STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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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	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** Based on interview, record review and policy review, the facility failed to notify the transfer of Resident #10 to their Power of Attorney (POA). This affected one (Resident #10) of three residents reviewed for transfers and notification to their POAs. The facility census was 91.Findings include : Review of the medical record for Resident #10, revealed an admission date of 08/16/25 and a transfer to the hospital date of 08/27/25. Diagnoses included but were not limited to chronic kidney disease, stage 4, chronic obstructive pulmonary disease, chronic diastolic heart failure, and iron deficiency anemia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 that suggested cognitive intactness. The resident was assessed to be independent with bed mobility, to require setup or clean-up assistance with toilet hygiene, supervision or touching assistance with transfers, and total dependence on shower/bathe self. This resident was also assessed to have heart failure.Review of the closed record for Resident #10 revealed an emergency contact to be the POA.Review of the progress note dated 08/27/25 at 6:37 A.M. revealed Resident #10 to be transferred to the hospital and the emergency contact/POA was not notified. Interview on 09/16/25 at 10:57 A.M. with the Director of Nursing verified when Resident #10 was transferred to the hospital on [DATE] at 6:37 A.M. and the emergency contact/POA was not notified and should have been. Review of the facility policy titled Change in a Resident's Condition or Status revised on May 2017 revealed a nurse will notify the resident's representative when it is necessary to transfer the resident to a hospital.This deficiency represents non-compliance investigated under Complaint Number 2611549 and Complaint Number 2609966.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	366259	A. Building B. Wing	10/09/2025

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, record reviews and facility policies, the facility failed to notify the physician of weight gain for a congestive heart failure resident. This affected one (Resident #10) of three residents reviewed. The facility also failed to ensure non pressure skin alterations were treated per physician orders. This affected two (resident #20 and resident #300) of three residents reviewed. The facility census was 91. Findings include:1.Review of the medical record for Resident #10, revealed an admission date of 08/16/25 and a transfer to the hospital date of 08/27/25. Diagnoses included but were not limited to chronic kidney disease, stage 4, chronic obstructive pulmonary disease, chronic diastolic heart failure, and iron deficiency anemia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 which suggested cognitive intactness. The resident was assessed to be independent with bed mobility, to require setup or clean-up assistance with toilet hygiene, supervision or touching assistance with transfers, and total dependence on shower/bathe self. This resident was also assessed to have heart failure.Review of the discharge instructions from the hospital for admission to the facility dated 08/16/25 for Resident #10 revealed weight monitoring for congestive heart failure and to call the physician if there is a weight gain of 2-3 pounds or more per day over a 2-day period or 5 pounds in one week.Review of the plan of care dated 08/18/25 revealed Resident #10 to have an impaired cardiovascular status related to congestive heart failure with interventions including but not limited to monitor weight as ordered/as needed and to monitor and report to physician signs/symptoms of congestive heart failure such as weight gain unrelated to intake.Review of the physician order dated 08/18/25 for Resident #10 revealed a daily weight. Review of the weight log for Resident #10 revealed the following weights: 08/21/25 268.2 pounds, 08/22/25 269.1 pounds, 08/23/25 273 pounds, 08/24/25 275 pounds, 08/25/25 277 pounds and 08/26/25 278.9 pounds.Interview on 09/16/25 at 11:03 A.M. with the Director of Nursing verified the Resident #10 did have weight gain and per discharge instructions from the hospital the physician should have been notified and was not at any point. Review of the facility policy titled Change in a Resident's Condition of Status revised March 2017 revealed the nurse will notify the residents attending physician or physician on call when there has been a specific instruction to notify the physician of changes in the resident condition.2.Review of the medical record for Resident #20, revealed an admission date of 08/21/25 and a (left against medical advice) AMA date of 09/10/25. Diagnoses included but were not limited to urinary tract infection, acute on chronic systolic heart failure, pneumonia and history of falling. