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	12/31/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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

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

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F 0610 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, resident representative interview, resident interview, staff interview, and facility policy review, the facility failed to investigate an allegation of abuse thoroughly. This affected one (Resident #39) of three residents reviewed for abuse. The census was 111.Findings Include:Resident #39 was admitted to the facility on [DATE]. Her diagnoses were seizures, chronic embolism and thrombosis, osteoarthritis, peripheral vascular disease, hyperlipidemia, dementia, major depressive disorder, anxiety disorder, and Parkinson's disease. Review of her minimum data set (MDS) assessment, dated 11/20/25, revealed she had a mild cognitive impairment.Review of Resident #39's progress notes, dated 12/02/25, confirmed an incident that happened between Resident #39 and Resident #79. Resident #79 became agitated and grabbed Resident #39, but did not strike her. Resident #79 was removed from the situation to calm the environment. Resident #39 was fully assessed and no injuries were noted. Resident #39 indicated she had a stress induced headache which was a result of the negative interaction she had with Resident #79. Staff addressed the headache with pain reliever.Review of Resident #39 and Self Reported Incident (SRI) investigative documents, dated 12/01/25, revealed it was reported that Resident #79 was hitting Resident #39. The facility completed an investigation and determined no abuse had occurred. There was no documentation that indicated Resident #79 had touched Resident #39 during this entire incident; it only referenced that Resident #79 did not abuse Resident #39. There was documentation that Resident #39's representative was near the incident when it occurred, but there was no documentation that Resident #39's representative was interviewed to provide clarity on this incident. Interview statement from Licensed Practical Nurse (LPN) #166, who was the nurse that was directly involved with this incident, stated Resident #79 was aggressive and agitated, but did not reflect there was any physical interaction between the two residents. Interview statement written by Director of Nursing (DON) regarding an interview she completed with Resident #39, indicated Resident #39 was never struck by Resident #79. There was no mention of any physical interaction between the two residents. Finally, an interview statement given by LPN #164 indicated she was called to the area by staff. She stated she was given information about the incident, but there was nothing specific about what was told to her about the incident.Interview with Resident #39's representative on 12/30/25 at 9:50 A.M. confirmed she was in the facility and in the immediate vicinity when Resident #79 attacked Resident #39, clarifying that Resident #79 was aggressive toward Resident #39 and grabbed her shoulders. Resident #39's representative stated LPN #166 quickly intervened, but Resident #79 had grabbed Resident #39 prior to the LPN intervening. She stated she spoke to the facility management about this and feels they are covering it up because they told her they did not have any evidence that Resident #39 was touched/grabbed by Resident #79 at all.Interview with LPN #166 on 12/30/25 at 10:02 A.M. confirmed she was in the area of the building where Resident #39 and Resident #79 had their incident. She confirmed Resident #39's daughter was in the area and saw everything as well. She confirmed she reported to management that Resident #79 had grabbed Resident #39 on the shoulders prior to LPN #166 intervening and removing Resident #79 from the area. She confirmed the only pain that Resident #39 expressed was a stressed induced headache after the incident, which she addressed with pain reliever.Interview with Resident #39 on 12/30/25 at 10:10 A.M. confirmed that Resident #79 grabbed her shoulders. She felt like he was doing this to intimidate her. She did state she did not feel intimidated, but she did not want him grabbing her.Interview with the DON on 12/30/25 at 11:10 A.M. revealed she completed the investigation for this incident and there were no reports to her of any physical interaction between Resident #39 and Resident #79. She stated she interviewed LPN #166 and Resident #39 and neither of them had told her Resident #39 was grabbed by Resident #79. Also, she stated that she spoke with Resident #39's daughter a couple days after the incident and she did not mention that Resident #79 had grabbed Resident #39. She confirmed she did not document the interview she had with Resident #39. She stated she was not aware of any documentation (progress note written by LPN #166 on 12/02/25) or any interview statements in which Resident #39 was grabbed.Review of facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated March 2024, revealed the facility will report and investigated any allegation of abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. All new employees will have criminal and professional background checks completed prior to starting employment. When an allegation is made, the facility will ensure the resident is safe. All

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to implement physician orders to care for an indwelling urinary catheter. This affected one resident, (Resident #72) of three residents reviewed for urinary catheters. The facility census was 111.Findings Include:Record review for Resident #72 revealed this resident was admitted to the facility on [DATE] with diagnoses including: chronic obstructive pulmonary disorder, tracheostomy, obstructive sleep apnea, muscle wasting and atrophy. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require assistance with self-care activities.Review of the care plan dated 12/09/26 revealed Resident# 72 was at risk for a urinary tract infection.Review of the physician's order for Resident #72 as of 12/29/25 revealed no catheter care, catheter cleansing or catheter flush orders.During an interview with Licensed Practical Nurse (LPN) #162 on 12/30/25 at 2:15 P.M. she stated catheter care is conducted per the physician orders appearing in the system of record.During an interview with Director of Nursing, (DON) on 12/30/25 at 2:48 P.M. she confirmed Resident #72 did have an indwelling urinary catheter and no physician orders had been entered pertaining to catheter care for Resident #72. Later that afternoon she confirmed that she added the orders in Resident #72's electronic medical record for his catheter care. Review of policy titled Urinary Catheter Care dated February 2024 revealed the purpose of this procedure is to prevent catheter-associated urinary tract infections. Routine hygiene (e.g. cleansing of the meatal surface during daily bathing or showering) is appropriate. Empty the drainage bag regularly, at least every shift and as needed. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction. Observe residents for complications associated with urinary catheters. This deficiency represented non-compliance investigated regarding complaint numbers 2676997.