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	12/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on observations, resident interviews, staff interviews, medical record review, and review of facility policy, the facility failed to provide dignified living conditions for two residents. This affected two (Resident #49 and #81) residents out of three residents (#49, #81, and #220) reviewed for dignity. The facility census was 109 residents. Findings include: 1. Review of medical record for Resident #49 revealed that she was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, major depressive disorder, suicidal ideations, obsessive compulsive disorder, and unspecified psychosis not due to a substance or known physiological condition. Review of her Minimum Data Set on 11/20/24 revealed that she had a Brief Interview for Mental Status score of 15, indicative of intact cognitive status. Interview with Resident #49 on 12/16/24 at 10:46 A.M. revealed that on many occasions over multiple days, she observed another resident (Resident #63) in his room across the hallway from her exposing himself to her, masturbating, and licking his fingers from his open doorway. Resident #49 explained that she did not feel that it was sexual abuse, but she found Resident #63 to be creepy. She stated that she did not have any adverse affects related to these incidents but it was an undignified way to live. Resident #49 stated she reported her concerns to management and she was told to deal with it, and close (her) door. Interview with Social Services Designee #320 on 12/17/24 at 2:42 P.M. revealed Resident #49 and Resident #63 both had recent room moves that were unrelated to the incidents, but Social Services Designee #320 confirmed she was aware of Resident #49's concerns about Resident #63's sexual acts in his room Resident #49 could observe. Interview with the Administrator on 12/17/24 at 3:00 P.M. confirmed he was aware of Resident #49 being upset that she could see Resident #63 exposing himself from his open door in his room where Resident #49 could see him. Administrator stated that he temporarily moved Resident #63's room, but Resident #63 had to move back to that room again soon thereafter because of a need for an isolation room. He confirmed he did ask Resident #49 if she felt that it was sexual abuse, and that she denied that. (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

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	12/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 2016 facility policy called Resident Rights revealed residents had a right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. 32654 2. Review of the medical record for Resident #81 revealed an initial admitted [DATE] with the latest readmitted [DATE] with diagnoses including but not limited to pneumonitis due to inhalation of food and vomit, bacteremia, metabolic encephalopathy, severe sepsis with septic shock, intestinal obstruction, dysphagia, severe protein calorie malnutrition, acute respiratory failure with hypoxia, aphasia, anxiety disorder, periodontal disease, seizures, traumatic brain injury, tracheostomy, anemia, gastro-esophageal reflux disease, hypertension, chronic obstructive pulmonary disease, constipation, insomnia and cerebral infarct. Review of the plan of care dated 11/01/24 revealed the resident had an activities of daily living (ADL) self-care performance deficit related to cerebral infarct, functional limitation in range of motion, generalized weakness, impaired mobility, traumatic brain injury and non-ambulatory status. Interventions included assist with ADLs as needed, bed mobility per two assists, mechanical lift for transfers, monitor for pain during ADL tasks and provide medication per physician order, place call light within reach, prefers to be in gown rather than personal clothing, prefers to stay in bed, resident is bedfast all or most of the time and resident uses a manual wheelchair for ambulation. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident had functional limitation in range of motion to both upper and lower extremities and was dependent on staff for ADL. On 12/16/24 at 11:46 A.M., observation of Resident #81 revealed he was laying in bed without a gown or clothing. Further observation revealed the resident's soiled incontinence brief was visible from the hallway. On 12/16/24 at 3:25 P.M., observation of Resident #81 revealed he was laying in bed without a gown or clothing. Further observation revealed the resident's soiled incontinence brief was visible from the hallway. On 12/16/24 at 4:26 P.M., interview with Licensed Practical Nurse (LPN) #158 verified the resident had no clothing on and his soiled incontinence brief was visible from the hallway. Review of a 2016 facility policy called Resident Rights revealed residents had a right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality.

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	12/31/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on resident and staff interviews, the facility failed to give one resident timely access to her social security benefits and failed to ensure one resident was appointed a legal guardian appropriately. The deficient practices affected two residents (Residents #61 and #163) of three reviewed for accommodation of needs. The facility census was 109 residents. Findings include: Resident #61 was admitted to the facility on [DATE] with diagnoses that included epilepsy, hemiplegia and hemiparesis following cerebral infarction, muscle weakness and need for assistance with personal care. Review of her Minimum Data Set 3.0 assessment on 11/12/24 revealed that her Brief Interview for Mental Status score was 15, indicative of intact cognition. Interview with Resident #61 on 12/16/24 at 10:14 A.M. revealed that she did not have access to her social security benefits. Resident #61 stated that she had been asking administration about access to her social security benefits since March 2024 when she was readmitted to the facility. She stated she would like access to the monthly allowance to pay for toiletry items that she prefers. Interview with the Administrator on 12/17/24 at 3:06 P.M. revealed he had been talking with Resident #61 about getting access to her social security benefits since he started working at the facility in September 2024. He revealed the facility was without a Business Office Manager at this time, and he did not know how to get Resident #61 a state identification card and she could not recall her last known address due to her previously transient status. The Administrator stated he did not have an answer as to how to help Resident #61 access her social security benefits. Interview with Interim Director of Nursing #506 on 12/18/24 at 4:23 P.M. revealed that Resident #61's social security benefits had stopped because the social security office does not know where she is. Interview with Admissions Director #317 on 12/18/24 at 5:10 P.M. revealed when Resident #61 had a previous admission to the facility in 2022, she was receiving her monthly allowance from Medicaid, but then when she was discharged out into the community, something happened and Social Security no longer knows where she is located. Admissions Director #317 stated that she will try to figure out if Resident #61 has a Resident Fund Management Service account at another facility that she can find. Review of Resident #61's progress notes in her medical chart revealed on 12/19/24 at 9:32 A.M., Admissions Director #317 wrote a progress note reporting Resident #61 was assisted in calling Social Security and was able to determine where her Social Security was going and to have it rerouted to the facility, which will start in January 2025. Review of a policy named Resident Rights updated in 2016 revealed that if the resident has delegated the responsibility to managing her funds to the facility, that a complete record of all of their funds will be deposited for safekeeping with the home for use by the resident or the resident's sponsor. (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	12/31/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32654 2. Review of the medical record for Resident #163 revealed an initial admitted [DATE] with the latest readmission of 12/01/24 with diagnoses including but not limited to gastrostomy malfunction, asthma, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, syncope and collapse, repeated falls, cerebrovascular accident with left sided hemiplegia, anxiety disorder, dysphagia, aphasia and hypertension, hypothyroidism. Review of the plan of care dated 10/01/24 revealed the resident had an impaired cognitive process for daily decision making and was at risk for further decline in cognitive status related to CVA. Interventions included document observations and interventions, encourage resident to make routine daily decisions, assist through as needed, administer medications as ordered and observe for side effects, approach in a calm, reassuring manner, observe, record all changes in mental status and promote dignity, converse with resident and ensure privacy while providing care, provide cues, prompting, demonstration if resident is unable to complete a task independently and reorient and redirect as needed. Review of the medical record revealed no evidence of a Power of Attorney (POA) or guardianship in place. Review of the social service progress note dated 12/03/24 at 11:38 A.M., authored by Social Services Designee (SSD) #320 revealed a volunteer guardian came to the facility for an evaluation and she did not find the resident was appropriate for guardianship at that time. On 12/17/24 at 8:28 A.M., interview with the resident's Payee revealed the organization she was employed with assisted the resident with his financial matters, assisted the resident with appointments, transportation and grocery shopping. She revealed the organization does not have the legal ability to make decisions for the resident. She revealed she had multiple conversations with SSD #320 educating the facility of the organization's role and the resident's need for guardianship. The Payee revealed the friend listed on the resident's record wants no contact with the resident and she had educated the facility on that also. On 12/18/24 at 10:30 A.M., interview with SSD #133 and SSD #320 revealed the facility had a volunteer guardian come to the facility and evaluate the resident. SSD #320 revealed the volunteer guardian felt he was not appropriate. SSD #320 revealed the resident's primary care physician had no been involved in determining if the resident required guardianship. SSD #320 revealed the facility did not have a Licensed Social Worker (LSW) and verified she was unaware of the guardianship process and how to initiated and complete it.

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	12/31/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interview, and facility policy review, the facility failed to ensure an accurate code status was in place for one resident (Resident #97). The deficient practice affected one resident (Resident #97) of one reviewed for advanced directives. The facility census was 109. Findings Include: Review of the medical record for Resident #97 revealed an admitted on [DATE]. Medical diagnoses included Type II diabetes mellitus with diabetic neuropathy, unspecified protein-calorie malnutrition, dementia without behavioral disturbance, encounter for surgical aftercare following surgery on the digestive system, and other intestinal obstruction unspecified as to partial versus complete obstruction. Resident #97's advance directive was noted as full code. Resident #97's daughter was listed as the resident's Durable Power of Attorney (DPOA). Review of the current physician orders revealed Resident #97 had an order for Full Code dated [DATE]. Resident #97 also had an order to admit to hospice with a diagnosis of cerebral atherosclerosis dated [DATE]. Review of the Five Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #97 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #97 required a varied amount of assistance from staff to complete Activities of Daily Living (ADLs). Review of the care plan revised [DATE] revealed Resident #97 was a full code. The resident chose to have Cardiopulmonary resuscitation (CPR) attempted during a cardiac arrest. Interventions included if code status changes, code status would be posted in the resident's chart and physician's orders. Review of the progress note dated [DATE] at an unknown time completed by Certified Nurse Practitioner (CNP) #509 revealed Resident #97 was seen to review a urine culture in the context of dysuria (blood in urine) and a history of urinary tract infections (UTIs) on [DATE]. Resident #97's code status was noted as full code confirmed with patient on [DATE]. Review of the hospice Admission Orders/Initial Plan of Care, dated [DATE], revealed Resident #97 was admitted to hospice services with the diagnosis of cerebral atherosclerosis. A Do Not Resuscitate (DNR) order was completed as of [DATE]. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #97 had impaired cognition and scored an eight out of 15 on the BIMS assessment. (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	12/31/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:22 A.M. with Assistant Director of Nursing (ADON) #151 revealed staff should verify a resident's code status in the hard chart and/or in the electronic medical record on the profile page. The code status should match in all places it is listed and should be kept up to date at all times. ADON #151 confirmed Resident #97 was alert and oriented with confusion. ADON #151 confirmed the resident's daughter was the resident's DPOA. ADON #151 confirmed the hospice admission paperwork indicated Resident #97's code status changed to DNR. ADON #151 confirmed there was no evidence a DNR order had been received or followed up on by the facility staff to verify the resident's code status. Review of the hard chart for Resident #97 on [DATE] at 11:29 A.M. revealed the resident's code status was full code dated [DATE]. There was no evidence Resident #97's code status had been changed to DNR in the hard chart or the electronic medical record. Interview on [DATE] at 12:04 P.M. with ADON #151 confirmed the admitting hospice nurse, Registered Nurse (RN) #510 verified Resident #97's DPOA/daughter agreed to change Resident #97's code status to DNR upon admission to hospice services. RN #510 provided the DNR order to the physician to sign and return. ADON #151 confirmed Resident #97's code status should have been updated to DNR effective [DATE] when the DNR order was signed by the physician. ADON #151 confirmed the staff should have reviewed the admission paperwork and followed up to confirm the resident's code status change. Review of the DNR Comfort Care order provided by hospice on [DATE] at approximately 12:05 P.M. (following surveyor intervention) was dated [DATE] and confirmed Resident #97's DPOA and the physician signed the order for the resident's code status to be changed to DNR Comfort Care-Arrest. Review of the facility policy, Code Status Policy: Full Code/DNRCC/DNRCC-Arrest, dated [DATE], revealed the policy stated, when a DNR Comfort Care or a DNR Comfort Care-Arrest status has been chosen by the resident and/or responsible party, the physician will be notified. An Ohio Do Not Resuscitate Order (DNR) form must be completed and signed by the Attending Physician and placed in the front of the resident's medical record. If the physician is not available to sign the DNR form, a verbal order for DNR status may be obtained and documented by two witnesses, one of whom must be a nurse, and a copy of the form signed by the physician within 14 days. Review of the facility policy, Hospice Coordination/Collaboration of Services, dated [DATE], revealed the policy stated, The interdisciplinary (IDT) team will develop and maintain a system of communication and integration with hospice services. The hospice provider and the IDT coordinate resident care.

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	12/31/2024

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** 32654 Based on record review, staff interview and facility policy review, the facility failed to notify one resident's (#81) family of a room change. This affected one of 29 sampled residents. The facility census was 109. Findings Include: Review of the medical record for Resident #81 revealed an initial admitted [DATE] with the latest readmitted [DATE], diagnoses include but were not limited to pneumonitis due to inhalation of food and vomit, bacteremia, metabolic encephalopathy, severe sepsis with septic shock, intestinal obstruction, dysphagia, severe protein calorie malnutrition, acute respiratory failure with hypoxia, aphasia, anxiety disorder, periodontal disease, seizures, traumatic brain injury, tracheostomy, anemia, gastro-esophageal reflux disease, hypertension, chronic obstructive pulmonary disease, constipation, insomnia and cerebral infarct. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the room change notification dated 11/06/24 revealed the resident had a room change on 11/06/24 from 301 bed A to 332 for more room. Review of the room change notification dated 11/25/24 revealed the resident was moved from room [ROOM NUMBER] to 307 bed A per resident request due to upcoming programing changes on 11/25/24. Review of the resident's medical record revealed the resident was moved on 12/10/24 from 307 bed A to 315 bed A while the resident was admitted to an acute care hospital. Further review revealed no documentation of the room change, reason for the room change and notification of the room change to the resident's family. On 12/17/24 at 4:32 P.M., interview with Social Service Designee (SSD) #320 verified the medical record contained no documented evidence the resident's family was notified of the room change. Review of the facility policy titled, Change in a Resident's Condition or Status, dated 05/17 revealed the facility shall promptly notify the resident, his or her physician and representative of changes in the resident's medical/mental condition and/or status. Unless otherwise instructed by the resident a nurse will notify the resident's representative when there is a need to change the resident's room assignment. This deficiency represents non-compliance investigated under Complaint Number OH00160119.