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 out of 15 which suggested moderate cognitive impairment. The resident was assessed to require total dependence on bed mobility, transfers, toilet hygiene and shower/bathe self. This resident was also assessed to be frequently incontinent of bowel and bladder functions. This resident was noted to also have a stage 4 pressure ulcer injury on admission. Review of the plan of care dated 08/21/25 for Resident #20 revealed potential for skin impairment due to fragile skin with an intervention including but not limited to initiate wound treatment and continue treatment as ordered by the physician/nurse practitioner. Review of the discharge orders from the hospital dated 08/21/25 for Resident #20 revealed for the right lower extremity non pressure skin alteration: cleans with soap and water. Apply non-adherent contact layer and wrap with gauze and ace Monday, Wednesday, and Friday. For the left lower extremity non pressure skin alteration: cleanse with soap and water. Apply foam dressing, wrap with kerlix and ace every Monday, Wednesday and Friday. Review of the physician order dated 08/21/25, with a discontinue date of 09/09/25 for Resident #20 revealed for the right lower extremity: cleans with soap and water. Apply non-adherent contact layer and wrap with gauze and ace Monday, Wednesday, and Friday.Further review of the physician order dated 08/21/25, with a discontinuation date of 09/09/25 for this resident revealed for the left lower extremity: cleanse with soap and water. Apply foam dressing, wrap with kerlix and ace every Monday, Wednesday and Friday.Review of the Wound Consultant Wound Practitioner (WCNP) #777 visit dated 08/26/25 for Resident #20 revealed bilateral lower legs were stasis dermatitis and recommended bilateral lower legs have ammonia lactate applied and to be wrapped in an ace wrap daily. Review of the physician's orders dated 08/26/25 through 09/01/25 for Resident #20 revealed no order for bilateral lower legs have ammonia lactate applied and to be wrapped in an ace wrap daily. Review of the WCNP #777's visit dated 09/02/25 for Resident #20 revealed to continue bilateral lower legs have ammonia lactate applied and to be wrapped in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

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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 in on interviews and record reviews, the facility failed to accurately document and treat pressure ulcers for three residents (#20, #60, and #70) out of four residents reviewed for pressure ulcer care. The facility census was 91.Findings include:1.Review of the medical record for Resident #20, revealed an admission date of 08/21/25 and a left against medical advice (AMA) on 09/10/25. Diagnoses included but were not limited to urinary tract infection, acute on chronic systolic heart failure, pneumonia and history of falling. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 out of 15 which suggested moderate cognitive impairment. The resident was assessed to require total dependence on bed mobility, transfers, toilet hygiene and shower/bathe self. This resident was also assessed to be frequently incontinent of bowel and bladder functions. This resident was noted to also have a stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer injury on admission. Review of the plan of care dated 08/21/25 for Resident #20 revealed to have an actual skin impairment related to pressure area of the sacrum with an intervention related to but not limited to initiate wound treatment and to continue treatment as ordered by the MD/NP. Review of the admission skin assessment dated [DATE] for Resident #20 revealed a sacrum pressure ulcer with no measurements and no staging. Review of the physician orders dated 08/27/25 for Resident #20 revealed to cleanse the area with soap and water, apply Medi honey to dry gauze and pack wound, cover with dry dressing daily. Review of the Certified Wound Nurse Practitioner #777's consultations on 08/26/25, 09/02/25 and 09/09/25, for the sacrum pressure ulcer stage 4's treatment recommendations were to cleanse with normal saline, pack with Dakin's soaked kerlix and cover with a dry dressing daily. Review of the physician orders dated 08/26/25 through 09/08/25 for Resident #20 revealed the order for the sacrum pressure ulcer stage 4 was to cleanse the area with soap and water, apply Medi honey to dry gauze and pack wound, cover with dry dressing daily. Interview on 09/18/25 at 10:32 A.M. with the Director of Nursing verified for Resident #20's sacrum pressure ulcer, the orders should have been entered and administered to the resident, that the Wound Nurse Practitioner #777 had ordered as they follow her recommendations for all pressure ulcer treatments and upon admission, the admitting nurse should have measured and staged the pressure wound. 2. Review of the medical record for Resident #60 revealed an admission date of 06/20/2025 and a discharge date of 07/11/2025. Diagnoses included non-pressure chronic ulcer of the right foot, peripheral vascular disease, and muscle weakness. (continued on next page)

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	366259	A. Building B. Wing	10/09/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #60's admission MDS 3.0 assessment dated [DATE] revealed this resident experienced long and short-term memory impairment and had a severely impaired cognition for daily decision-making abilities. Per this assessment, Resident #60 was noted with one unstageable or deep tissue injury wound which was present upon admission to the facility. Review of a progress note dated 06/24/25 at10:01 P.M. created by Wound Nurse # 325 revealed, Wound Nurse in to see resident, new admit, resident has area to left foot venous, right foot gangrene, right heel deep tissue injury. Start betadine, wound culture obtained due to purulent drainage, family in with resident, resident aware. Review of physician orders for Resident #60 revealed the following treatment orders: -Cleanse the left foot with normal saline, pat dry, apply betadine and cover with an (abdominal) ABD pad and kerlix daily and as needed. This order was dated from 06/25/2025-07/08/2025. -Cleanse the left foot with normal saline, pat dry, apply betadine and leave open to air daily and as needed. This order was dated from 06/25/2025-07/14/2025. -Cleanse the right heel with normal saline, pat dry, apply betadine and cover with an ABD pad and kerlix daily and as needed. This order was dated from 06/25/2025-07/14/2025. -Daily monitoring of the wound to the left foot, right foot, right heel, monitor for dry and clean areas and signs and symptoms of infection. Notify the prescriber if decline is noted every shift. Dated from 06/25/2025 through 07/14/2025. Interview on 09/16/2025 at 1:30 P.M. with the Director of Nursing confirmed this resident was admitted to the facility on [DATE] and no treatment orders were put in place until 06/25/2025. The DON also confirmed there who different orders for the left foot with different instructions and should have been clarified. 