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	03/10/2026

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 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 closed medical record review, interview and facility policy review, the facility failed to ensure the physician and the resident representative was notified of a change in condition. This affected one resident (#30) of three residents reviewed for change in condition. The facility census was 116. Findings Include:Review of the closed record for Resident #30 revealed an initial admission date of 01/22/26 with the diagnoses including but not limited to protein calorie malnutrition, depression, congestive heart failure, obstructive sleep apnea, metabolic encephalopathy, anemia, atrial fibrillation, pleural effusion, acute respiratory failure with hypoxia, hypertension, hyperlipidemia, myotonic muscular dystrophy and rheumatoid arthritis. Review of the resident's discharged physician orders identified orders dated 01/22/26 suction tracheostomy routinely and as needed for excessive secretions change tracheostomy inner cannula every shift and as needed size six cuffed or cuffless, tracheostomy care every shift and as needed, change tracheostomy ties every [NAME] and Thursday on day shift and 01/23/26 oxygen via tracheostomy mask at 4 liters continuously every shift. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was in a persistent vegetative state/no discernible consciousness. The assessment indicated the resident was always incontinent of both bowel and bladder. The resident received oxygen therapy, suctioning and tracheostomy care. Review of the progress note dated 01/31/26 at 7:33 P.M. revealed the resident's tracheostomy was found laying on the floor bedside his bed. The resident was noted to have mild respiratory distress and an oxygen saturation rate of 78%. The nurse immediately initiated emergency tracheostomy protocol. The nurse inserted a new size six tracheostomy tube without complications. The resident's oxygen saturation rate improved to 96%. The nurse documented the resident tolerated the procedure well and the resident was placed on close supervision. Review of the medical record revealed no documented evidence the resident's primary care physician (PCP) or family representative was notified the resident's tracheostomy was on the floor, the resident's mild respiratory distress and a new tracheostomy was inserted. On 03/10/26 at 3:15 P.M., an interview with the Director of Nursing (DON) verified the resident's PCP or family representative was not notified of the resident's tracheostomy was on the floor, the resident's mild respiratory distress and a new tracheostomy was inserted. Review of the facility's policy titled, Change of Condition Policy, dated 09/24 revealed the facility will promptly identify, assess and respond to any significant change in a resident's physical, mental or psychosocial condition. The licensed nurse will ensure timely notification of the physician and resident representative and implement appropriate interventions to maintain the resident's health and safety. This deficiency represents non-compliance investigated under Complaint Number 2735768.

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
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interviews and facility policy review, the facility failed to ensure one resident who was dependent on staff received routine nail care. This affected one resident (#100) of three residents reviewed for activities of daily living. The facility census was 116. Findings Include:Review of the medical record for Resident #100 revealed an initial admission date of 09/23/25 with the latest readmission of 01/10/26 with the diagnoses including but not limited to end stage renal failure, congestive heart failure (CHF), diabetes mellitus, hypertension, hyperlipidemia, benign prostatic hyperplasia, obstructive sleep apnea, major depressive disorder and fracture of lower end of right femur. Review of the plan of care dated 11/03/25 revealed the resident exhibited unsafe and unhygienic behavior during incontinence care, including smearing fecal matter and placing soiled fingers in mouth, which increases risk of infection, skin breakdown and cross contamination. Interventions included administer medications as ordered. Observe for effectiveness and side effects, approach resident using calm, reassuring communication to reduce agitation during incontinence care, educate on the risks of putting fecal matter in his mouth and give non-judgmental support. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident was dependent on staff for showers. On 03/09/26 at 11:07 A.M., an interview and observation with Resident #100 revealed the resident's nails were long, jagged and had a brown substance under the nail. The resident's stated, they will not cut my nails. On 03/09/26 at 1:32 P.M., an interview with the Director of Nursing (DON) verified the resident's nails were long, jagged with a brown substance under them. The DON stated she would cut the resident's nails. On 03/10/26 at 11:21 A.M., an observation of Resident #100 revealed the resident's nails remained long, jagged with a brown substance under them. Review of the facility policy titled, Nail Care, dated 07/24 revealed the purpose of the policy was to ensure residents receive safe and appropriate nail care to promote comfort, hygiene and prevent infection or injury. Nursing staff or trained nursing assistants may provide routine fingernail care, including cleaning and trimming. This deficiency represents non-compliance investigated under Complaint Number 2735768 and 2715847.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, interview and facility policy review, the facility failed to obtain physician ordered diagnostic laboratory tests. This affected one resident (#40) of three residents reviewed for diagnostic laboratory test. The facility census was 116. Findings Include:Review of the closed record for Resident #40 revealed an initial admission date of 12/24/25 with the latest readmission of 01/05/26 with the diagnoses including but not limited to acute and chronic respiratory failure, need for assistance with personal care, hyperlipidemia, congestive heart failure, atrial fibrillation, nicotine dependence, anxiety disorder, chronic obstructive pulmonary disease, hypertension, peripheral vascular disease and benign prostatic hyperplasia. Review of the plan of care dated 12/25/25 revealed the resident was at risk for rehospitalization due to recent hospitalization and required individualized interventions to detect early changes in condition and avoid unnecessary transfers. Interventions included CHF chronic disease, monitor weights as ordered, monitor edema and provide diet as ordered, COPD chronic disease, monitor oxygen saturations as ordered, monitor inhaler use as ordered, monitor shortness of breath (SOB), ensure follow up appointments and labs are scheduled, follow provided orders, labs and diagnostics, medication reconciliation post hospitalization and as needed, monitor for fever, confusion and appetite decline, monitor high risk medications and therapy consults as needed. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's discharged physician orders identified an order dated 01/06/26 for a vitamin B level and a vitamin D level. Review of the medical record revealed no evidence the facility obtained the physician ordered vitamin B level and the vitamin D level. On 03/10/26 at 4:28 P.M., an interview with the Assistant Director of Nursing (ADON)verified the facility failed to obtain the physician ordered vitamin B and the vitamin D level. Review of the facility policy titled, Lab and Diagnostic Test Results, last revised in 2025 revealed the physician will identify and order diagnostic laboratory testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for the tests. This deficiency is an incidental finding discovered during the course of this complaint investigation.