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	12/31/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on record review, staff interviews, and resident interviews, the facility failed to provide written transfer notices and inform residents or their families of their rights regarding hospitalization for three (Residents #41, #76, and #106) out of three residents reviewed for hospitalization s. The facility census was 109. Findings include: 1. Review of the medical record for Resident #41 revealed an admitted [DATE] with a re-entry date of 08/18/24. The resident was diagnosed with multiple chronic conditions, including pleural effusion, chronic sinusitis, dependence on respirator, chronic diastolic heart failure, cirrhosis of liver, chronic kidney disease stage IIIB, type II diabetes mellitus with diabetic neuropathy, morbid obesity, chronic respiratory failure with hypoxia, venous insufficiency, dependence on wheelchair, hypokalemia, obstructive sleep apnea, cardiomegaly, dependence on supplemental oxygen, hypothyroidism, acquired absence of left leg below knee, chronic pain, presence of urogenital implants, lymphedema, and chronic obstructive pulmonary disease (COPD). Review of the census and discharge summaries indicated Resident #41 was admitted to an acute care hospital on the following dates: 01/31/24 - 02/28/24, 06/26/24 - 07/19/24, 07/20/24 - 07/21/24, 08/13/24 - 08/18/24, and 11/03/24 - 11/07/24. Review of transfer notice documentation revealed only one transfer notice dated 11/03/24 was present for Resident #41; however, this notice did not include a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity receiving such requests. Additionally, there was no information on how to obtain an appeal form or assistance in completing and submitting the appeal hearing request. There was also no evidence that transfer notices were provided for any other hospitalization s. Interview with the Administrator on 12/18/24 at 3:15 PM confirmed no other transfer notices were completed for Resident #41's other hospitalization s. The Administrator stated that the facility does not provide written transfer notices for residents transferred to the hospital. He further explained at the end of each month, he sends an email to the Ombudsman's office reporting all hospitalization s for the month and would provide evidence of those emails. However, the Administrator did not provide evidence of the emails being sent to the Ombudsman. Interview with Resident #41 on 12/23/24 at 3:50 PM confirmed the resident had not received a transfer notice when being transferred to the hospital. (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	12/31/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #76 revealed an admitted [DATE] with a re-entry date of 10/31/24. The resident was diagnosed with hemiplegia and hemiparesis, type II diabetes mellitus without complications, hyperlipidemia, chronic kidney disease, presence of other cardiac implants and grafts, morbid obesity, hypertension, cutaneous abscess of perineum, seizures, convulsions, long-term use of insulin, muscle weakness, reduced mobility, unsteadiness on feet, need for assistance with personal care, cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery, angina pectoris, vertigo of central origin, and irritable bowel syndrome with constipation. Review of the census and discharge summaries indicated Resident #76 was admitted to an acute care hospital on the following dates: 07/27/24 - 07/30/24, 08/09/24 - 08/12/24, 10/25/24 - 10/31/24, and 12/07/24 - 12/11/24. Review of the transfer notice documentation revealed that transfer notices were completed on 08/09/24, 07/27/24, and 12/07/24. However, there was no evidence the transfer notices included required information such as the resident's appeal rights, contact information, or the process for submitting an appeal. Furthermore, there was no evidence of transfer notices being provided to the resident or family, nor was there any written documentation provided to the resident regarding their rights to appeal the transfer, the contact information for the relevant parties, or the process for maintaining their bed hold status. Interview with the Administrator on 12/18/24 at 3:15 PM confirmed that the facility does not provide written transfer notices for residents transferred to the hospital. The Administrator explained the only time they submit transfer notices is when the resident is being discharged from the facility. At the end of each month, the Administrator sends an email to the Ombudsman ' s office reporting all hospitalization s for the month and would provide evidence of these emails if requested. However, the Administrator did not provide evidence of the emails being sent to the Ombudsman. Interview with the resident #76's daughter on 12/18/24 at 4:13 PM confirmed that the resident has not received written transfer documentation, including appeal rights, contact information, or the reason for the transfer. 41266 3. Review of the closed medical record for Resident #106 revealed an admitted on 06/26/24. Medical diagnoses included osteomyelitis, type II diabetes mellitus with hyperglycemia, morbid obesity due to excess calories, acquired absence of left leg below knee, peripheral vascular disease, chronic kidney disease stage IV (severe), major depressive disorder, personal history of pulmonary embolism, and encounter for orthopedic aftercare following surgical amputation. Review of the clinical census revealed Resident #106 was hospitalized on [DATE] and had not returned to the facility. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #106 was discharged to a short-term general hospital from the facility. (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	12/31/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes revealed on 10/04/24 at 2:10 A.M., Resident #106 was noted to be different today. The resident was not aware of where she was, was hallucinating and stated someone had a gun. The resident refused to be put in bed due to someone being in her room. Resident #106 repeatedly called for staff and asked what was going on and why the staff was there. After staff reassurance, Resident #106 agreed to be put in bed and medications were administered. Resident #106 was recently on antibiotics for a urinary tract infection (UTI) and was recently taken off dialysis. The physician was ordered and an order for labs was verbally given. On 10/04/24 at 1:11 P.M., Resident #106's grandson arrived at the facility for a planned discharge to home from the facility however, the resident started having a change in condition with an altered mental status and would not answer any questions. Resident #106's vital signs were within normal limits. The resident's ordered labs were still pending. Resident #106's grandson did not feel comfortable taking the resident home in her current condition and requested the resident be sent to the hospital for an evaluation. The Certified Nurse Practitioner (CNP) was notified and agreed to have the resident sent out to the hospital for further evaluation. Review of the Transfer/Discharge Report, undated, revealed Resident #106 was transferred to a local acute care hospital on 10/04/24 at 12:01 P.M. for an altered mental status. The report did not include an explanation of the right to appeal the transfer or discharge to the State, the name, address, and telephone number of the State entity which received such appeal hearing requests, information on how to obtain an appeal form, information on obtaining assistance in completing and submitting the appeal hearing request, or the name, address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman. Interview on 12/18/24 at 5:30 P.M. with the Administrator confirmed Resident #106's transfer notice did not include all required information according to the federal regulation. The Administrator confirmed the facility only sent transfer notices for hospitalization s if the resident would not be allowed to return and had not been completing transfer notices for all facility-initiated transfers from the facility, including emergency transfers. Review of the facility policy, Discharging the Resident, dated May 2023, revealed the policy stated, if the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and telephone report is called to the receiving facility.

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	12/31/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on record review, staff interviews, and resident interviews, and facility policy, the facility failed to provide a bed hold notice to inform residents or their families of their rights regarding the retention of their room and bed during hospitalization s for two (Residents #41 and #76) out of three residents reviewed for hospitalization s. The facility census was 109. Findings include: 1. Review of the medical record for Resident #41 revealed an admitted [DATE] with a re-entry date of 08/18/24. The resident's diagnoses included pleural effusion, chronic sinusitis, dependence on a respirator, chronic diastolic heart failure, cirrhosis of the liver, chronic kidney disease stage IIIB, type II diabetes mellitus with diabetic neuropathy, morbid obesity, chronic respiratory failure with hypoxia, venous insufficiency, dependence on a wheelchair, hypokalemia, obstructive sleep apnea, cardiomegaly, dependence on supplemental oxygen, hypothyroidism, acquired absence of the left leg below the knee, chronic pain, presence of urogenital implants, lymphedema, and chronic obstructive pulmonary disease (COPD). Review of hospitalization records revealed Resident #41 was hospitalized on the following dates: 01/31/24-02/28/24, 06/26/24-07/19/24, 07/20/24-07/21/24, 08/13/24-08/18/24, and 11/03/24-11/07/24. Review of the bed hold notices in the medical record revealed an undated and unsigned notice that lacked essential information, including the number of bed hold days available. During an interview on 12/18/24 at 1:53 P.M., the interim Director of Nursing (IDON) #506 stated that two bed hold notices were completed on 06/26/24 and 11/03/24. However, the notices were incomplete, missing correct information and required signatures. Later in the interview, the IDON reported that these notices could no longer be located and requested they be disregarded. An interview conducted on 12/23/24 at 2:12 P.M. with Resident #41 revealed that during a hospitalization , her room was reassigned without her knowledge. She stated she was pissed about the lack of written communication and expressed frustration at learning of the room reassignment only through a phone call prior to her return to the facility. Review of the Admission Agreement revealed the facility will provide written notice of bed hold rights at the time of transfer to a hospital or therapeutic leave, ensuring that residents and their representatives are fully informed. However, there is no evidence that the required written notice was provided. This omission deprives the resident and their representative of the opportunity to make informed decisions regarding care and bed retention during hospitalization , violating both the terms of the Admissions Agreement and regulatory requirements. (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	12/31/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #76's medical record revealed an admitted [DATE] with a re-entry date of 10/31/24. The resident was diagnosed with hemiplegia and hemiparesis, type II diabetes mellitus without complications, hyperlipidemia, chronic kidney disease, presence of other cardiac implants and grafts, morbid obesity, hypertension, cutaneous abscess of the perineum, seizures, convulsions, long-term use of insulin, muscle weakness, reduced mobility, unsteadiness on feet, need for assistance with personal care, cerebral infarction due to unspecified occlusion or stenosis of the left posterior cerebral artery, angina pectoris, vertigo of central origin, and irritable bowel syndrome with constipation. Review of the census and hospitalization records revealed Resident #76 had hospital stays on the following dates: 07/27/24 - 07/30/24, 08/09/24 - 08/12/24, 10/25/24 - 10/31/24, and 12/07/24 - 12/11/24. Review of the medical record and facility documentation revealed no evidence of bed hold notices being provided to Resident #76 or their family for any of the above hospitalization s. Interview with Resident #76's daughter on 12/18/24 at 4:13 P.M. confirmed that the family did not receive any written documentation regarding bed hold rights. The daughter stated, We've never received any notices about the bed or what we needed to do to keep it when she goes to the hospital. Interview with the Administrator on 12/18/24 at 3:15 P.M. confirmed that bed hold notices are not completed or provided to residents or families. The Administrator stated that the facility does not complete bed hold notices when residents are hospitalized . Review of the Admission Agreement revealed the facility will provide written notice of bed hold rights at the time of transfer to a hospital or therapeutic leave, ensuring that residents and their representatives are fully informed. However, there is no evidence that the required written notice was provided. This omission deprives the resident and their representative of the opportunity to make informed decisions regarding care and bed retention during hospitalization , violating both the terms of the Admissions Agreement and regulatory requirements.

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	12/31/2024

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation,record review, interview, and Resident Assessment Instrument (RAI) manual review the facility failed to conduct an accurate assessment of each resident's functional capacity. This had the potential to affect two residents (#27, and #87), reviewed for accurate, comprehensive assessments, and the facility failed to timely complete a comprehensive assessment for one (#220) of four reviewed for accurate, comprehensive assessments. The facility census was 109. Findings Include: 1. Resident #27 had an admitted [DATE] with diagnoses including: Coronary artery heart disease, hypertension, hypercholesterolemia, orthostatic hypotension, hyperlipidemia, type two diabetes, age related physical debility, major depressive disorder, need for assistance with personal care, dizziness and giddiness, anxiety disorder, bipolar disorder, history of falling, vitamin deficiency, and dementia with behavioral disturbance. Observation on 12/19/24 at 10:25 A.M. revealed Resident #27 in his bed. There was a wanderguard in place to his left ankle. Review of an order dated 03/15/24 revealed that Resident #27 was to have a wanderguard in place to left ankle at all times, and staff were to check placement and function of the wanderguard every shift for elopement risk. Review of the quarterly minimum data set (MDS) assessment dated [DATE] for Resident #27 revealed physical Restraints, Wander/elopement Alarms, was marked not in use. Interview on 12/24/24 with MDS nurse #356 confirmed that the wanderguard alarm was not meant to restrict Resident #27's movement, but was meant to alert staff if Resident #27 got close to an exit. MDS nurse #356 stated the facility did not consider wanderguard alarms restraints, therefor, the question was marked not in use despite the fact that Resident #27 was wearing, ordered, and care planned for wanderguard. 47059 2. Record review revealed Resident #87 was admitted on [DATE] with the most recent readmitted [DATE] with diagnoses that included dysarthria and dysphagia following cerebral infarction, Type II diabetes mellitus, end stage renal disease requiring hemodialysis, atherosclerotic heart disease, atrial fibrillation, depression, malignant neoplasm of the prostate, atrioventricular block and presence of a cardiac pacemaker. Review of the admission Medicare 5-day minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #87 was cognitively intact with no signs of psychoses or behaviors noted. Resident #87 had no difficulties chewing or swallowing and was reported to have a recent significant weight gain and not on a physician-prescribed weight-gain regime. Resident #87 received antidepressant, anticoagulant, and anticonvulsant medications with indications present. Resident #87 was receiving dialysis. (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	12/31/2024