3. Review of the medical record for Resident #70 revealed an admission date of 06/26/2025 and a discharge date of 07/14/2025. Diagnoses included heart disease, peripheral vascular disease, and nondisplaced intertrochanteric fracture of the left femur. Review of Resident #70's admission Assessment with Baseline Care Plan dated 06/26/2025 revealed under section B. Skin integrity, this resident was noted to have a skin tear to the top of the left second toe which measured 1 centimeter (cm) in length by 0.5 cm in width by 0 cm in depth. Continued review indicated this resident was noted to have a surgical incision to the left trochanter (hip) measuring 12 cm in length by 0.5 cm in width by 0 cm in depth. No other skin injuries or wounds were noted. Review of physician orders for Resident #70 for June 2025 revealed the following: -Discontinue the pleura dressing on left lung one time only for wound dressing until 06/27/2025. -Top of left foot/left second toe- cleanse with normal saline, pat dry, place Aquacel AG to wound bed, and cover with a bandage every night shift every 2 days for wound dressing. This was ordered from 06/26/2025 through 07/02/2025. (continued on next page)

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	366259	A. Building B. Wing	10/09/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left hip, cleanse site with normal saline, pat dry and cover with a clean dry dressing every night shift for wound dressing. Ordered from 06/26/2025 through 07/02/2025. Review of Resident #70's admission MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #70 was noted to be admitted to this facility with one surgical wound, one stage one pressure ulcer and one deep tissue injury. Review of the progress note dated 07/01/25 at 9:19 P.M. created by the Wound Nurse #325 revealed Wound Nurse in to see resident, new admit, deep tissue injury to the right heel start skin prep, stage 2 coccyx wound start zinc, skin tear the left 2nd toe dorsal start skin prep, skin tear left 2nd toe medial start skin prep, surgical wound to the left upper hip pad and protect, surgical left lower hip pad and protect, skin tear right elbow start skin prep, resident has no complaints of pain or discomfort, no signs of infection noted, primary physician aware, resident aware, resident self. Interview on 09/16/2025 at 1:30 P.M. with the Director of Nursing confirmed Resident #70 was noted to be admitted to the facility with multiple wounds that was not captured on the nursing admission assessment and treatment orders were not put in place for these orders. This deficiency represents non compliance investigated under Master Complaint Number 2624710 and Complaint Number 2618524,2616238, and 2604216.

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	366259	A. Building B. Wing	10/09/2025

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F 0689 Level of Harm - Minimal harm or potential for 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 interviews, observations, record review and policy review, the facility failed to implement fall preventions for Resident #30 and Resident #90. The facility also failed to ensure two staff members were used when transferring Resident #30 with a Hoyer lift resulting in a fall. This affected two (Resident 330 and Resident #90) of three residents reviewed for accidents/falls. The facility census was 91. Findings include:1.Review of the medical record for Resident #90, revealed an admission date of 08/19/25. Diagnoses included but were not limited to encounter for orthopedic after care, displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing, and a new diagnosis of displaced fracture of right great toe, initial encounter for closed fracture as of 9/4/25. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 suggested cognitive intactness. The resident was assessed to require substantial/maximal assistance with shower/bathe self, bed mobility, total dependence on toilet hygiene, and transfers. Review of the plan of care dated 08/20/25 for Resident #90 revealed at risk for fall related to weakness, needs for assistance with activities of daily living, obesity and recent fracture with an intervention included but not limited to a mat to the floor next to bed when occupied that was initiated on 09/02/25. Review of the fall risk evaluation completed on 08/31/25 for Resident #90 revealed a score of 4, not high risk for falls. Review of the physician order dated 09/02/25 for Resident #90 revealed a fall at to both sides of bed and to check placement every shift. Observation on 09/18/25 at 12:50 P.M. of Resident #90 in bed revealed no fall mats to either side of the bed. The mats were against the wall behind the bed. Observation and interview on 09/18/25 at 1:01 P.M. with Registered Nurse #1000 verified Resident #90's floor mats were against the wall behind the bed and should be placed on both sides of the bed since the resident was in bed. 2.Review of the medical record for Resident #30 revealed an admission date of 12/20/2024. Diagnoses included acute respiratory failure, adult failure to thrive, and chronic obstructive pulmonary disease. Review of Resident #30's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #30 was noted to experience impairment to his bilateral lower extremities and required the use of a wheelchair for mobility. Resident #30 was dependent on staff for toileting hygiene, bathing, and dressing and required substantial to maximal assistance for bed mobility, and transfers. (continued on next page)