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, interview and facility policy review, the facility failed to notify the physician of diagnostic radiology results. This affected one resident (#40) of three residents reviewed for diagnostic laboratory tests and x-rays. The facility census was 116. Findings Include: Review of the closed record for Resident #40 revealed an initial admission date of 12/24/25 with the latest readmission of 01/05/26 with the diagnoses including but not limited to acute and chronic respiratory failure, need for assistance with personal care, hyperlipidemia, congestive heart failure, atrial fibrillation, nicotine dependence, anxiety disorder, chronic obstructive pulmonary disease, hypertension, peripheral vascular disease and benign prostatic hyperplasia. Review of the plan of care dated 12/25/25 revealed the resident was at risk for rehospitalization due to recent hospitalization and required individualized interventions to detect early changes in condition and avoid unnecessary transfers. Interventions included CHF chronic disease, monitor weights as ordered, monitor edema and provide diet as ordered, COPD chronic disease, monitor oxygen saturations as ordered, monitor inhaler use as ordered, monitor SOB, ensure follow up appointments and labs are scheduled, follow provided orders, labs and diagnostics, medication reconciliation post hospitalization and as needed, monitor for fever, confusion and appetite decline, monitor high risk medications and therapy consults as needed. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the progress noted dated 02/13/26 at 3:01 P.M., revealed the Certified Nurse Practitioner (CNP) examined the resident and a new order was received for a chest x-ray due to cough. The note indicated the resident's lungs were clear when auscultated with stethoscope. Review of the resident's discharged physician orders identified an order dated 02/13/26 for a two view chest x-ray. Review of the progress note dated 02/13/26 at 7:12 P.M. revealed the chest x-ray was obtained and results were pending. Review of the chest x-ray results dated 02/13/26 with a reported time of 9:28 P.M. revealed the resident was post-sternotomy status, bilateral hilar prominence, generalized prominence of bronchovascular markings, concerning for bronchitis, ill defined patchy radio opacities in the right middle and lower zone, concerning with pneumonia with follow up imaging was recommended. Review of the medical record revealed no documented evidence the physician was notified of the diagnostic chest x-ray results. On 03/09/26 at 2:58 P.M., an interview with the Director of Nursing (DON) verified the medical record contained no documented evidence the resident's physician was notified of the diagnostic radiology results obtained on 02/13/26. Review of the facility policy titled, Lab and Diagnostic Test Results, last revised in 2025 revealed the physician will identify and order diagnostic laboratory testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for the tests. The laboratory, diagnostic radiology provider, or other testing source will report the test results to the facility. The nursing staff will review the resident's results and notify the physician via preferred method. This deficiency represents non-compliance investigated under Complaint Number 2715847.