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes revealed on 10/09/24 at 12:32 P.M. dietitian #121 documented current weight triggers for a significant weight loss of 15 pounds a 10.7% significant loss in less than 30 days. Dialysis dry weight is 134.2 lbs. Weight changes can be expected with dialysis due to fluid shifts. Review of weights revealed on 10/02/24, Resident #87 weighed 132.4 lbs. On 10/26/2024, the resident weighed 135.3 pounds which is a 2.19 % Gain. 11/01/24 the MDS indicated a greater than 5% weight gain in a month. (the month prior to 11/01/24). Review of the Resident Assessment Instrument (RAI) manual instructions revealed for coding section K the definition/instructions for figuring WEIGHT GAIN IN 30 DAYS - Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight. Interview on 12/24/24 at 8:15 A.M. with MDS nurse registered nurse (RN) #356 confirmed the weights for the look back period for the minimum data set (MDS) 3.0 dated 11/01/24 showed a 2.2% weight gain but that section was filled out by the dietician. Interview on 12/24/24 at 8:39 A.M. MDS nurse RN #356 confirmed the process the facility used to calculate the weight gain was by taking the lowest weight in the month of October of 124 pounds on 10/07/24 and the highest weight in the month of 135.3 on 10/26/24 to get to a weight gain of more than 5% in the month. 3. Record Review revealed Resident #220 was admitted on [DATE] with the most recent readmission on 12/03/24 with diagnoses that included encounter for orthopedic after care following surgical amputation, acquired absence of right leg below the knee, type II diabetes mellitus with diabetic polyneuropathy and hyperglycemia, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, and pain. Admission minimum data set (MDS) 3.0 assessment dated [DATE] was still in progress as of 12/19/24 and had not been submitted. Completed sections reflected Resident #220 was cognitively intact and participating in goal setting with the overall goal to discharge to the community. Interview on 12/19/24 at 12:02 P.M. with MDS nurse RN #356 verified the Medicare 5-day MDS 3.0 dated 12/09/24 has not been completed. Review of the Resident Assessment Instrument (RAI) manual chapter two required assessment summary chart, the admission comprehensive assessment should be completed and submitted by the 14th calendar day of the resident's admission (admitted + 13 calendar days).

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	12/31/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review and staff interview, the facility failed to ensure an accurate significant change Minimum Data Status (MDS) 3.0 assessment was completed for two residents (Residents #97 and #163). The deficient practice affected two residents (Residents #97 and 163) of two reviewed for significant change MDS assessments. The facility census was 109. Findings Include: Review of the medical record for Resident #97 revealed an admitted on 08/14/24. Medical diagnoses included Type II diabetes mellitus with diabetic neuropathy, unspecified protein-calorie malnutrition, dementia without behavioral disturbance, encounter for surgical aftercare following surgery on the digestive system, and other intestinal obstruction unspecified as to partial versus complete obstruction. Review of the hospice Admission Orders/Initial Plan of Care, dated 11/05/24, revealed Resident #97 was admitted to hospice services with the diagnosis of cerebral atherosclerosis. Review of the current physician orders revealed Resident #97 had an order to admit to hospice with a diagnosis of cerebral atherosclerosis dated 11/07/24. Review of the significant change Minimum Date Set (MDS) 3.0 assessment dated [DATE] revealed Resident #97 had impaired cognition and scored an eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The assessment did not indicate Resident #97 received hospice services. Interview on 12/24/24 at 1:00 P.M. with the MDS Nurse #356 confirmed the significant change MDS assessment did not indicate Resident #97 received hospice services and the assessment should have. MDS Nurse #356 confirmed the assessment was inaccurate. Interview on 12/24/24 at 1:15 P.M. with Regional Nurse (RGN) #504 confirmed the facility did not have a MDS policy. RGN #504 stated the facility followed the Resident Assessment Instrument (RAI) guidelines. 32654 2. Review of the medical record for Resident #163 revealed an initial admitted [DATE] with the latest readmission of 12/01/24 with the diagnoses including but not limited to gastrostomy malfunction, asthma, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, syncope and collapse, repeated falls, cerebrovascular accident with left sided hemiplegia, anxiety disorder, dysphagia, aphasia and hypertension, hypothyroidism. Review of the five day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was not receiving hospice services. Review of the medical record revealed a progress note dated 11/7/2024 at 10:51 A.M. a referral was sent for a hospice evaluation. (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	12/31/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record revealed the resident was admitted to hospice services on 11/08/24. Review of the resident's MDS assessments list revealed a significant change MDS was not completed to reflect the hospice service admission. On 12/18/24 at 10:13 A.M., interview with the Interim Director of Nursing (IDON) verified the required significant change MDS assessment was not completed.

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	12/31/2024

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 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** 32654 Based on observation, record review, staff interview and facility policy review, the facility failed to ensure one resident (#163) received assistance with meals. This affected one resident of four residents reviewed for activities of daily living (ADL). The facility census was 109. Findings Include: Review of the medical record for Resident #163 revealed an initial admitted [DATE] with the latest readmission of 12/01/24, diagnoses included but were not limited to gastrostomy malfunction, asthma, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, syncope and collapse, repeated falls, cerebrovascular accident (CVA) with left sided hemiplegia, anxiety disorder, dysphagia, aphasia, hypertension, and hypothyroidism. Review of the plan of care dated 10/12/24 revealed the resident had a self-care performance deficit related to CVA with hemiparesis. Interventions included requires extensive to dependent assistance to reposition and turn in bed, requires extensive assistance to dependent assistance to dress, explain all procedures/tasks before starting, monitor/document/report to nurse as needed any changes in ADL ability, any potential for improvement, reasons for inability to perform ADL, required extensive to dependent assistance with mouth care, prefers bed baths, therapy evaluation and treatment per physician orders, requires extensive to dependent assistance for toileting and requires mechanical lift for transfers. Review of the resident's state optional Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit and required supervision following set-up of the meal for eating. On 12/17/24 at 9:07 A.M., observation of the resident revealed he was laying in bed with his head covered. The resident uncovered his head when his name was called. The resident's breakfast try was sitting on the bedside table covered and untouched. The resident stated, yes, when asked if he was hungry. On 12/17/24 at 9:32 A.M., interview with Certified Nursing Assistant (CNA) #172 stated, with the facility cutting an aide from the hallway we don't have time to set the resident up until after both hallways are passed. The CNA verified the resident's tray sat untouched for over 30 minutes prior to being served to the resident. Review of the facility policy titled, ADL Support, dated 03/19 revealed resident will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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	12/31/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on observations, resident interviews, staff interviews and review of facility policies, the facility failed to treat and monitor conditions for two residents within professional standards of practice. This affected two (Residents #85 and #87) of twenty-nine residents reviewed during the survey. The facility census was 109 Residents. Findings include: 1. Resident #85 was admitted to the facility on [DATE] with diagnoses that included hematuria, acquired absence of kidney, chronic heart failure, chronic kidney disease stage III and obstructive and reflux uropathy. Physician orders were silent for diuretics and treatments for edema. Review of Minimum Data Set on 10/29/24 revealed that resident had a Brief Interview Mental Status score of 13, indicative of intact cognition. Review of Resident #85's weights revealed that within thirty days, he had gained 24.6 pounds, indicative of a 11.1% significant weight gain in thirty days. He weighed 211 pounds on 11/14/24, and he weighed 234.6 pounds on 12/04/24. Observation on 12/23/24 at 10:31 A.M. revealed that while Resident #85 was lying in bed, his right and left lower extremities, including his feet, were edematous. Interview with Resident #85 on 12/23/24 at 10:31 A.M. revealed that Resident #85 complained about the edema in his bilateral lower extremities, and he stated the edema in his feet was uncomfortable and he was concerned about it. Interview with Licensed Practical Nurse (LPN) #214 on 12/23/24 at 10:35 A.M. revealed that Resident #85 had mentioned the edema in his bilateral lower extremities to her during the previous week. Interview confirmed the presence of edema in his bilateral lower extremities. Interview with Dietitian #121 on 12/23/24 at 11:43 A.M. confirmed that Resident #85's weight gain had not been addressed with the physician, the nurse practitioner, or the nursing staff at the facility. Dietitian #121 confirmed that she had not addressed Resident #85's significant weight gain in his medical chart. Review of a facility policy named Change in a Resident's Condition or Status revised May 2017 revealed that the nurse will notify the resident's attending physician and resident/ resident representative when there is a significant change in the resident's physical condition. 47059 2. Record review revealed Resident #87 was admitted on [DATE] with the most recent readmitted [DATE] with diagnoses that included dysarthria and dysphagia following cerebral infarction, Type II diabetes mellitus, end stage renal disease requiring hemodialysis, atherosclerotic heart disease, atrial fibrillation, depression, malignant neoplasm of the prostate, atrioventricular block and presence of a cardiac pacemaker. (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	12/31/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Medicare 5-day minimum data set (MDS) 3.0 dated 11/01/24 revealed Resident #87 was cognitively intact with no signs of psychoses or behaviors noted. Resident #87 received antidepressant, anticoagulant, and anticonvulsant medications with indications present. Resident #87 was receiving dialysis. Review of progress notes and weekly skin assessments revealed the weekly skin assessments were focused on pressure ulcers and there was not mention in progress notes of any skin issues. There was no order for monitoring skin for bruising, bleeding or rashes. Review of the care plan for Resident #87 revealed the care plan addressed Risk for abnormal bleeding related to anticoagulant therapy and the interventions dated 09/12/24 included avoid the use of aspirin, monitor and review with the resident or family/responsible party of signs and symptoms of bleeding. (blood-tinged urine, black tarry stools, dark or bright red blood in stools, increased bruising, muscle/joint pain). Monitor/document/report to the provider as needed any signs & symptoms of abnormal bleeding: blood-tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Review of records for Resident #87 revealed Resident is on a blood thinner and had a history of a clot affecting his fistula. Observation on 12/16/24 at 10:56 A.M. revealed Resident #87 currently had a discolored bruise like area on his left forearm but is unsure how he got it. Review of incident/accident log revealed no entries for bruising, bleeding, or skin issues noted. Observation on 12/24/24 at 10:23 A.M. Resident #87 had a discolored bruise like area on the left forearm. Resident stated it was there last week but is healing now and he doesn't remember how he got it. Interview on 12/24/24 at 10:25 A.M. with registered nurse (RN) #173 confirmed a discolored bruise like area on residents left forearm. RN#173 confirmed normal practice if a non-pressure skin issue is found is to do an incident report and document in a progress note. RN #173 confirmed there currently is no order to monitor for bruising, or altered skin integrity and there is no documentation Resident #87 had a discolored bruise like area on his left forearm in the medical record. Interview on 12/24/24 at 10:45 A.M. with RN #504 regional nurse confirmed residents on coumadin always have an order for monitoring for bleeding and bruising. Residents on other anticoagulants may not have that order the instructions for monitoring will be in the care plan. All bruising, bleeding, or non-pressure skin issues should be documented in the chart. Review of policy Skin and Wound Management dated October 2024 revealed a policy focused on prevention, recognition and treatment of pressure ulcers. There were no other skin polices supplied by the facility.