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	366259	A. Building B. Wing	10/09/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders for Resident #30 revealed the following current fall intervention orders: -Bed enabler for mobility positioning to both sides of the bed, -Floor mat to the floor on the right side of bed while in bed -Perimeter air mattress for fall prevention and safety Review of the plan of care dated 01/03/2025 revealed Resident #30 had a potential risk for falls related to cognitive function, decreased physical function, and recent admission to a new environment. Interventions for this plan was to assist with transfers as needed, keep a floor mat on the floor on the right side of the bed while resident is in bed, keep bed in the lowest position while occupied, increase room rounds to identify frequent fall times, place a perimeter mattress to the bed, and educate staff. Review of the nursing progress note dated 08/27/2025 at 10:00 A.M. created by Licensed Practical Nurse (LPN) #155 revealed, Certified Nursing Assistant (CNA) made this nurse aware that Resident #30 was on floor in his room. Upon entering room, this nurse observed resident sitting on his bottom, underneath the Hoyer lift next to his wheelchair. CNA and resident both stated that while lowering resident into his wheelchair via Hoyer lift, he slipped out and fell onto his bottom approximately 2 feet from floor. This nurse obtained vital signs, conducted skin check and neuro eval. All within normal limits. Resident denied pain at time of fall, stating I am completely fine. Resident was assisted back into his wheelchair via stand/pivot by 2 CNA's. This nurse reeducated CNA that resident is a stand/pivot assist x2, not a Hoyer lift transfer. This nurse also provided CNA w/written warning. CNA stated understanding. All parties made aware. Review of the nursing progress note dated 08/27/25 at 7:19 P.M. created by LPN #155 revealed, At approximately 5:00 P.M., resident began to complaint of pain in tailbone area related to earlier fall. physician notified. Order received for STAT (immediate) coccyx x-ray. resident and resident's family aware and states understanding. Review of the nursing progress note dated 08/28/25 at 1:49 P.M. created by LPN #762 revealed, X-Ray completed of sacrum/coccyx no fractures noted. Review of the fall investigation for Resident #30 dated 08/27/2025 revealed CNA made this nurse aware that the resident was on the floor in room. This nurse entered room and observed resident sitting on the floor underneath the Hoyer lift next to his wheelchair. CNA stated that during a Hoyer lift transfer, the resident slipped out of the Hoyer pad and fell on his bottom. The fall was witnessed by the CNA. Resident stated he slipped out of the Hoyer lift pad during transfer to his wheelchair and fell on his bottom. Resident stated CNA was lowering him into his wheelchair at that time and he was about 2 feet from the floor when he fell out of the Hoyer pad. Resident denies pain at time of incident and states I am perfectly fine. Observation of Resident #30 on 09/16/2025 at 2:30 P.M., on 09/17/2025 ay 11:00 A.M. and again at 1:10 P. M. and 09/22/2025 at 3:00 P.M. revealed Resident #30 laying supine in bed resting with his eyes opened. Resident #30's bed was noted to be raised up in the air and not in the lowest position as per care plan fall interventions. (continued on next page)

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	366259	A. Building B. Wing	10/09/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/16/25 at 1:32 P.M. with CNA #97 revealed that she was the CNA working and completing the Hoyer transfer when Resident #30 slipped out onto the floor. Claimed on the day the fall incident occurred she was trying to wait for another staff member to assist her with getting him up into his wheelchair with the use of the Hoyer lift. CNA #97 claimed this resident was becoming agitated and started to yell at her because he didn't want to wait for assistance, so she went ahead and got him up on her own. She thinks the other aide forgot to come to help or got busy with someone else. While transferring him with the Hoyer lift the strap was not on the hook properly and slipped off. Claimed that this resident is usually a two staff assist with a pivot, and this method has been used since then. Interview on 09/22/2025 at 12:00 P.M. with LN #333 confirmed this resident had a care plan for his bed to be in the lowest position while occupied and currently it was not in the lowest position. Review of the facility policy titled. Mechanical Lift Education, no date noted revealed that at least two staff members are used during a lift transfer. Review of the facility policy titled Fall Prevention and Management dated November 2024 revealed based on assessment results, the nurse will meet with the direct care staff to establish and implement approaches to minimize the risk. These deficiencies represents non-compliance investigated under Complaint Number 2624117, Complain Number 2618524, and Complaint Number 2609966.

