RN) #119 administered medication to Resident #15 at the bedside. RN #119 spoke loudly and had to repeat instructions during the medication pass and had to lean over the bed and speak the information directly into Resident #15's left ear.</p> <p>Interview on 02/03/25 at 1:26 P.M. with RN #119 confirmed Resident #15 was extremely hard of hearing and sometimes reads lips. RN #119 stated she had not seen Resident #15 with hearing aids for at least a year, and if the facility couldn't find the hearing aids, the facility should replace the hearing aids.</p> <p>Interview on 02/03/24 at 2:39 P.M. with the Administrator confirmed that the facility would attempt to locate the hearing aids for Resident #15, and if not found, the facility should replace the hearing aids.</p> <p>51524</p> <p>2. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including profound hearing loss in both ears, schizophrenia, mood affective disorder, and personality disorder.</p> <p>Review of the MDS assessment for Resident #48 dated 07/28/23 revealed the resident's hearing was highly impaired.</p> <p>Review of the audiology report for Resident # 48 dated 09/20/23 revealed the resident was a candidate for a cochlear implant, an electronic medical device that could improve hearing and speech perception in individuals who did not benefit from traditional hearing aids.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the therapy progress note for Resident #48 dated 09/11/24 revealed the resident missed having conversations with people, had inquired about hearing aids, and was still awaiting a response from the facility.</p> <p>Interview on 02/05/25 at 10:05 A.M with Resident #48 confirmed she had requested information about obtaining hearing aids. Resident #48 confirmed staff had discussed the possibility of a cochlear implant.</p> <p>Interview on 02/06/25 at 12:29 P.M. with Licensed Social Worker (LSW) #120 confirmed Resident #48 was not a candidate for hearing aids due to congenital deafness. LSW #120 confirmed the facility had no documentation the facility had discussed cochlear implants with Resident #48.</p> <p>Review of the facility policy titled Ancillary-Additional Services and Fees dated 02/14/13 revealed the facility would provide appropriate hearing services to residents.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>41266</p> <p>Based on medical record review, observation, resident representative interview, resident interview, staff interview, and review of the facility policy, the facility failed to pressure ulcer interventions were implemented for residents with pressure ulcers. This affected one (Residents #25 ) of five residents reviewed for pressure ulcers. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #25 revealed an initial admitted on 01/03/25 and a readmitted on 02/02/25 with diagnoses including type two diabetes mellitus without complications, acute on chronic diastolic (congestive) heart failure, neuromuscular dysfunction of bladder, and morbid obesity. Resident #25 was hospitalized from 01/29/25 to 02/02/25.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #25 dated 01/10/25 revealed the resident had intact cognition, required staff assistance with activities of daily living (ADLs), and had no pressure ulcers.</p> <p>Review of the care plan for Resident #25 dated 01/20/25 revealed the resident had an actual pressure injury to the coccyx noted 01/20/25. Interventions included adding a low air loss mattress to the resident's bed.</p> <p>Review of the physician's orders for Resident #25 revealed an order dated 01/24/25 for an air mattress to the resident's bed which was discontinued 01/30/25 the day after the resident was hospitalized .</p> <p>Review of the readmission physician's orders for Resident #25 dated 02/05/25 revealed an order to cleanse the coccyx wound with normal saline and pat dry and cover with calcium alginate and a foam dressing daily. There was no order for an air mattress upon readmission.</p> <p>Observations on 02/04/25 at 9:26 A.M. and 02/05/25 at 2:42 P.M. revealed Resident #25 did not have a low air loss mattress in place.</p> <p>Interview on 02/05/25 at 2:14 P.M. via telephone with Resident #25's representative confirmed Resident #25 had an open wound on his coccyx area. The resident's representative stated the resident had been laying on an air mattress prior to being hospitalized and did have an air mattress during his hospitalization . Resident #25's representative confirmed Resident #25 had not received an air mattress again since he returned to the facility.</p> <p>Interview on 02/05/25 at 2:42 P.M. with Resident #25 confirmed he had an air mattress at the facility prior to being hospitalized but he had not had an air mattress since he returned to the facility. Resident #25 stated he was on an air mattress during his hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/05/25 at 2:44 P.M. with Unit Manager (UM) #148 confirmed Resident #25 was not on an air mattress. UM #148 confirmed Resident #25 had an air mattress prior to going out to the hospital due to having an open wound on his coccyx area but the facility had not initiated an order for an air mattress since Resident #25 returned to the facility.</p> <p>Interview on 02/05/25 at 2:47 P.M. Licensed Practical Nurse (LPN) #192 confirmed Resident #25 had an order for an air mattress prior to being hospitalized and had an open pressure ulcer to his coccyx area with an active wound treatment in place. LPN #192 confirmed Resident #25 should have an air mattress to help prevent the pressure ulcer from worsening.