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	12/31/2024

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 0686 Level of Harm - 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** 51068 Based on observation, record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of avoidable pressure ulcers, timely identify areas of new skin impairment, promote optimal healing, ensure pressure ulcer dressings were provided as ordered and/or prevent the risk of pressure ulcer infection. Actual Harm occurred beginning on 11/19/24 when Resident #54, who had moderate cognitive impairment and was at high risk for pressure ulcer development, was assessed to have a Stage II (partial-thickness skin loss with exposed dermis) pressure ulcer to the right buttocks that originated from Moisture Associated Skin Damage (MASD). Due to a lack of individualized and effective interventions, on 11/26/24 Resident #54's right buttock pressure ulcer expanded to a bilateral buttock pressure ulcer. On 12/03/24 the pressure ulcer progressed to a Stage III (full-thickness tissue loss into subcutaneous tissue but does not go into the muscle or bone) bilateral buttock pressure ulcer without evidence of adequate and individualized pressure ulcer prevention interventions being in completed prior to the deterioration/progression. Actual harm occurred on 10/29/24 when Resident #163 who had severe cognitive impairment, was dependent on staff for toileting and transfers, was assessed and documented to be at high risk for pressure ulcer development but had no individualized plan developed to prevent pressure ulcers was identified to have of an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer to the sacrum. The facility failed to create and implement an individualized plan to prevent the pressure ulcer resulting in the development and identification of the unstageable ulcer. Actual harm occurred on 08/13/24 when Resident #89, who was at high risk for pressure ulcer development and had a history of unstageable pressure ulcers, developed a new Stage III pressure ulcer to the right ischium. On 08/08/24, the resident's prescribed air mattress malfunctioned and was replaced with a regular bed and a gel overlay, which failed to provide adequate pressure relief. On 08/12/24, a new air mattress was ordered, but documentation on 08/13/24 indicated the replacement air mattress also malfunctioned, causing the resident's buttocks to come into direct contact with the metal bed frame. This resulted in tissue breakdown and the development of the new Stage III pressure ulcer. The facility failed to ensure timely replacement and proper functioning of pressure-relieving equipment, resulting in the development of the Stage III pressure ulcer. This affected three residents (#54, #89, and #163) of five residents reviewed for pressure ulcers. The facility census was 109. Findings include: (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	1.Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including a wedge compression fracture of thoracic (T)11-T12 vertebra, chronic respiratory failure, urinary tract infection (UTI), unspecified combined systolic and diastolic heart failure, benign prostatic hyperplasia with lower urinary symptoms, atrial fibrillation, hypertension (HTN), left bundle-branch block, low back pain, bilateral primary osteoarthritis of first carpometacarpal joints, malignant neoplasm of prostate, vitamin D deficiency, presence of cardiac pacemaker, repeated falls, hyperlipidemia, major depressive disorder, constipation, wedge compression fracture of first lumbar vertebra, chronic obstructive pulmonary disease (COPD), tinea unguium, and psoriasis vulgaris. Review of the skin risk/Braden Scale Assessment (a tool used to assess a resident's risk of developing pressure ulcers), dated 7/10/24 revealed Resident #54 was assessed to be at mild risk for pressure injury. Review of a nursing progress note dated 07/10/24 at 7:48 P.M. revealed Resident #54 admitted to the facility with an excoriating skin rash all over back area down to coccyx and blisters on the coccyx. Zinc oxide cream and Triad paste (a zinc oxide based hydrophilic paste for light to moderate levels of wound exudate/drainage used to help maintain an optimal wound healing environment) were to be applied on rash twice daily. Review of the physician orders revealed the following orders were in place: Zinc Oxide External cream 10% apply to lower back topically two times a day for excoriating rash with a start date of 7/11/24. Ammonium lactate external cream 12% apply to upper and lower back topically as needed for soilage with a start date of 07/12/24 and an end date of 07/19/24. Review of the Medication Administration Report (MAR) for Resident #54 revealed no evidence the physician orders for Ammonium lactate external cream 12% was administered at all during incontinence episodes during this time period. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 10/29/24 revealed Resident #54 had moderately impaired cognition, required moderate (staff) assistance with toileting, moderate (staff) assistance with upper extremity dressing, maximum (staff) assistance with lower extremity dressing, maximum (staff) assistance with putting on and taking off footwear, and had no pressure ulcers. A skin risk/Braden Scale Assessment completed on 11/01/24 which revealed a high risk for pressure injury development. Review of the comprehensive care plan for Resident #54 revealed a focus on potential alterations in skin integrity. The goal was to prevent skin breakdown through comprehensive review. Interventions included (on 07/10/24) educate resident/family on skin breakdown risk factors and preventative measures, encourage floating heels while in bed, pressure-reducing cushion to the chair, pressure-reducing mattress to the bed, assist with hygiene, including peri-care as needed and barrier cream during showers and after incontinent episodes. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	A plan of care (dated 08/08/24) revealed the resident had current area of skin impairment to the right buttock. The goal was to heal the existing impairment and prevent further skin breakdown and infection with a target date of 10/08/2024. Interventions included (on 08/08/24) to initiate wound treatment, continue as ordered by the medical director or nurse practitioner, observe and document wound character weekly, and monitor for clinical changes such as infection or worsening of the wound, (on 11/08/24) encourage repositioning as tolerated, (on 11/19/24) apply barrier cream after each incontinent episode and encourage repositioning with pillows as tolerated, (on 12/04/24) air mattress to bed, monitor for proper functioning, and (12/17/24) encourage resident to allow staff to reposition every two hours. Review of Bed Mobility task documentation from 11/24/24 to 12/23/24 for Resident #54 revealed staff documented the resident was totally dependent on staff for bed mobility during this time period. The resident had orders for Triad Hydrophilic wound dress external paste (wound dressings) apply to bilateral buttocks topically every shift for wound care with a start date of 09/11/24 and an end date of 10/30/24. Triad Hydrophilic wound dress external paste (wound dressings) apply to bilateral buttocks topically as needed for incontinence with a start date of 09/11/24 and an end date of 10/30/24. Triad Hydrophilic wound dress external paste (wound dressings) apply to bilateral buttocks topically as needed for soilage with a start date of 10/17/24 and an end date of 12/17/24. Review of a nursing progress note dated 10/09/24 revealed Resident #54 returned to the facility with a skin tear on the right arm and a reddish spot on the buttock with no open area. Review of the skin assessments from contracted Wound Provider #1050 for Resident #54 revealed the following information: 10/16/24: Initial assessment: Wound on the right buttock diagnosed as Moisture-Associated Skin Damage (MASD) 9.0 centimeters (cm) length by (x) 3.5 cm width x <0.1 cm depth. Irritant contact dermatitis due to fecal, urinary, or dual incontinence. Treatment orders: Cleanse area, pat dry, apply zinc barrier cream (20% or greater) every shift and as needed (PRN). No new interventions or changes to the resident's plan of care were noted at this time. 10/30/24: Right buttock pressure ulcer still diagnosed as MASD. 12.0 cm length x 10 cm width x <0.1 cm depth. Additional treatment: Triad paste to buttocks every day and PRN. However, record review revealed no documented evidence of the Triad paste being provided as needed after incontinence episodes between July and 10/30/24. 11/19/24: Right buttock pressure injury progressed to a Stage II pressure ulcer (related to exposed dermis) 11 cm length x 9.0 cm width x 0.1 cm depth. Irritant contact dermatitis due to fecal, urinary, or dual incontinence. Record review revealed no additional interventions were implemented to address the resident's fecal/urinary/dual incontinence to prevent skin breakdown. 11/26/24: Right buttock pressure injury remained at Stage II, 13 cm length x 11 cm width x 0.1 cm depth, treatment orders remained the same on this date. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	12/03/24: Right buttock worsened to a Stage III (full thickness) pressure ulcer, 9.0 cm length x 13 cm width x 0.1 cm depth with 90% granulation and 10% slough. Treatment remained the same. Record review revealed no additional or new interventions were implemented to prevent additional skin breakdown and/or to promote healing. 12/10/24: Right buttock pressure ulcer remained at Stage III, 8.0 cm length x 5.0 cm width x 0.1 cm depth with 100% granulation. Irritant contact dermatitis due to fecal, urinary, or dual incontinence. Resident agreeable to air mattress. Wound physician measured the entire wound region, reporting eight pressure ulcers with skin bridges and MASD resolved. Treatment orders: Triad paste open to air, reapply triad paste as needed, air mattress in place. 12/17/24: Right buttock pressure ulcer remained at Stage III, 8.0 cm length x 4.5 cm width x 0.1 cm depth with 100% granulation. Comments and treatment remain the same. Review of the Medication Administration Report (MAR) for Resident #54 revealed no evidence the physician orders for Triad Hydrophilic wound dress external paste (wound dressings) was administered at all during incontinence episodes from July 2024 to December 2024. On 12/19/24 at 1:54 P.M., observation of Resident #54's Stage III pressure ulcer to the right buttocks revealed the wound bed was red with active bleeding on the incontinence brief. Further observation revealed the physician ordered treatment of Triad following each incontinence episode was not in place. Interview with Registered Nurse (RN) Wound Nurse #500 during the time of the observation verified the resident was provided incontinence care prior to entering the room for the wound observation and the physician ordered treatment of Triad was not in place. Interview on 12/18/24 at 2:35 P.M. with the Wound Doctor (WD) #122 verified Resident#54's wound started as MASD and turned to an open Stage II pressure ulcer wound on 11/19/24. He stated he doesn't remember seeing blisters on his initial assessment. WD #122 stated they were doing zinc barrier and then collogen. He stated there were multiple open areas and the wound changed to a bilateral wound on 11/26/24, but stated there was not a wound on the left buttock only multiple wounds on the right buttock. WD#122 stated he did not measure each area. During the interview, the WD revealed the wound was not being offloaded so it would not heal properly. He stated the Triad paste should be applied on during changes and soilage and stated there were eight separate wounds but since they were in the same area he measured the wounds as one big area. He stated the Triad paste and leaving the areas open to air was the current treatment. Additionally, WD #122 stated the area around the wound wasn't MASD so he didn't want adhesive on the skinned area around the wound. Review of the medical record revealed the facility did not implement the wound/skin prevention interventions as listed in the care plan for Resident #54. The care provided to Resident #54 was also not consistently delivered as planned, resulting in the progression of the MASD to a Stage III pressure ulcer. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Despite the progression of Resident #54's skin alteration from Moisture-Associated Skin Damage (MASD) to a Stage II pressure ulcer and then Stage III pressure ulcer, no changes were made to the wound treatments implemented for the resident. The wound, was initially assessed as MASD on 10/16/24, progressed to Stage II on 11/19/24 and later to Stage III on 12/03/24, yet the same treatment plan was followed without modification. Specifically, the use of zinc barrier cream and Triad paste was continued, even after the wound had deepened and required more advanced management. No adjustments were made in the frequency or nature of wound care, nor was the offloading of pressure more rigorously addressed. As a result, the wound failed to heal properly and worsened in severity. 2. Review of the medical record for Resident #163 revealed an initial admitted [DATE] with a latest readmission of 12/01/24 with diagnoses including gastrostomy malfunction, asthma, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, syncope and collapse, repeated falls, cerebrovascular accident (CVA) with left sided hemiplegia, anxiety disorder, dysphagia, aphasia, hypertension, and hypothyroidism. Review of the resident's plan of care dated 10/12/24 revealed the resident had the potential for pressure ulcer development related to CVA with hemiparesis. Interventions included follow facility policies/protocols for the prevention/treatment of skin breakdown, incontinence care check and change for incontinence on a routine basis and as needed, turn and reposition as ordered and use lifting device to reduce friction. Review of the resident's readmission admission assessment with baseline care plan dated 10/17/24 revealed the resident was readmitted on [DATE] with no pressure ulcers. Review of a revised plan of care (originally dated 10/17/24) revealed the resident had an actual area of skin impairment related to pressure to sacrum and unstageable pressure ulcer to the resident's left elbow that was present on admission from the hospital and resident prefers to lay on his back most of the day. Interventions included air mattress as ordered on 10/29/24, encourage to reposition as tolerated, evaluate for pain and provide pain relieving interventions as ordered, initiate wound treatment, continue treatment as ordered by the physician/nurse practitioner (NP), limit time out of bed, nursing to observe the wound dressing daily to ensure that the dressing remains intact and that there are no signs/symptoms of infection or increased drainage, observe for clinical changes, such as infection and/or worsening of wound, pressure reducing cushion to chair, refer to dietician to determine need/no need for dietary intervention and skin observation and document on bath/shower days, charge nurse to notify the wound nurse, physician and family of any new areas. Review of the resident's Braden scale dated 10/24/24 revealed a score of 15 indicating the resident was at risk for skin breakdown. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for bed mobility, toileting and transfers. The assessment indicated the resident was always incontinent of both bowel and bladder. The assessment indicated the resident was at risk for skin breakdown and had no skin issues. The facility implemented a pressure reducing device to his bed. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note dated 10/29/24 at 7:54 A.M. revealed the nurse performed a weekly skin assessment and discovered an open area to sacrum measuring 2.0 centimeters (cm) by 2.0 cm. The area was cleansed with normal saline (NS) and pad and protect order initiated. The physician and wound nurse were made aware of the wound. Review of the skin observation dated 10/29/24 revealed the resident was found to have a pressure ulcer to his sacrum measuring 2 cm by 2 cm. The observation contained no description or staging of the wound. Review of the facility's incident report dated 10/29/24 revealed the nurse performed an ordered weekly skin assessment and discovered open area to sacrum. The resident was unable to verbalize when the area started or how the area occurred as the resident was unaware of the area. The area was cleansed with NS and pad and protect order initiated. The physician and wound nurse were made aware of the wound. Review of the weekly pressure skin grid dated 10/30/24 revealed the resident was found to have a Stage III pressure ulcer to the sacrum measuring 1.6 centimeters (cm) by 1.4 cm by 0.2 cm with the wound bed being 100% slough. The peri-wound was within normal limits. The wound had a moderate amount of serosanguineous drainage. The facility implemented the treatment cleanse, apply Santyl, cover with normal saline (NS) soaked gauze. Review of the weekly pressure skin grid dated 11/05/24 revealed the Stage III was now classified as an unstageable pressure ulcer measuring 1.0 cm by 1.5 cm with the depth being unable to determine due to the wound bed being 100% slough. The wound had a moderate amount of serous exudate. No changes to the treatment were made at this time. Review of the weekly pressure skin grid dated 11/12/24 revealed resident had an unstageable pressure ulcer measuring 1.0 cm by 1.0 cm with the depth being unable to determine due to the wound bed being 100% slough. The wound had a moderate amount of serosanguineous exudate. There were no changes to treatment at this time. The resident was discharged to an acute care hospital on 11/14/24 and readmitted to the facility on [DATE]. Review of the resident's monthly physician orders for December 2024 identified orders dated 11/11/24 cleanse right sacrum with normal saline, pat dry, apply nickel thick Santyl to wound bed, cover with saline moistened gauze then cover with a clean dry dressing daily and as needed, 11/13/24 air mattress to bed, ensure proper functioning every shift and 12/04/24 enhanced barrier precautions (EBP) every shift due to wound. Review of the skin observation dated 12/01/24 revealed the resident was readmitted to the facility with a previously identified wound to the sacrum. Further review revealed no comprehensive assessment (measurements/description) of the pressure ulcer was completed upon re-admission to the facility. Review of the readmission pressure skin grid dated 12/02/24 revealed the unstageable pressure ulcer to the resident's sacrum measured 1.5 cm by 1.5 cm with the depth being unable to determine due to the wound bed being 100% slough. The wound had a minimal exudate. The facility resumed the previous treatment to cleanse wound, apply Santyl and cover with NS soaked gauze. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the re-admission pressure skin grid dated 12/03/24 revealed the unstageable pressure ulcer to the resident's sacrum measured 1.3 cm by 1.3 cm with the depth being unable to determine due to the wound bed being 100% slough. The wound had a minimal exudate. The facility did not determine if the wound had improved, declined or remained unchanged. The facility made no changes to the treatment. Review of the re-admission pressure skin grid dated 12/10/24 revealed the unstageable pressure ulcer to the resident's sacrum measured 1.3 cm by 1.0 cm with the depth being unable to determine due to the wound bed being 100% slough. The wound had a minimal exudate. The facility determined the wound had improved and made no changes to the treatment. Review of the re-admission pressure skin grid dated 12/17/24 revealed the unstageable pressure ulcer to the resident's sacrum measured 1.2 cm by 1.0 cm with the depth being unable to determine due to the wound bed being 100% slough but able to see tips of granulation. The wound had a minimal exudate. The facility determined the wound had improved and made no changes to the treatment. On 12/18/24 at 9:32 A.M., observation of Registered Nurse Wound Nurse (RNWN) #500 and Unit Manager (UM) #214 provide the physician ordered treatment to the resident's unstageable pressure ulcer revealed RNWN #500 donned personal protective equipment (PPE) (gown), entered the room washed their hands and donned gloves. RNWN #500 cleansed the resident's bedside table with a sani-wipe, washed her hands and donned gloves. She then placed a barrier on the table and set-up the required supplies. RNWN #500 removed the soiled dressing to the sacral wound. The wound was quarter sized with pink edges and a yellow center. She then washed her hands and donned a pair of gloves and cleansed the wound with NS and a 4X4, pat dry. RNWN #500 then washed her hands and donned gloves. She then used a tongue depressor and placed Santyl on the center of the wound, covered the wound with a NS soaked gauze and covered the wound with a bordered gauze dressing. On 12/18/24 at 1:39 P.M., interview with the Interim Director of Nursing (IDON) and Registered Nurse Wound Nurse (RNWN) #500 revealed the sacral wound was actually an unstageable pressure ulcer when the wound was discovered, however the wound physician documented the wound as a Stage III pressure ulcer. The IDON and RNWM #500 revealed they were unaware of why the staff had not identified the pressure ulcer prior to an unstageable pressure ulcer. The facility provided no evidence of an individualized skin breakdown prevention program for the resident. 3. Review of the medical record revealed Resident #89 was admitted on [DATE] and readmitted on [DATE], with diagnoses including paraplegia, epilepsy, heart failure, atrial fibrillation, hypertension, muscle weakness, and a colostomy and indwelling catheter in place. Resident #89 was admitted (on 04/03/24) with a Stage III pressure ulcer to the right ischium which measured 4.5 cm in length X 1.5 cm in width, and 1.5 cm in depth. The pressure ulcer healed on 06/04/24. On 07/10/24, a skin risk/Braden Scale Assessment indicated the resident was at mild risk for pressure injury development. However, a follow-up skin assessment conducted on 11/01/24 identified the resident as being at high risk for pressure injury development. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the comprehensive care plan for Resident #89 revealed a focus on skin integrity, specifically addressing areas of skin impairment related to pressure on the sacrum and right ischium, as well as non-pressure concerns on the right second toe. The goal was to heal the current impairment and prevent further skin breakdown. Interventions included on 04/04/24 pressure reducing cushion to chair, Prevalon boots to bilateral lower extremities as tolerated, monitor for pain and provide pain-relieving interventions as ordered. On 04/24/24 check function of air mattress every shift was added and revised on 11/19/2024. On 04/27/24 ask resident about pain level prior to dressing change procedure, medicate if needed and air mattress as ordered. On 08/08/24 the care plan was updated to include observe and document the character of the wound weekly, observe for clinical changes, such as infection and/or worsening of wound, and initiate wound treatment as ordered by the medical director (MD)/Nurse practitioner (NP). On 11/08/24 encourage repositioning as tolerated, and on 12/13/24 apply shoes for outside doctor appointments were added. The care plan also had a focus on enhancing the overall management of skin integrity, including interventions initiated on 04/04/24 of daily skin observation and documentation on bath/shower days, on 11/19/24 padding to the right lateral wheelchair, on 12/04/24 to limit time out of bed, and implement enhanced barrier precautions due to wound and colostomy. On 12/17/24 encouraging the resident to allow staff to reposition every two hours was added to the resident's plan of care. Review of the 10/01/24 Minimum Data Set (MDS) 3.0 assessment revealed Resident #89 was cognitively intact and required extensive (staff) assistance with personal care, including bed mobility, transfers, toileting, and sitting to lying positions. a.Review of a nursing progress note on 08/08/24 at 10:36 A.M. noted Resident #89's air mattress was noted to be malfunctioning and per the nurse practitioner discontinue the air mattress and order gel mattress. An order was placed with a medical supply company. Review of a nursing progress note on 08/13/24 at 10:46 A.M. noted the wound nurse conducted a weekly wound assessment for Resident #89 on this date. A new pressure injury was identified on the resident's right ischium. The wound bed presented with 100% granulation tissue, measuring 5.0 cm in length by 1.5 cm in width with 0.1 cm depth. A new order was provided to cleanse the wound with normal saline (NS) or wound cleanser (WC), pat dry, apply Calcium Alginate to the wound bed, and cover with a foam dressing. The dressing was to be changed daily (QD) and as needed (PRN). Additionally, the assessment revealed an issue with the air mattress placed beneath the resident. The mattress was noted to be deflated at the buttocks area, causing pressure on the metal frame, which was not detected by the pump's alarm for low pressure. The resident, who was alert and oriented (A&O x 4) was paraplegic and unable to feel sensations below the waist. A new order was provided to replace the malfunctioning air mattress. The resident was assisted out of bed and into a wheelchair. The medical supply company was contacted and requested to replace the air mattress. The mattress was replaced, and the new air mattress was confirmed to be functioning properly. Interview with Resident # 89 on 12/23/24 at 8:13 A.M. revealed he could feel when the air mattress failed as he was able to feel it on his back and he felt with his hands that the bed was deflated. He stated he alerted the staff, and it took approximately an hour for them to respond. The resident stated the bed had no audible alarm or any other type of notification that he was aware of when it malfunctioned. During the interview, the resident voiced concerns that staff did not actually observe his skin during repositioning. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/24/24 at 12:10 P.M. with Wound Nurse #500 confirmed on 08/08/24 she found the resident's air mattress was losing air, so the Certified Nurse Practitioner (CNP) ordered a gel overlay to put on a regular mattress. Wound Nurse #500 noticed the gel overlay was dispersing but not offloading for the wound, so she ordered a new air mattress that came on 08/12/24. That bed malfunctioned on 08/13/24 and a new bed was ordered. The resident was on regular mattress with a gel overlay for four days. The resident developed a Stage III pressure ulcer as a result. b. In addition, review of the care provided to Resident #89 related to pressure ulcers revealed the following concerns with treatments not completed as ordered: Santyl External Ointment 250 Unit/GM (Collagenase) with orders to apply to right ischium topically every day shift for wound care was not completed on 10/04/24,10/06/24, 10/08/24, 10/21/24, 11/07/24, 11/12/24 or 11/14/24. Right Ischium: Cleanse with NS, pat dry. Apply Santyl (nickel thick) to wound bed then moistened gauze and cover with clean dry dressing daily and as needed was not completed on 10/04/24, 10/08/24, 10/21/24, 10/24/24 or 11/06/24. Monitor Right Ischium, Bilateral buttocks, left 2nd toe for s/s of infection. If noted, report to NP/MD & management/wound nurse every shift was not completed on 10/17/24, 11/07/24 or 12/11/24. Interview on 12/23/24 at 3:44 P.M. with Wound Nurse #500 verified the dates of the missed wound treatments and interventions and stated there was no justification for the missed wound care and treatments. c. Review of the skin grid pressure assessments and wound provider assessment for Resident #89 revealed the following: 10/16/24 Skin grid assessment: Wound assessed as unstageable, measuring 1.7 cm length x 1.7 cm width x unable to determine depth; described as healing, the wound was documented to have 40 % slough and 60 % granulation tissue. MD #610 was documented as the practitioner who assessed the wound. 10/16/24 Wound provider assessment: Wound assessment and plan: Unstageable pressure wound, 2.0 cm length x 1.7 cm width x depth unknown, 40% granulation and 60% slough in wound bed, noted as healing. Treatment cleanse wound with normal saline or sterile water, Santyl nickel thick layer- cover with moist gauze and cry clean dressing every day and PRN. Assessment documented by MD #610. 11/05/24 Skin grid assessment: Wound classified as Stage III, measuring 0.2 cm length x 0.2 cm width x <0. 1 cm depth; noted as improved the wound was documented to have 100 % epithelial tissue present with a new treatment ordered and WD #122 was documented as the practitioner who assessed the wound. 11/05/24 Wound provider assessment: Wound assessment and plan: Stage IV wound, 0.2 cm length x 0.2 cm width x <0.1 cm depth, noted as healing. Full thickness with exposed underlying structure. 100% epithelial tissue in wound bed. Treatment Barrier cream twice daily and as needed. Assessment completed by WD #122. (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	12/31/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	12/03/24 Skin grid assessment: Wound became unstageable, measuring 2.0 cm length x 1.5 cm width x unable to determine depth; noted decline by facility assessment, the wound was documented to have 70 % slough and 30% granulation tissue present and to continue with the current treatment. WD #122 was documented as the practitioner who assessed the wound. 12/03/24 Wound provider assessment: Wound assessment and plan: Stage 4 pressure wound, 2.0 cm length x 1.5 cm width x 0.2 cm depth, 30 % granulation and 70 % slough in wound bed. Wound documented as same/stable. No documentation present why stage was changed from Stage 3 to Stage 4. Assessment completed by WD #122. Interview on 12/24/24 at 10:15 A.M. with the Regional Nurse #504 and Interim Director of Nursing (IDON) #506 revealed there were discrepancies between the wound nurse and wound physicians' assessment. They stated the wound nurse and wound physician should be communicating those differences and additionally verified the wound nurse and wound physician are not communicating their differences in assessment. Review of the Skin and Wound Management Policy dated October 2024 revealed the purpose of the Skin and Wound Management policy was to provide an approach in the prevention and management of pressure injuries and skin alterations using the nursing process and other strategies to assist in identifying residents at risk for developing pressure injuries. This approach was in accordance with State and federal regulations. Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. The physician would assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.). The physician would order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. The physician would guide the care plan as appropriate, especially when wounds were not healing as anticipated or new wounds develop despite existing interventions. The deficiency identifies non-compliance with Complaint Number OH00160119. 32654