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	366259	A. Building B. Wing	10/09/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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	366259	A. Building B. Wing	10/09/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and hospital paperwork review, the facility failed to ensure the medication Gabapentin, Oxycodone, and Tylenol was administered as per physician order for Resident #60. This affected one (Resident #60) of the four residents reviewed for accurate medication administration. The facility census was 91.Findings include: Review of the medical record for Resident #60 revealed an admission date of 06/20/2025 and a discharge date of 07/11/2025. Diagnoses included chronic non-pressure ulcer of the right foot, peripheral vascular disease, and cerebral infarction.Review of Resident #60's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed this resident experienced long and short-term memory impairment and had severely impaired cognition for daily decision-making abilities. Resident #60 experienced disorganized thinking and an alerted level of consciousness. Resident #60 was noted to receive opioids, antiplatelets and anticonvulsants daily.Review of Resident #60's hospital after visit summary dated 06/20/2025 with a list of medication this resident is to receive while at the facility. This list included the following:-Acetaminophen 325 milligrams (mg) tablet. Give 3 tablets (975 mg) by mouth every 8 hours.-Gabapentin 100 mg capsule. Give two capsules (200 mg) by mouth three times a day.-Oxycodone 10 mg immediate release tablet. Give one tablet (10 mg) by mouth every 8 hours if needed for every pain (7-10)-Oxycodone 5 mg immediate release tablet. Give one tablet (5 mg) by mouth every 6 hours if needed for moderate pain (4-6) Review of the medication administration record for Resident #60 for June 2025 revealed the following orders:-Acetaminophen 325 mg tablet, give one tablet my mouth three times a day for pain. This medication was scheduled at 9:00 A.M., 1:00 P.M., and 5:00 P.M. These time frames would allow 4 hours between the first dose and second dose and then 4 hours between the second dose and third dose. -Gabapentin oral capsule 100 mg. Give two capsules by mouth three times a day for pain.-There was another Gabapentin order written on 06/27/2025 for 100 mg, give one tablet every morning and at bedtime for pain.-Oxycodone HCL oral tablet 5 mg, give one tablet my mouth every 6 hours as needed for moderate pain.-Oxycodone HCL oral tablet 10 mg, give one tablet by mouth every 8 hours for severe pain. This order was noted to be changed on 06/24/2025 for Oxycodone HCL oral tablet 5 mg, give two tablets every 6 hours as needed for severe pain. Review of the medication administration record for July 2025 for Resident #60 revealed the following:-Acetaminophen oral tablet 325 mg, give 3 tablets by mouth three times a day for pain. 975 mg was to be administered at 9:00 A.M., 1:00 P.M., and 5:00 P.M.-Gabapentin oral capsule 100 mg. give 2 capsules by mouth three times a day for pain. This medication was ordered to start on 06/21/2025 and discontinued on 07/07/2025. Administration times was 8:00 A.M., 3:00 P.M., and 8:00 P.M.-Gabapentin 100 mg oral tablet. Give one tablet by mouth every morning and bedtime for pain. To be administered at 9:00 A. M. and 9:00 P.M. This order was dated to start 06/27/2025 and was discontinued on 07/07/2025.-Gabapentin oral capsule 300 mg, give 300 mg by mouth three times a day for pain. This medication was ordered to start 07/03/2025 and was discontinued 07/11/2025. This medication was to be administered at 8:00 A.M., 1:00 P. M. and 8:00 P.M.-Oxycodone HCL oral tablet 5 mg, give 2 tablet by mouth every 6 hours as needed for severe pain. This medication was ordered to start on 06/24/2025 and discontinued on 07/03/2025. -Oxycodone HCL oral tablet 10 mg, give 10 mg by mouth two times a day for pain. This order was dated to start on 07/04/2025 and to be administered at 9:00 A.M. and 5:00 P.M.-Oxycodone HCL oral tablet 10 mg, give 10 mg by mouth every 6 hours as needed for pain. This medication was ordered to start on 07/03/2025 and discontinued on 07/14/2025.-Oxycodone HCL oral tablet 5 mg, give 1 tablet by mouth every 6 hours as needed for moderate pain. This order was dated to start on 06/24/2025 and discontinued on 07/03/2025. Review of the progress note dated 07/11/2025 at 12:46 P.M. created by Licensed Practical Nurse (LPN) #333 revealed, Resident noted to be non-responsive to commands this shift. Certified Nurse Practitioner (CNP) in to assess with new orders for fluids, stat labs, and med changes noted. Stat labs obtained and orders updated. Unable to insert IV and all stat lab services notified to start IV. CNP reassessed Resident #60 and determined resident ‘s condition declined and gave new orders to send to emergency room for evaluation. Family in room with resident and notified of transfer. Review of the hospital paperwork dated 07/11/2025 revealed Patient is quite drowsy yet easily arousable and does answer many questions appropriately, although falls back asleep. Per his family, he was awake earlier at the nursing facility and was given his pain medication in the morning. Later on, his wife arrived to visit him and found him very drowsy. He has a known right sided weakness from a prior stroke, but there is no mention of any new deficits. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** Based on medical record review, and staff interview, the facility failed to ensure residents medical records accurately reflected current health status, care and treatments including an accurate Advanced Directive (code status), wound notes and assessment completed by a Certified Wound Nurse Practitioner, and ensure staff did not continue to chart on a residents daily health status days after being discharged from the facility. This affected three (Resident #30, #50, and #70) of the ten residents reviewed for accurate medical record information. The facility census was 91. Findings include:1.Review of the medical record for Resident #30 revealed an admission date of [DATE]. Diagnoses included acute respiratory failure, adult failure to thrive, and chronic obstructive pulmonary disease. Review of Resident #30's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Review of a physician order for Resident #30 dated [DATE] revealed this resident wished to be a Full Code indicating all possible life-saving measure would be attempted in the event of a medical emergency. Review of the plan of care for Resident #30 dated [DATE] revealed this resident has chosen that Cardiopulmonary Resuscitation (CPR) will be attempted during a cardiac arrest. Continued review of Resident #30's medical record indicated this resident started receiving Hospice services on [DATE] with a code status of Do-Not-Resuscitate Comfort Care (DNRCC) indicating this resident will not receive CPR or other resuscitative measures but will receive care focused on their comfort. Interview on [DATE] at 3:00 P.M. with Resident #30 confirmed he was receiving Hospice services and he had his code status was a DNRCC. Interview on [DATE] at 2:10 P.M. with the Director of Nursing (DON) claimed that she was not sure what Resident #30's code status was currently and would have to follow up on it. Review of a code status document that was noted to have been uploaded in Resident #30's medical record on [DATE] indicated Resident #30 had a current code status of DNRCC dated [DATE] which had been signed by Resident #30's Power of Attorney and this resident's current physician. Continued review of Resident #30's medical record on [DATE] showed a updated code status in the physician orders and care plan. 2.Review of the medical record for Resident #70 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, heart failure, and type two diabetes mellitus. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated [DATE] at 12:42 P.M. created by Licensed Practical Nurse (LPN) #333 revealed Resident #70 had experienced a change of condition while out of the facility at a doctor appointment and was transferred to the hospital for evaluation. Continued review of progress notes for Resident #70 indicated this resident was out of the facility at the hospital. Resident #70 was noted to be officially discharged from the facility on [DATE]. Review of nursing progress notes for Resident #70 dated [DATE] at 2:57 P.M. created by Registered Nurse (RN) revealed Temperature, 97.6 degrees, route: Forehead (non-contact), pulse at 66 beats per minute, respiration at 18 breaths per minute. [DATE]. Resident is alert and easily aroused. Resident is alert and oriented to person/ Not oriented to place. Not oriented to time. Oriented to situation. Resident is able to make own decisions. Resident is free of signs or symptoms of delusions. Resident weight bearing as tolerated. Steady gait noted. Weakness not noted. Able to move all extremities has full sensation. No changes in ADL capability noted. Does not require assistance with bed mobility. Does not require assistance with transfers. Changes to mood and behavior noted. Bladder function unchanged. Resident is continent of urine. Denies Nausea Denies emesis. Interview on [DATE] at 10:30 A.M. with the DON confirmed Resident #70 had not returned to the facility after an physician appointment on [DATE] and had officially discharged from the facility on [DATE]. The DON confirmed there was a nursing progress note entered on [DATE] indicating Resident #70's vitals had been obtained that day as well as the residents current health status. The DON verified this was not accurate since Resident #70 had not been at the facility since [DATE]. 3. Review of the medical record for Resident #50 revealed an admission date of [DATE] with a transfer to the hospital date from a doctor's appointment offsite of [DATE]. Diagnoses included but were not limited to type 2 diabetes mellitus, retention of urine, personal history of transient ischemic attack, anxiety disorder, depression, unspecified dementia, and muscle weakness. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 8 out of 15 which indicated moderate cognitive impairment. The resident was assessed to require partial/moderate assistance with bed mobility, substantial/maximal assistance with transfers, and total dependence on toilet hygiene, shower/bathe self. This resident was also assessed to have an unstageable pressure ulcer and a stage 3 pressure ulcer on admission as well as a venous/arterial ulcer. Review of the progress note dated [DATE] at 3:06 P.M. for Resident #50 revealed this resident's pressure ulcers were assessed by a Wound Nurse Practitioner. Review of the medical record for Resident #50 revealed no note from the Wound Nurse Practitioner for [DATE]. Interview on [DATE] at 11:32 A.M. with the Assistant Director of Nursing verified Resident #50 was seen by an outside wound consultant from a previous company on [DATE] that included assessment and treatment recommendations, and the visit was never received from them to upload into this resident's chart. Verified it should have been received and uploaded to make Resident #50's medical record complete and accurate. This deficiency represents noncompliance investigated under Complaint Number 2609966.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, observations, and facility policy review, the facility failed to ensure infection control measures were in place including ensuring dirty linen was off the facility hallway floors, ensuring the Glucometer machine was cleaned between resident use, ensuring sterile techniques was used and maintained during trach care and ensuring Enhanced Barrier Precautions were implemented for residents who required this form of precaution. This affected seven (Resident #13, #20, #60, #70, #92, #250, and #275) of the ten residents reviewed for infection control with the potential to affect all residents residing at this facility. The facility census was 91. Findings include: 1.Observations completed on 09/18/2025 at 1:50 P.M. of the facility's hallways revealed on the hallways named [NAME], there was a pile of dirty bed linen laying on the floor outside a resident's room. Interview on 09/18/2025 at 2:00 P.M. with Certified Nursing Assistant (CNA) #56 confirmed there was a pile of dirty bed linen on the unit hallway floor and also confirmed this dirty lined was supposed to be bagged up prior to leaving a resident's room and is not supposed to be placed on the floor for infection control purposes. 2. Observation on 09/18/2025 at 9:11 A.M. of Licensed Practical Nurse (LPN) #653 administering medication revealed infection control concerns when LPN #653 was observed leaving a resident's room (Resident #13) with a glucometer machine followed by placing it directly in the medication cart without properly cleaning it. LPN was then observed going to another resident's room (Resident #92) with the same glucometer machine just previously used and not cleaned, to check that residents blood glucose reading. LPN #653 then returned the glucometer machine to the medication cart again without properly cleaning it. Interview on 09/18/2025 at 9:30 A.M. with LPN #653 confirmed she had used the same glucometer on multiple different residents to check their blood glucose levels without cleaning the equipment between each resident. LPN #653 claimed there was approved disinfectant wipes in the bottom of the medication cart that is supposed to be used on the glucometer machine after each use. 3.Observations completed 09/22/2025 at 12:40 P.M. of Respiratory Therapist (RT) #422 completing trach care for Resident #250 revealed prior to entering room, hand hygiene was not completed, RT #422 did apply a isolation gown and gloves. RT #422 then obtained a trach suction kit, then removed all the sterile supplies inside the tray with non-sterile gloves. RT #422 then proceeded to grab the sterile gloves from the package with nonsterile gloves and place them on over his nonsterile gloves and used a nonsterile glove to press down between the finders of the sterile gloves to help put them on. RT #422 proceeded to remove all old trach dressing items and used the closed suction system to suction Resident #250's trach. RT #422 then used provided sterile items to clean around the trach site. A clean dry split gauze was placed behind the trach plate. RT #422 then removed the sterile gloves but kept the non-sterile gloves on. RT #422 proceeded to grab a new inner cannula which is inserted into the trach opening. RT #422 pulled out the old trach inner cannula all while doing this was observed holding the new inner cannula with his nonsterile gloved hands and touching the actual inner cannula tubing which is supposed to remain sterile. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/22/2025 at 12:58 P.M. with RT #422 confirmed trach care is a sterile procedure and confirmed there was multiple occurrences where infection control was not maintained and the sterile field was broken. Review of the facility policy titled, Tracheostomy Care, dated 12/2024 revealed, Aseptic (sterile) technique must be used: a. During cleaning and sterilization of reusable tracheostomy tubes. c. During all dressing changes until the tracheostomy wound has granulated (healed); and c. During tracheostomy tube changes, either reusable or disposable. Preparation and Assessment: check physician orders, explain procedure to resident, wash hands, put exam gloves on both hands, remove supplemental oxygen mask from tracheostomy, inspect skin and stoma site for signs or symptoms or infection, leakage, subcutaneous crepitus or dislodged tubing, assess resident for respiratory distress, remove old dressing, pull soiled gloves over dressing and discard into appropriate receptacle, wash hands. Cleaning the Disposable Inner Cannula: open the tracheostomy cleaning kit, Set up supplies on sterile field, maintaining sterile field, pour normal saline in one compartment of opened kit, pour normal saline in another compartment. Open two gauze pads and saturate with sterile saline, open two gauze pads, keep them dry. Put on sterile gloves. Secure the outer neck plate with non-dominant gloved hand. Unlock the inner cannula with gloved dominant hand. Gently remove the inner cannula and discard. Soak the inner cannula in normal saline. Remove and discard gloves into the appropriate receptacle, Wash hands and put on fresh gloves. Replace the cannula carefully and lock in place. 