</p> <p>Review of the facility policy titled Skin and Wound Guidelines revised 03/20/24 revealed the facility would implement individual interventions to reduce the resident's risk for new or worsening skin breakdown.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49039</p> <p>Based on medical record review, observation, and staff interviews, the facility failed to ensure oxygen was administered according to physician orders. This affected one resident (Resident #45) of two residents reviewed for oxygen administration. The facility identified 13 residents (#2, #28, #34, #41, #44, #45, #121, #122, #162, #165, #170, #173, #174) who were receiving oxygen. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including chronic idiopathic constipation, hypertension, type two diabetes mellitus, dementia, osteomyelitis, occlusion and stenosis of bilateral carotid arteries, and respiratory failure.</p> <p>Review of Minimum Data Set (MDS) assessment for Resident #45 dated 01/20/25 revealed the resident was severely cognitively impaired and received oxygen therapy.</p> <p>Review of physician's orders for Resident #45 revealed an order dated 01/31/24 for humidified oxygen via nasal cannula at three liters per minute (LPM).</p> <p>Review of the care plan for Resident #45 dated 09/13/24 revealed the resident had a diagnosis of respiratory failure. Interventions included the following: monitor for signs or symptoms of respiratory distress or abnormal breathing patterns and report to the physician, administer oxygen via nasal cannula at three LPM.</p> <p>Observation on 02/04/25 at 4:41 P.M. revealed Resident #45's oxygen was set at 3.5 LPM.</p> <p>Observation on 02/05/25 at 11:14 A.M. revealed Resident #45's oxygen was set at 5.0 LPM.</p> <p>Observation on 02/05/25 at 3:04 P.M. revealed Resident #45's oxygen was at 5.0 LPM.</p> <p>Interview on 02/05/25 at 3:07 P.M. with Licensed Practical Nurse (LPN) #180 confirmed Resident #45's oxygen was incorrectly set at 5.0 LPM and should be set at 3.0 LPM. LPN #180 confirmed the oxygen setting may have been accidentally adjusted by a visitor or knocked out of place. LPN #180 relocated the unit to prevent accidental increases in oxygen level.</p> <p>Review of facility policy titled Administration of Oxygen dated 09/25/13 revealed the facility would manage residents utilizing oxygen according to physician orders and clinical best practices.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50536</p> <p>Based on medical records review staff interview the facility failed to respond in a timely manner to consultant pharmacist recommendations. This affected one (Resident #42) of five residents reviewed for unnecessary medications. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including paraplegia, congestive heart failure, type two diabetes mellitus, hypothyroidism, bipolar disorder, depression, and sleep apnea.</p> <p>Review of the drug regimen review per the consultant pharmacist for Resident #42 dated 12/19/24 revealed a recommendation to reduce the anticoagulant, Eliquis, for the resident from 5 milligrams (mg) two times a day to 2.5 mg two times a day. The recommendation was not addressed until 02/06/25.</p> <p>Interview on 02/06/25 at 1:22 P.M. with the Regional Clinical Services Director (RCSD) confirmed that the facility missed the recommendation in December 2024 and had not addressed the recommendation for Resident #42 with the nurse practitioner until 02/06/25.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41266</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility staff failed to ensure residents were free from significant medication errors. This affected one (Residents #48) of five residents reviewed for unnecessary medications. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #10 revealed an admitted on 11/18/24 with diagnoses including type two diabetes mellitus, diastolic (congestive) heart failure, chronic kidney disease stage three, anxiety disorder, and essential primary hypertension. Resident #10 was discharged [DATE] and readmitted [DATE].</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 11/25/24 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs).</p> <p>Review of the physician's orders for Resident #10 revealed an order dated 11/19/24 for clonidine 0.1 milligrams (mg) one tablet by mouth daily for a systolic blood pressure greater than 160.</p> <p>Review of the blood pressure record for Resident #10 revealed the resident had a systolic blood pressure greater than 160 on the following dates: 11/26/24, 11/28/24, 12/01/24, 12/02/24, 12/06/24, and 12/17/24.</p> <p>Review of the Medication Administration Records (MARs) for Resident #10 dated November and December 2024 revealed the resident did not receive clonidine on the following dates: 11/26/24, 11/28/24, 12/01/24, 12/02/24, 12/06/24, and 12/17/24.</p> <p>Interview on 02/06/25 at 2:20 P.M. with Regional Nurse (RGN) #500 confirmed Resident #10 had not received clonidine on 11/26/24, 11/28/24, 12/01/24, 12/02/24, 12/06/24, and 12/17/24 even though the resident's systolic blood pressure was over 160 and the resident should have received the medication.</p> <p>Review of the facility policy titled Medication Administration dated 08/07/23 revealed the facility staff should administer medication in accordance with frequency prescribed by physician and per acceptable standards of practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  New Albany Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>41266</p> <p>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure kitchen staff blended pureed food to an appropriate texture prior to serving to the residents. This affected two residents (Residents #32 and #33) of two residents with orders for a pureed diet. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Observation on 02/06/25 at 10:30 A.M. of pureed food preparation per [NAME] #188 revealed the cook confirmed she would be making two servings of pureed lasagna. [NAME] #188 added two scoops of lasagna, one-quarter cup of water, and two plastic spoonfuls of thickener to the blender and started blending. At 10:38 A.M. [NAME] #188 stopped the blender, used a clean spatula to scrape the sides down and confirmed she felt the lasagna was an appropriate texture to serve to the residents. [NAME] #188 plated the pureed lasagna onto two plates and did not taste the food prior to plating it for resident consumption.</p> <p>Interview on 02/06/25 at 10:38 A.M. with [NAME] #188 confirmed the lasagna was ready to serve to the residents.</p> <p>Observation on 02/06/25 at 10:40 A.M. revealed the Surveyor tasted the pureed lasagna with a clean spoon and noted there were lumps of ground meat in the lasagna.</p> <p>Observation on 02/06/25 at 10:41 A.M. revealed Chef #166 tasted the pureed lasagna with a clean spoon.</p> <p>Interview on 02/06/25 at 10:41 A.M. with Chef #166 confirmed the pureed lasagna was not an appropriate texture to serve to the residents and directed [NAME] #188 to place the lasagna back into the blender to blend further prior to serving to the residents.</p> <p>Review of the facility policy titled Step by Step Guide to Puree Foods undated revealed staff should blend the food until it was formed into a pudding like or mashed potato consistency. Staff should taste the finished product using clean plastic spoons to assure the food was smooth prior to serving to the residents.</p>		

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NAME OF PROVIDER OR SUPPLIER  New Albany Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5691 Thompson Road Columbus, OH 43230	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41266</p> <p>Based on observation, staff interview, and review of the facility policy, the facility failed to properly store and date food items in the kitchen. This had the potential to affect 60 of 61 residents who resided in the facility who received foods prepared in the facility kitchen. The facility identified (Resident #45) who had an ordered was ordered a nothing by mouth diet.</p> <p>Findings include:</p> <p>Observation on 02/03/25 at 11:38 A.M. revealed there was an opened undated package of cherry gelatin powder wrapped in clear cellophane and placed in a plastic bag in the dry storage area.</p> <p>Observation on 02/03/25 at 11:44 A.M. revealed the following items were being stored in the refrigerator: a large metal tray of cooked roast beef uncovered and exposed to the air, a large metal tray of chicken with another metal tray that did not fully cover the kitchen and left it exposed to the air, a plastic bucket of scrambled eggs uncovered and exposed to the air.</p> <p>Observation on 02/03/25 at 11:52 A.M. revealed there was a large bag of opened undated onion rings in the freezer.</p> <p>Interview on 02/03/25 at 11:55 A.M. with Dining Services Manager (DSM) #157 confirmed the gelatin powder in the dry storage area and the onion rings in the freezer were opened and undated and food items should be dated upon opening. Further interview with DSM #157 confirmed the roast beef, chicken, and eggs in the refrigerator were not covered and foods should not be exposed to air during storage.</p> <p>Review of the facility policy titled Food Storage Guidelines dated 02/02/11 revealed cereal products, flour, sugar and broken lots of bulk foods were to be stored in plastic containers with tight fitting covers. All containers must be labeled and dated. All stock must be rotated and properly dated with each new order received. Old stock was always used first. All refrigerated and frozen foods should be covered, labeled and dated.</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50536</p> <p>Based on observation, staff interview, and record review the facility failed to ensure that residents who were at risk for developing multidrug-resistant organisms (MDRO) were placed in enhanced barrier precautions (EBP) per facility policy. This affected one (Resident #57) of 23 residents reviewed for EBP. The facility census was 61 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including sepsis, protein-calorie malnutrition and gastroesophageal reflux disease.</p> <p>Observation on 02/05/25 at 11:18 A.M. of Resident #57's room revealed there was no signage indicating the resident was on EBP nor was there personal protective equipment (PPE) outside or in the vicinity of the resident's room.</p> <p>Review of the physician's orders for Resident #57 dated February 2025 revealed the resident had wound care orders for an unstageable pressure wound to the left buttock.</p> <p>Interview on 02/05/25 at 11:32 A.M. with Unit Manager (UM) #148 confirmed that Resident #57 had an unstageable pressure ulcer which required the resident to be placed on EBP per facility policy. UM #148 stated that the order was erroneously discontinued, and Resident #57 should have been on EBP and had appropriate signage on the door to alert staff and visitors and PPE should have been available outside the resident's room.</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions dated 03/28/24 revealed that EBP was an infection control intervention designed to reduce the transmission of MDROs. EBP involved gown and glove use during high-contact resident activities for residents with colonized MDRO infections or residents at increased risk of developing MDRO infections such as those with open wounds.</p>