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	12/31/2024

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review and staff interview, the facility failed to ensure one resident (#81) received podiatry care. This affected one resident of 29 sampled residents. The facility census was 109. Findings Include: Review of the medical record for Resident #81 revealed an initial admitted [DATE] with the latest readmitted [DATE], diagnoses included but were not limited to pneumonitis due to inhalation of food and vomit, bacteremia, metabolic encephalopathy, severe sepsis with septic shock, intestinal obstruction, dysphagia, severe protein calorie malnutrition, acute respiratory failure with hypoxia, aphasia, anxiety disorder, periodontal disease, seizures, traumatic brain injury, tracheostomy, anemia, gastro-esophageal reflux disease, hypertension, chronic obstructive pulmonary disease, constipation, insomnia and cerebral infarct. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was dependent on staff for activities of daily living (ADL). On 12/19/24 at 9:35 A.M., observation of Resident #81 during tracheostomy care revealed the resident's toenails were long, thick and various toenails were curling down over his toes. On 12/19/24 at 11:42 A.M., interview with the Interim Director of Nursing (IDON) revealed the facility contracted podiatrist was at the facility on 12/11/24. The IDON was unsure if the resident was offered podiatry services. On 12/19/24 at 11:58 A.M., upon entry into the resident's room Registered Nurse Wound Nurse (RNWN) #500 was in the process of trimming the resident's nails. The RNWN verified the resident's nails were long, thick and starting to curve down over his toes.