4.Review of the medical record for Resident #60 revealed an admission date of 06/20/2025 and a discharge date of 07/11/2025. Diagnoses included a non-pressure chronic ulcer of the right foot, peripheral vascular disease, and muscle weakness. Review of Resident #60's admission minimum data set (MDS) 3.0 assessment dated [DATE] revealed this resident experienced long and short-term memory impairment and had a severely impaired cognition for daily decision-making abilities. Resident was noted with on unstageable or deep tissue injury which was present upon admission to the facility which required pressure ulcer injury care and the application of dressings to the site. Review of multiple wound assessments noted Resident #60 had a venous ulcer to the left foot, gangrene to the right foot, a deep tissue injury to the right foot which all required treatments. Review of Resident #60's care plan confirmed this resident had skin integrity concerns but revealed no care plan for Enhanced Barrier Precautions (EBP). Review of Resident #60's physician orders from 06/20/2025 through 07/11/2025 revealed no orders for EBPs. Interview on 09/18/2025 at 3:00 P.M. with the Director of Nursing (DON) confirmed Resident #60 did not have an order for enhanced barrier precautions and due to have wounds, should have had this precaution in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	10/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Review of the medical record for Resident #70 revealed an admission date of 06/26/2025 and a discharge date of 07/14/2025. Diagnoses included heart failure, respiratory failure, and peripheral vascular disease. Review of Resident #70's admission MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #70 was noted to be admitted with one stage 1 pressure ulcer and one deep tissue injury as well as a surgical wound, all which required care and the application of ointments. Review of the care plan for Resident #70 revealed no evidence to indicate EBP were implemented as required due to wounds and surgical care. Review of physician orders for Resident #70 revealed an order for EBP was not implemented until 07/09/2025. Interview on 09/18/2025 at 3:00 P.M. with the DON confirmed Resident #70 did have multiple wounds including a surgical wound and EBP should have implemented upon admission to the facility but was not put in place timely. 6)Review of the medical record for Resident #275 revealed an admission date of 08/05/2025. Diagnoses included dependence on respiratory vent status, heart failure, and tracheostomy status. Review of Resident #275's admission MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #275 was noted to require supplemental oxygen for respiratory support as well as trach care. Review of physician orders for Resident #275 revealed an order dated 07/31/2025 for EBP due to vent and trach status. Review of the plan of care for Resident #275 dated 08/06/2025 revealed this resident requires Enhanced Barrier Precautions due to a vent and trach status. Interview on 09/18/2025 at 3:00 P.M. with the DON confirmed Resident #275 did not have an order for enhanced barrier precautions upon admission to the facility and due to her trach status should have. 7. Review of the medical record for Resident #20, revealed an admission date of 08/21/25 and a left AMA date of 09/10/25. Diagnoses included but were not limited to urinary tract infection, acute on chronic systolic heart failure, pneumonia and history of falling. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 out of 15 suggested moderate cognitive impairment. The resident was assessed to require total dependence on bed mobility, transfers, toilet hygiene and shower/bathe self. This resident was also assessed to be frequently incontinent of bowel and bladder functions. This resident was noted to also have a stage 4 pressure ulcer injury on admission. Review of the active care plan dated 09/04/25 revealed Resident #20 had an actual skin impairment related to a pressure area on the sacrum with no intervention for enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the discontinued physician orders dated 08/21/25 through 09/10/25 for Resident #20 revealed no order for enhanced barrier precautions during facility stay. Interview on 09/18/25 at 2:12 P.M. with the Director of Nursing verified no order for enhanced barrier precautions during facility stay for Resident #20. This deficiency was an incidental finding discovered during the complaint investigation completed on 10/09/25.