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	12/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50536 Based on observation, interview, and record review the facility failed to ensure the environment remained free of accident hazards by providing adequate supervision and assistance devices to prevent accidents for three of three residents (#17, #56, and #163) reviewed for accidents. The facility also failed to ensure a wanderguard alarm (alarm used to temporarily lock an exterior door and sound an audible alarm alerting staff that a resident is close to the door) was functioning for two (#27 and #87) of two reviewed . The facility census was 109. Findings Include: 1. Resident #17 had an admitted [DATE] with diagnoses including: benign neoplasm of meninges, aphasia following cerebral infarction, peripheral vertigo, dizziness and giddiness, abdominal aortic anurysm without rupture, hypertension, hyperlipidemia, angina, dependence on wheelchair, seizures, nicotine dependence cigarettes, obesity, venous thrombosis and embolism, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side. Observation on 12/18/24 at 1:20 P.M. revealed Resident # 17 seated in his motorized wheelchair smoking a cigarette in the resident smoking area. No staff or other residents were observed. Resident #17 was noted with an elastic wrap to his right hand and his fingers are visibly edematous. The right hand was positioned on top of the right thigh. Resident #17 stated that he can't move or use the right side of his body since having a stroke. Resident #17 stated he was an unsupervised smoker and didn't require any type of adaptive equipment to smoke. A black hole with burnt edges was observed to the upper, right thigh area of Resident #17's green jeans. Resident #17 stated it was a cigarette burn from dropping his ashes and presented cigarettes and a lighter from a pouch on the side of his motorized wheelchair. Interview with the Unit Manager (UM) of the 400 unit on 12/18/24 at 1:20 P.M. confirmed that Resident #17 had a cigarette burn to the upper, right thigh area of his green jeans. UM confirmed that Resident #17 was in need of supervision while smoking. UM was unsure of how staff would designate which residents were supervised smokers and which residents were unsupervised smokers. Observation on 12/18/24 at 3:32 P.M. revealed Resident #17 outside in the resident smoking area smoking a cigarette. There were no staff members observed in the area. Resident #17 was not utilizing any adaptive equipment while smoking. Review of a document titled Smoking Safety Evaluation dated 03/20/24 revealed that Resident #17 did not have total or limited range of motion in the arms/hands. Review of a document titled Smoking Safety Evaluation dated 09/18/24 revealed that Resident #17 did have total or limited range of motion in the arms/hands. (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	12/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #17 revealed: Resident #17 was non-compliant with the smoking policy, but did not require supervision to smoke. The goal was for Resident #17 to remain free from injury related to non-compliance with the smoking policy. Interventions included Resident #17's son was advised that cigarettes must be given to the nurse, and smoking assessments would be completed upon admission, and quarterly thereafter. Review of the medical record for Resident #17 reveaeld there were no smoking assessments noted on admission, nor on a quarterly basis for Resident #17. Review of the facility's policy titled Smoking Policy dated November of 2024 revealed that the facility will maintain a safe environment for all residents by assessing smoking status upon admission, quarterly, and as needed. Residents who smoke would be assessed to determine if they were safe to smoke independently or if they needed supervision, and/or adaptive equipment while smoking. 2. Resident #56 had an admitted [DATE] with diagnoses including: Human immunodeficiency virus, thrombocytopenia, pancytopenia, type two diabetes, hypotension, dementia, anemia, chronic gastric ulcer, anxiety disorder, schizophrenia, major depressive disorder, hypertension, constipation, alcohol dependence, hyperlipidemia, insomnia, and alcoholic cirrhosis of the liver with ascites. Observation on 12/17/24 at 8:58 A.M. revealed Resident #56 kept his cigarettes and lighter in his coat pocket. Resident #56 went to his coat and pulled out cigarettes in a clear plastic case, along with four lighters. States staff does not supervise him, and he doesn't require any adaptive equipment for smoking. Observation on 12/19/24 at 9:15 AM revealed Resident #56 in the doorway of his room with his rollator. On the rollator was a blue seat cushion that had four scattered burn holes on top of it, and one burn hole on the left side. Resident #56 stated it happened when the fire fell from his cigarettes while smoking outside. Resident #56 had a cigarette burn hole on the right leg of his sweat pants. Interview on 12/18/24 at 9:46 AM with the Social Services Designee (SSD) and the Administrator confirmed that SSD was not responsible for completing smoking assessments, staff nurses were responsible for that. Staff nurses were responsible for reviewing the smoking policy, and making sure no residents had smoking material in their rooms. SSD was asked if she was aware that Resident #56 had smoking materials in his room. SSD stated that she was unaware, and confirmed that it was a problem. Review of the medical record for Resident #56 revealed no smoking assessments on admission, quarterly or as needed. Review of the care plan for Resident #56 revealed: Resident #56 was at risk for injury related to smoking: Needed supervision when smoking. The goal was Resident #56 would remain compliant with facility smoking procedures and restrictions. Interventions included nursing would maintain all smoking materials for Resident #56 in the designated area, and Resident #56 was to be supervised while smoking. (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	12/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Smoking Policy dated November of 2024 revealed that the facility will maintain a safe environment for all residents by assessing smoking status upon admission, quarterly, and as needed. Residents who smoke would be assessed to determine if they were safe to smoke independently or if they needed supervision, and/or adaptive equipment while smoking. There were no assessments noted on admission, nor on a quarterly basis for Resident #56. 32654 3. Review of the medical record for Resident #163 revealed an initial admitted [DATE] with the latest readmission of 12/01/24 with the diagnoses including but not limited to gastrostomy malfunction, asthma, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, syncope and collapse, repeated falls, cerebrovascular accident with left sided hemiplegia, anxiety disorder, dysphagia, aphasia, hypertension, and hypothyroidism. Review of the plan of care dated 09/30/24 revealed the resident was at risk for falls related to age and cognitive function. Interventions included bolsters to side of bed, encourage resident to wear non-skid socks/footwear when out of bed, ensure call light within reach at all times, keep bed in lowest position at all times, mat to right side of bed, offer toileting between, prior and post meals and when awake at night and reacher at bedside. Review of the resident's five day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident required substantial assistance with bed mobility and transfers. The assessment indicated the resident had one or more falls with no injury since prior assessment. On 12/18/24 at 9:32 A.M., observation of Registered Nurse Wound Nurse (RNWN) #500 and Unit Manager (UM) #214 provide the physician ordered treatment to the resident's unstageable pressure ulcer revealed the staff donned PPE (gown), entered the room washed their hands and donned gloves. Observation of the resident's air mattress revealed the mattress had no bolsters in place on either sides of the mattress at the bottom edges. UM #214 verified the air mattress should have four bolsters in place, two at the top of the bed and two at the bottom of the bed. UM #214 verified the fall intervention of bolsters was not implemented. Review of the facility policy titled, Fall Prevention and Management, dated 11/24 revealed the facility strives to creat the safest possible environment for residents and promote a strong culture or safety by minimizing the resident's risk, hazards and complications from falling. Based on assessment results the nurse will meet with direct care staff to establish and implement approaches to minimize risk. 4. Resident #27 had an admitted [DATE] with diagnoses including: coronary artery heart disease, hypertension, hypercholesterolemia, orthostatic hypotension, hyperlipidemia, type two diabetes, age related physical debility, major depressive disorder, need for assistance with personal care, dizziness and giddiness, anxiety disorder, bipolar disorder, history of falling, vitamin deficiency, and dementia with behavioral disturbance. (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	12/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #27 dated 08/27/20 revealed Resident #27 was at risk for elopement related to impaired cognition, dementia, and wandering. The goal was for Resident #27 to not leave the building unescorted by an approved person. Interventions included Resident #27 would wear a wanderguard bracelet at all times, function and placement would be checked every shift. Review of the quarterly minimum data set (MDS) for Resident #27 dated 10/24/24 revealed Wander/elopement Alarms, was marked not in use. Review of an order dated 03/15/24 revealed Resident #27 was to have a wanderguard in place to left ankle at all times, and staff was ordered to check placement and function of the wander guard every shift for elopement risk. Review of the treatment administration record (TAR) dated December 2024 for Resident #27 revealed the order to check placement and function of the wander guard for Resident #27 was signed off as completed by LPN #365 on 12/04/24, 12/05/24, 12/08/24, and 12/18/24. LPN #365 confirmed that she had not checked function for the wanderguard on those dates. Review of a document titled Elopement Risk Evaluation dated 07/19/24 revealed that Resident #27 was at risk for elopement, had a history of elopement or an attempted elopement without informing staff, had a history of wandering, and had wandering behavior that was likely to affect the safety or well-being of himself or others. Observation on 12/19/24 at 10:25 A.M. revealed Resident #27 in his bed. There was a wanderguard in place to his left ankle. Interview with LPN #365 on 12/18/24 at 10:32 A.M. confirmed that Resident #27 was ordered a wander guard due to an elopement risk, and staff were responsible to check for placement and function of the wanderguard each shift. LPN #365 confirmed that she only checked placement of the wanderguard each shift because she didn't know how to check for function. LPN #365 was unable to locate the device used to check for function of the wanderguard. Interview with the Unit Manager (UM) of the 400 unit on 12/18/24 at 10:38 A.M. confirmed that staff were to use a device to check the function of Resident #27's wanderguard each shift. UM was unable to locate the device, and two attempts were made to escort Resident #27 to the door to verify the function of the wanderguard. Resident #27 refused both attempts and function could not be verified. Interview on 12/24/24 with MDS nurse #356 confirmed that the wanderguard alarm was not meant to restrict Resident #27's movement but was meant to alert staff if Resident #27 got close to an exit, therefor, the facility did not consider wander guard alarms restraints. Review of a document titled Wander Alarm Policy dated May 2024 revealed: Wander alarm bracelets were checked daily for function and placement. If wander alarm bracelets were found non-functioning, they would be replaced immediately. 47059 (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	12/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review revealed Resident #87 was admitted on [DATE] with the most recent readmitted [DATE] with diagnoses that included dysarthria and dysphagia following cerebral infarction, Type II diabetes mellitus, end stage renal disease requiring hemodialysis, atherosclerotic heart disease, atrial fibrillation, depression, malignant neoplasm of the prostate, atrioventricular block and presence of a cardiac pacemaker. Review of the admission Medicare 5-day minimum data set (MDS) 3.0 dated 11/01/24 revealed Resident #87 was cognitively intact with no signs of psychoses or behaviors noted. Resident #87 received antidepressant, anticoagulant, and anticonvulsant medications with indications present. Resident #87 was receiving dialysis. Review of active orders revealed Resident #87 had an order for Wanderguard left ankle dated 10/17/24 and Wanderguard check placement to left ankle every shift dated 10/17/24. Progress note dated 10/16/24 at 8:57 P.M. revealed on registered nurse (RN) #163 performed and elopement risk assessment that revealed Resident #87 was at risk for elopement. Progress note dated 10/16/24 at 8:59 P.M. revealed RN #163 heard a door alarm sounding on the unit. Noted Resident #87 exit seeking. Resident #87 wandering aimlessly stating he wanted to go home. Elopement assessment completed, wanderguard placed on Resident #87's left ankle. All parties made aware. Progress note dated 10/17/24 at 8:55 A.M. reveaeld an elopement for Resident #87 on 10/16/24 at 7:00 P.M. Resident#87 was noted exit seeking and was outside by the time staff caught up with resident. Resident #87 was seen by staff as he attempted to leave the facility. Resident #87 was wandering aimlessly. Resident #87 stated he wanted to go home. Resident #87 redirected and immediately taken inside by staff. Wanderguard placed to left ankle. Elopement assessment complete. 15 min checks initiated. Intervention- Wanderguard placed. Interdisciplinary team feels this intervention is appropriate. Review of medication administration record (MAR) and treatment administration record (TAR) for October, November, and December indicated both Wandergard ordered were signed off every shift. Interview on 10/19/24 at 4:45 P.M. with unit manager licensed practical nurse (LPN) #214 confirmed the Wandergard is checked every shift to be sure it is on the resident. The device is taken near a door prior to application to verify it is functioning correctly and the resident is wheeled past a door to verify the door locks only on an as needed basis. UN #214 stated there is a device or box that can be used to test the Wandergard's functionality but is not sure if the facility has one. Interview on 10/19/24 at 5:00 P.M. with LPN #158 confirmed a Wandergard is checked every shift to verify the resident is wearing it, and when there is a need to confirm it is working the resident is wheeled past a door to be sure the door locks, sometimes the alarm goes off. Interview on 12/23/24 at 11:25 A.M. with regional nurse - registered nurse (RN) #504 confirmed the Wanderguards are used and monitored per the order. RN was not aware of a policy but stated they would try to locate one. (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	12/31/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Wander Alarm Policy dated May 2024 revealed each resident will be assessed for elopement risk on admission and/or change in status. If at risk, a plan of care will be formulated with the Interdisciplinary Team to address the resident's risk for elopement and necessary interventions. Wander alarm bracelets are checked daily for function and placement. If wander alarm bracelet is found to be non-functioning it will be replaced immediately.

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	12/31/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, staff interview and facility policy review, the facility failed to monitor behaviors and side effects for two residents (#9, #81) who received psychotropic and anticoagulant medications. Additionally, the facility failed to complete an abnormal involuntary movement scale (AIMS) when resident #9 was started on an antipsychotic medication. This affected two residents of five residents reviewed for unnecessary medications. The facility census was 109. Findings Include: 1. Review of the medical record for Resident #9 revealed an initial admitted [DATE] with the latest readmission of 04/24/24 with the diagnoses including but not limited to diabetes mellitus, cirrhosis of liver, chronic kidney disease, morbid obesity, hypertension, congestive heart failure, chronic obstructive pulmonary disease, dysphagia, dependence on supplemental oxygen, hyperlipidemia, retention of urine, major depressive disorder, anxiety disorder, atrial fibrillation, obstructive sleep apnea, anemia, malignant neoplasm of bronchus or lung, chronic respiratory failure and insomnia. Review of the plan of care dated 03/30/24 revealed the resident had suicidal thoughts, feeling of not wanting to be around, had history of suicidal thoughts but will also verbalize the desire to keep fighting. Intervention included staff will provide empathetic listening and provide support as needed, consider pain, discomfort, hunger, boredom and personal needs that the resident is unable to communicate as possible causes of behavior, anticipate and meet needs to attempt to control behavior problems, provide calm reassurance redirection or distraction and assess effectiveness, provide positive reinforcement for appropriate behavior, confront gently and respectfully when behavior is inappropriate and set limits, encourage activities and socialization, include resident in care, explain care before giving and segment tasks to promote, resident's involvement and control over care and update physician as needed regarding changes in behavior problem status. (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	12/31/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 06/05/24 revealed the resident had potential for adverse side effects of psychotropic drug use, resident takes an antidepressant for depression and insomnia, psychotropic for depression and an antianxiety for anxiety, known to be verbally aggressive, withdrawn and tearful, anxiety and depression often triggered by thoughts of family, resident had several family members commit suicide. Interventions included if resident is verbally aggressive, reapproach at a later time, monitor for signs/symptoms of increased depression, anxiety, insomnia. If resident is withdrawn and/or tearful, verbally aggressive or expresses suicidal thoughts, encourage him to discuss his feelings, notify physician/nurse practitioner (NP) as soon as possible, notify physician/NP of any mental status changes that occur, observe and document any abnormal behavior or moods and notify physician/NP, observe, document, report to physician/NP as needed, signs/symptoms of drug related complications: cognitive/behavioral impairment (signs/symptoms of delirium, altered mental status, decline in mood or behavior, hallucinations or delusions, isolation or withdrawal, deterioration in activities of daily living (ADL), continence, cognitive function), drug related discomfort (constipation, fecal impaction, urinary retention), gait disturbance, hypotension (syncope, accidents, dizziness or vertigo), movement disorder (tardive dyskinesia, motor agitation,tremors), obtain vital signs as ordered and report abnormalities to physician/NP, pharmacist to review medication quarterly for gradual dose reduction (GDR) as clinically indicated and send recommendations to the physician, report pertinent lab results to physician/NP and review for ability to decrease dosage or discontinue as needed. Review of the resident's quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated anxiety and depression were the only current psychiatric/mood disorders for the resident. The resident received daily insulin injections, received antipsychotic, antianxiety, diuretic, antiplatelet and hypoglycemic medications. The assessment indicated the resident received antipsychotic medications on a routine basis, a GDR was not attempted and the physician had not documented a GDR was not clinically contraindicated. Review of the resident's monthly physician orders for December 2024 identified orders dated 07/16/24 Abilify (antipsychotic medication) 5 milligrams (mg) by mouth daily for major depressive disorder and anxiety disorder, 11/26/24 Zoloft (antidepressant medication) 150 mg by mouth daily for depression 12/08/24 Buspar (antianxiety medication) 15 mg by mouth three times daily for anxiety disorder, 11/30/24 Trazadone (antidepressant medication) 50 mg one half tablet by mouth daily at bedtime for insomnia and Bupropion (antidepressant medication) Extended Release (ER) 150 mg by mouth daily for major depressive disorder. Review of the medical record revealed no documented evidence the resident was being monitored for targeted behaviors or side effects of the use of psychotropic medications. Additionally, the facility failed to complete an AIMS scale (rating scale to measure involuntary movements known as tardive dyskinesia that sometimes develop as a side effect of long-term treatment with antipsychotic medications) when the resident was started on an antipsychotic medication. On 12/19/24 at 10:39 A.M., interview with the Interim Director of Nursing (DON) verified the facility had not completed an AIMS scale upon the initiation of the antipsychotic medication. Additionally, the facility failed to provide any documented evidence the facility was monitoring targeted behaviors and side effects for the use of the psychotropic medications routinely. (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	12/31/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #81 revealed an initial admitted [DATE] with the latest readmitted [DATE] with the diagnoses including but not limited to pneumonitis due to inhalation of food and vomit, bacteremia, metabolic encephalopathy, severe sepsis with septic shock, intestinal obstruction, dysphagia, severe protein calorie malnutrition, acute respiratory failure with hypoxia, aphasia, anxiety disorder, periodontal disease, seizures, traumatic brain injury, tracheostomy, anemia, gastro-esophageal reflux disease, hypertension, chronic obstructive pulmonary disease, constipation, insomnia and cerebral infarction. Review of the plan of care dated 11/01/24 revealed the resident was at risk for abnormal bleeding or hemorrhage related to anticoagulant therapy and anemia. Interventions included avoid activities that could result in injury, monitor and review with the resident or family/responsible party signs and symptoms of bleeding, monitor labs as ordered, report abnormal results to the physician/Nurse Practitioner (NP)/Physician Assistant (PA), review medication list for adverse interactions and use a soft toothbrush and an electric razor when saving. Review of the plan of care dated 11/01/24 revealed the resident was at risk for/had an impaired psychiatric/mood status related to anxiety and depression. Interventions included administer medications and treatments as indicated by the physician's orders. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident received daily injections, antidepressant and anticoagulant medications. Review of the plan of care dated 11/18/24 revealed the resident had a potential for side effects of psychotropic drug use, resident takes antidepressant for depression and insomnia. Interventions included document side effects of medication: dry month, dizziness, drowsiness, constipation, extrapyramidal effects, seizures, notify physician/NP of any changes, monitor for increased restlessness and agitation and provide one on one reassurance, notify physician/NP of any mental status changes that occur, observe and document any abnormal behavior or moods, notify physician/NP. Observe, document, report to physician/NP as needed signs/symptoms of drug related complications: cognitive/behavioral impairment (signs/symptoms of delirium, altered mental status, decline in mood or behavior, hallucinations or delusions, isolation or withdrawal, deterioration in activities of daily living, continence, cognitive function), drug related discomfort (constipation, fecal impaction, urinary retention), gait disturbance, hypotension (syncope, accidents, dizziness or vertigo), movement disorder (tardive dyskinesia, motor agitation and tremors, obtain vital signs as ordered and report abnormalities to physician/NP and pharmacist to review medication quarterly for gradual dose reduction (GDR) as clinically indicated and send recommendations to the physician. Review of the resident's monthly physician orders for December 2024 identified orders dated 12/12/24 Enoxaparin Sodium (anticoagulant medication) injection solution prefilled syringe 40 milligrams (mg)/0.4 milliliters (ml) with the special instructions to inject 40 mg subcutaneously daily for deep vein thrombosis, 12/13/24 Zoloft (antidepressant medication) 100 mg via peg tube daily for depression and 12/17/24 Trazadone (antidepressant medication) 50 mg via peg-tube daily for insomnia. (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	12/31/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed no evidence of behavior monitoring or monitoring of potential side effects for the use of the antidepressant medication. Additionally, the medication record had no evidence the resident was being monitored for abnormal bleeding related to the use of the anticoagulant medication Enoxaparin Sodium injection. On 12/17/24 at 3:09 P.M., interview with Interim Director of Nursing (IDON) verified the lack of behavior monitoring and side effects of the antidepressant and anticoagulant medication use. Review of the facility policy titled, Antipsychotic Medication Use, dated 12/16 revealed antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and review.

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	12/31/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on observation, staff interview and policy review the facility failed to ensure medications were not left unattended and the medications and medical supplies were not expired. This had the ability to affect all 29 residents in the 100 unit and three (27, #62, and #88) who lived on the 400 hall who were identified as being cognitively impaired and independently mobile. The facility census was 109. Findings Include: 1. Observation [DATE] at 3:05 P.M. in the medication room on the 100 unit revealed a box of vacutainers 22 gage needles, the box expired in 2023 and REF number on needles did not match the reference number on the box. The individual needles did not have expiration dates on them. The prefilled sodium chloride syringes expired [DATE]. Interview on [DATE] at 2:10 P.M. with licensed practical nurse (LPN) #158 confirmed the expired items were identified during the review of the medication storage room and disposed of the items according to facility protocol. Review of the policy Storage of Medications last revised [DATE] revealed discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Compartments containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. 50536 2. Observation on [DATE] at 10:22 A.M. on the 400 unit revealed an unlocked medication cart sitting in the hallway. No staff were visible in the vicinity of the medication cart. LPN #365 was seated at the nurse's station using the computer, then was observed entering the medication storage room with the door closing behind her, leaving the medication cart unlocked and out of direct sight. Interview with LPN #365 on [DATE] at 10:26 A.M. confirmed that LPN #365 was the nurse assigned to the unlocked medication cart. LPN#365 confirmed that she didn't realize she had left the cart unlocked when she walked away from it. LPN #365 confirmed that medication carts were required to be locked at all times when not in use or in direct sight of the assigned staff member. Interview with the Unit Manager (UM) of the 400 unit on [DATE] at 10:28 A.M. confirmed that LPN #365 had left her assigned medication cart unlocked earlier in the shift and had received education from the UM regarding the policy for medication storage at that time. (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	12/31/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Storage of Medications, dated 2001 and revised April of 2019 confirmed the following: The facility stored all drugs in a safe, secure, and orderly manner. The nursing staff was responsible for maintaining medication storage in a safe manner. Compartments (including medication carts) containing drugs were to be locked when not in use or in direct sight of the authorized staff member assigned to the medication cart. Unlocked medication carts were not to be left unattended. Only persons authorized to administer medications were to have access to locked and stored medications.

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	12/31/2024

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 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** 41266 Based on record review, staff interview, and review of the laboratory contract, the facility failed to ensure prothrombin time (PT) and international normalized ratio (INR) laboratory tests were completed timely as ordered for one resident (Resident #84). The deficient practice affected one resident (Resident #84) of two reviewed for anticoagulant medications. The facility census was 109. Findings Include: Review of the medical record for Resident #84 revealed an admitted on 06/20/24. Medical diagnoses included atrial fibrillation (A-Fib), heart failure, hypertension, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, and a personal history of venous thrombosis and embolism. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 had impaired cognition and scored a ten out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Review of the Medication Administration Record (MAR) dated November 2024 revealed Resident #84 had a physician order for PT-INR laboratory (lab) test every Monday and Thursday dated 07/22/24. The labs were not marked as completed on 11/21/24, 11/25/24, or 11/29/24. Additionally, there were one-time orders for PT-INR lab on 11/29/24. This order was marked as completed on 11/29/24 at 5:06 P.M. Review of the Medication Administration Record (MAR) dated December 2024 revealed Resident #84 had a physician order for PT-INR lab test every Monday and Thursday dated 07/22/24 still in place. The labs were not marked as completed on 12/02/24 or 12/19/24. Additionally, there were one time orders for PT-INR labs to be completed on 12/02/24, 12/03/24, 12/09/24, and 12/13/24. These labs were marked completed 12/02/24 at 9:00 A.M., 12/03/24 at 6:24 P.M., 12/09/24 at 1:01 P.M., and 12/13/24 at 11:45 P.M. Review of all PT-INR lab results for Resident #84 for the months of November and December 2024 provided by the facility revealed the resident received the ordered lab test on 11/22/24, 11/23/24, 12/05/24, 12/09/24, 12/10/24, 12/12/24, 12/13/24, and 12/16/24. There was no evidence the ordered PT-INR lab tests were completed as ordered on 11/21/24, 11/25/24, 11/28/24, or 11/29/24 in November 2024. There was no evidence the ordered PT-INR lab tests were completed as ordered on 12/02/24, 12/03/24, or 12/19/24. (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	12/31/2024

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated in November 2024 revealed on 11/21/24 at 8:01 P.M., Resident #84's labs were not obtained. The Certified Nurse Practitioner (CNP) was notified. New orders given to draw in the morning (11/22/24). On 11/25/24 at 4:13 P.M., 11/25/24 at 4:14 P.M., and 11/25/24 at 6:32 P.M., the lab was contacted with no PT-INR lab results yet. On 11/26/24 at 6:29 P.M., the CNP was in the facility today. The nurse notified the CNP the previous nurse reported Resident #84 did not receive PT-INR lab draw on 11/25/24. The CNP ordered to have the lab redrawn on 11/29/24. On 11/29/24 at 1:16 P.M., labs were not drawn on 11/25/24, 11/26/24, or 11/27/24. The CNP was notified and the lab was reordered for 12/02/24. Review of progress notes dated December 2024 revealed on 12/02/24 at 5:27 P.M., still awaiting labs to be drawn. On 12/03/24 at 4:27 P.M., no PT-INR result. 12/03/24 at 5:59 P.M., called lab regarding status on PT-INR lab results. The lab had not been drawn but the lab would be in the facility tomorrow morning to obtain the specimen. Resident #84 was notified. On 12/16/24 at 8:05 P.M. and 8:06 P.M., PT-INR results aren't available yet. Medication was held. On 12/17/24 at 12:35 A.M. (a little after midnight), Resident #84's PT-INR lab results were received (for 12/16/24's lab draw). On 12/19/24 at 5:43 P.M., PT-INR lab results were still pending in order to administer Warfarin Sodium (Coumadin, an anticoagulant) at night. The CNP was notified and authorization was given to administer the medication for tonight based on the previous PT-INR levels. Interview on 12/19/24 at 3:49 P.M. with Regional Nurse (RGN) #504 and Interim Director of Nursing (IDON) #506 confirmed PT-INR results should be returned within the same day or sooner if the lab was ordered STAT (immediate). IDON #506 stated the facility had experienced issues with the contracted laboratory company not showing up to the facility on scheduled days and/or not completing all the ordered labs when the lab staff do arrive on-site at the facility. The facility was currently searching for a new lab company to contract with. IDON #506 confirmed Resident #84's PT-INR lab tests were not completed timely or as ordered by the physician. Interview on 12/23/24 at 4:02 P.M. with IDON #506 confirmed the facility did not have a lab test policy, the facility only had the signed contract with the lab. IDON #506 stated the facility would be obtaining their own PT-INR machine on-site to address the issue of not receiving the labs timely or as ordered by the physician. Review of the laboratory contract dated 12/29/23 revealed the contract stated, the contracted lab company shall provide facility the services described in Exhibit A attached hereto (the Services). The contracted lab company shall perform the Services in accordance with applicable law and generally accepted professional standards and practices. Exhibit A: will travel to Client Location to draw and/or collect patient specimens for duly ordered tests and will transport the specimens to one of the contracted laboratories for testing all in accordance with the terms of the Laboratory Services Agreement and this Exhibit.

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	12/31/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50008 Based on observations, staff interviews and review of facility policy, the facility failed to store and prepare food under sanitary conditions. This had the potential to effect 108 of 109 residents in the facility. One resident was identified as not eating by mouth. The facility census was 109. Findings include: Observations on 12/16/24 from 8:22 A.M. to 8:40 A.M. revealed a standing pool of liquid, approximately three feet by three feet on the dietary department floor next to the skilled dining room door. Observations revealed a similar puddle of a similar size in the dish room area. The pool of liquid had a sour smell. Several fruit flies were observed flying over the puddles of liquid. Observations revealed that the wall behind the three-compartment sink and the wall behind the beverage dispenser were dirty with various dried food and beverage stains on them. Interview with Dietary Director #364 on 12/16/24 at 9:14 A.M. confirmed the presence of two large pools of sour-smelling liquids on the floor of the dietary department and the presence of dried food and beverage materials on the walls of the dietary department. Dietary Director #364 stated that she would contact Maintenance Director #211 to find the source of the pooling liquid on the dietary department floors and that she would have someone clean the walls. Interview with Maintenance Director #211 on 12/17/24 at 10:15 A.M. confirmed that the three-compartment sink had been the source of a leak and led to the standing water in the kitchen. He confirmed one of the hoses for the three-compartment sink had been found to have a puncture in it. Review of Sanitation policy dated 2001 and revised October 2008 revealed that all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.

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	12/31/2024

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 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** 32654 Based on observation, medical record review, staff interview and facility policy review, the facility failed to ensure a complete and accurate medical record for one (#81) of 29 sampled residents. The facility census was 109. Findings Include: 1. Review of the medical record for Resident #81 revealed an initial admitted [DATE] with the latest readmitted [DATE] with the diagnoses including but not limited to pneumonitis due to inhalation of food and vomit, bacteremia, metabolic encephalopathy, severe sepsis with septic shock, intestinal obstruction, dysphagia, severe protein calorie malnutrition, acute respiratory failure with hypoxia, aphasia, anxiety disorder, periodontal disease, seizures, traumatic brain injury, tracheostomy, anemia, gastro-esophageal reflux disease, hypertension, chronic obstructive pulmonary disease, constipation, insomnia and cerebral infarct. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the room change notification dated 11/06/24 revealed the resident had a room change on 11/06/24 from 301 bed A to 332 for more room. Review of the room change notification dated 11/25/24 revealed the resident was moved from room [ROOM NUMBER] to 307 bed A per resident request due to upcoming programing changes on 11/25/24. Review of the resident's medical record revealed the resident was moved on 12/10/24 from 307 bed A to 315 bed A while the resident was admitted to an acute care hospital. Further review revealed no documentation of the room change, reason for the room change and notification of the room change to the resident's family. On 12/17/24 at 4:32 P.M., interview with Social Service Designee (SSD) #320 verified the medical record contained no documented evidence of the room change, reason for the room change and notification of the room change to the resident's family.

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	12/31/2024

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 41266 Based on review of Resident Council meeting minutes, staff interviews, review of previous job description, review of the Social Services Designee (SSD) #320's current resume, and review of the job description for Social Services Director, the facility failed to ensure a qualified social worker was on staff due to the facility having over 120 certified beds. The deficient practice had the potential to affect all 109 residents in the facility. Findings Include: Review of the Resident Council Meeting Minutes dated from 06/24/24 through 11/25/24 revealed SSD #320 was introduced as the facility's new social worker. SSD #320 was noted as a Licensed Social Worker (LSW) in the monthly meeting minutes. Interviews on 12/16/24 at approximately 9:00 A.M. and 12/18/24 at approximately 2:00 P.M. with SSD #320 revealed she had earned a Master's degree in Social Work however was not able to pass the State licensing board exam in the summer 2024. SSD #320 confirmed she was not a licensed social worker (LSW) currently and would not retake the State licensing board exam until January 2025. SSD #320 stated she worked at a local hospital for five years prior to being hired by the facility as the Social Services Director. SSD #320 stated her job title at the hospital was Patient Care Advocate. SSD #320 confirmed she was not supervised by a licensed social worker during her work experience at the hospital. Review of SSD #320's current work history resume revealed her previous work history included Patient Access Coordinator II at a local medical hospital from June 2019 to July 2024, Patient Care Representative from December 2018 to June 2019, and Home Support Staff from October 2016 to December 2018. The resume did not indicate SSD #320 was registered as an Academy of Certified Social Workers (ACSW) (to become an ACSW in Ohio, you must meet the following requirements: have a Bachelor's degree in social work from a regionally accredited university or one accredited by the Council on Social Work Education, pass the Association of Social Work Boards (ASWB) exam at the bachelor's level, and apply for a Licensed Social Worker license online) nor a member in good standing in the National Association of Social Workers (NASW). Review of the job description for Patient Experience Coordinator revealed the position summary stated, the Patient Access Coordinator was responsible for providing personalized guidance and support that promotes a positive patient/family experience throughout their care continuum. Minimum requirements included a Bachelor's degree with emphasis in Human relations, social work, communications or related field or equivalent combination of education and experience required. Excellent verbal and written communication skills, strong customer service, interpersonal, conflict resolution, program solving and program planning skills. Review of an email from SSD #320's former supervisor dated 12/19/24 at 4:43 P.M. revealed SSD #320's supervisor was a Registration Manager at the hospital. There was no evidence the manager was a LSW. SSD #320's responsibilities included providing resources, resolving patient concerns, deescalating emotional situations, and providing empathetic support. (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	12/31/2024

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/19/24 at approximately 5:00 P.M. with the Administrator confirmed SSD #320 was hired with knowledge she had not obtained a social work license yet. The Administrator expected SSD #320 to pass the State licensing exam in the summer 2024 but would need to retake the exam again in January 2025. The Administrator confirmed SSD #320 had not been directly supervised by a social worker in her previous work experience. Review of the facility's job description for Director of Social Services (SSD #320's current position), signed by SSD #320 on 05/31/24, revealed education requirements included a minimum of a Bachelor's Degree from an approved school of Social Work, experience requirements included a minimum of two years in a supervisory capacity in a hospital, nursing care facility, or other related medical facility, and specific requirements included must be registered as an ACSW and must be a member in good standing in the NASW and Academy of Certified Social Workers, Inc.

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	12/31/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on observations, resident interviews, staff interviews and review of facility policy, the facility failed to follow infection control policies for two residents. This affected two (Residents #85, and #164) of five (Resident #10, #81, #85, #163, and #164) residents reviewed for infection control. The facility census was 109 residents. Findings include: 1. Resident #85 was admitted to the facility on [DATE] with diagnoses that included hematuria, acquired absence of kidney, chronic heart failure, chronic kidney disease stage III and obstructive and reflux uropathy. Physician orders were silent for diuretics and treatments for edema. Review of Minimum Data Set, dated dated dated [DATE] revealed the resident had a Brief Interview Mental Status score of 13, indicative of intact cognition. Review of physician orders revealed he had orders to cleanse the nephrostomy site on his right flank, apply triple antibiotic ointment and apply a clean covered dressing daily on every night shift. Review of the Treatment Administration Record revealed that his treatments had been signed off on daily with the exception of 12/19/24 an 12/20/24, when the TAR indicated that Resident refused the treatment on those dates. Interview with Resident #85 on 12/16/24 at 10:45 A.M. revealed the Resident reported the nursing staff had never completed a dressing change to the nephrostomy tube. The Resident pulled his shirt up and no dressing was observed to be in place. Follow-up interview with Resident #85 on 12/19/24 at 1:12 P.M. revealed the resident reported the nursing had still never placed a dressing on the nephrostomy tube stoma. Observation of Resident #85 on 12/17/24 at 4:10 P.M. revealed that Resident was sitting in his wheelchair in his room, with the nephrostomy bag in a plastic trash bag sitting in the trash can next to the wheelchair. Observation of Resident #85 on 12/19/24 at 1:12 P.M. revealed that the nephrostomy collection bag was in a clear plastic trash bag in the trash can. Interview with Wound Nurse #500 on 12/19/24 at 1:17 P.M. confirmed that the nephrostomy bag was leaking and that is why it was in a plastic bag in the trash can. Observation of Resident #85's nephrostomy site on 12/23/24 at 10:51 A.M. revealed that there was not a dressing on the nephrostomy site. Interview with Resident #85 at that time revealed that he had not refused the dressing to be added, nor had nursing placed the dressing on at all on the prior night shift. Interview with Licensed Practical Nurse #214 on 12/23/24 from 10:54 A.M to 10:58 A.M. confirmed that Resident #85 did not have a dressing on his nephrostomy site as ordered, nor did she have an answer as to why the treatment had been signed off on and not completed. (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	12/31/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy named Urinary Catheter Care dated February 2024 revealed that if breaks in aseptic technique, disconnection, or a leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. 32654 2. Review of the medical record for Resident #164 revealed an initial admitted [DATE] with the diagnoses including osteomyelitis left ankle and foot, acute kidney failure, chronic kidney disease, anemia, hypertension, diabetes mellitus, open wound left foot, kidney transplant status, legal blindness, and management of vascular access device. Review of the resident's admission assessment with baseline care plan dated 12/13/24 revealed the resident had no cognitive deficit and was always continent of bowel and bladder. Review of the resident's bowel and bladder assessment dated [DATE] revealed the resident was continent of both bowel and bladder with extensive assistance of one staff member. The assessment indicated the resident declined a toileting program. Review of the resident's plan of care dated 12/18/24 revealed the resident had episodes of bowel and bladder incontinence related to decreased mobility status and kidney transplant in 2011. Interventions included administer medications per physician order, assist resident with toileting needs, check and change every two hours and as needed, monitor for no bowel movement in three days, monitor for signs/symptoms of urinary tract infection and report to physician, monitor peri-area for redness, irritation, skin excoriation/breakdown, monitor rectal area for redness, irritation, and skin excoriation/breakdown, provide disposable incontinence products, provide peri care after each incontinent episode, apply house barrier after incontinence care and report if resident had no output. Review of the plan of care dated 12/18/24 revealed the resident required enhanced barrier precautions (EBP) related to peripherally inserted central catheter (PICC) line. Interventions included hand hygiene before entering and after leaving room, Wear gloves and gown for the following High-Contact Resident Care Activities: dressing bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting and device care or use. Review of the resident's monthly physician orders for December 2024 identified an order dated 12/13/24 EBP due to PICC line. On 12/19/24 at 2:29 P.M., observation of Certified Nursing Assistant (CNA) #507 provide incontinence care to the resident revealed she entered the room and gained permission to provide incontinence care. The CNA washed her hands donned a pair of gloves, set-up the required supplies on a barrier on the resident's bedside table. The CNA pulled the resident's brief down, cleansed the resident with a soapy wash cloth from front to back using a different section of the cloth. The CNA rinsed and pat dry in the same manner. She assisted the resident onto her left side and removed the soiled brief. She then cleansed the resident's rectal area from front to back. She rinsed and dried in the same manner. She then replaced the brief, positioned the resident to comfort. CNA #507 verified the required personal protective equipment (PPE) of gown was not utilized during incontinence care as physician ordered. (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	12/31/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Infection Control and Modified Enhanced Barrier (EBP) Policy/Procedure, dated 09/24 revealed residents on the unit or wing where a resident that is known to be infected or colonized with a novel/targeted multi-drug resistant organism (MDRO) resides at a minimum wounds and/or indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status who reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides.

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	12/31/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50008 Based on observations, staff interviews and review of facility policy, the facility failed to have effective pest control in the kitchen. This had the potential to effect 108 of 109 residents in the facility. One resident was identified as not eating by mouth. The facility census was 109. Findings include: Observations on 12/16/24 from 8:22 A.M. to 8:40 A.M. revealed a standing pool of liquid, approximately three feet by three feet on the dietary department floor next to the skilled dining room door. Observations revealed a similar puddle of a similar size in the dish room area. The pool of liquid had a sour smell. Several fruit flies were observed flying over the puddles of liquid. Fruit flies were also observed on the clean silverware and dishes rack. Interview with Dietary Director #364 on 12/16/24 at 9:14 A.M. confirmed the presence of fruit flies in the dietary department. Review of Sanitation policy dated 2001 and revised October 2008 revealed that all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.