STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366299	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerburg Pointe	4531 Columbus Road Centerburg, OH 43011

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of facility investigation report, review of personnel file, and review of facility policy, the facility failed to protect Resident #55 from assault by Certified Nursing Assistant (CNA) #599. This affected one resident (#55) of four residents reviewed for facility self-reported incidents and had the potential to affect all 68 residents residing in the facility. The facility census was 68.Findings include:Resident #55 was admitted to the facility on [DATE] with diagnoses including chronic diastolic (congestive) heart failure, need for assistance with personal care, cognitive communication deficit, restlessness and agitation, Type II Diabetes Mellitus without complications, heart disease and depression. Review of quarterly Minimum Data Set (MDS) dated [DATE] for Resident #55 revealed she was severely cognitively impaired and had physical behavioral symptoms (hitting, kicking, pushing) towards others one to three days of the review period. Resident #55 required substantial/maximal assistance for toileting, showering/bathing, upper body dressing, lower body dressing and personal hygiene, rolling left to right, moving from sitting to lying and transferring to toilet. Resident #55 used a manual wheelchair and needed partial/moderate assistance for wheeling 50 feet and was dependent for wheeling 150 feet.Review of care plan entry for Resident #55 dated 04/02/24 revealed Resident #55 had behaviors towards staff and a history of refusing care. Interventions suggested included convey an attitude of acceptance towards the resident and maintain a calm environment and approach to the resident.Review of facility investigation report for Self Reported Incident (SRI) OH261885 written statement by CNA #599 dated 06/22/25 revealed CNA #599 stated she put her hand over Resident #55's mouth in response to Resident #55 spitting. In this written statement, CNA #599 said she asked the resident not to spit on her anymore.Review of the facility investigation report for SRI OH261885 written statement completed by CNA #611 dated 06/22/25 revealed CNA #611 wrote that CNA #599 had said to Resident #55 she would punch her in the face and when Resident #55 spit towards CNA #599, CNA #599 then grabbed Resident #55 by the face and said you do not spit on me. Review of the facility investigation report for SRI OH261885 undated written statement completed by the Administrator revealed there was a meeting in which the Administrator, Human Resources Staff #501, and the Director of Nursing (DON) met with CNA #599 on 06/24/25 regarding the incident. The Administrator documented CNA #599 changed how she described the incident each time they asked for more details. Review of Employee Separation Form for CNA #599 revealed CNA #599 was terminated, effective 06/22/25. The document noted the termination was involuntary and reason noted was for physical abuse to resident. Interview on 11/26/25 at 2:10 P.M. with the DON confirmed CNA #599 was terminated for due to abuse of Resident #55 and the termination was effective 06/22/25.Review of facility policy titled, Ohio Resident Abuse, published 07/11/24, revealed abuse includes willful infliction of injury [or] intimidation. Willful means the individual must have acted deliberately.This deficiency represents non-compliance investigated under Complaint Number 1293221.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on observation, review of the medical record, review of the facility's investigation, resident interview, staff interview and review of the facility policy, the facility failed to protect Resident #68 from misappropriation of his Oxycodone (opioid) medication. This affected one Resident (#68) of three reviewed for medication administration. The facility census was 68. Findings include:Review of the medical record revealed Resident #68 was initially admitted to the facility on [DATE]. Pertinent diagnoses included: cerebrovascular disease, acute and chronic respiratory failure, Type II Diabetes, acute kidney failure with tubular necrosis and chronic pain syndrome.Review of the quarterly Minimum Data Set (MDS) Section C dated 08/06/25 indicated Resident #68 was cognitively intact.Review of the physician's order, dated 06/13/25, revealed Resident #68 had an order for one Oxycodone 5 milligrams (mg) tablet at bedtime.Review of the shift change controlled substance inventory count sheet for 07/14/25 revealed one card of thirty 5 mg tablets of Oxycodone was received by the facility and added to the medication cart for Resident #68 on that date.Review of the Medication Administration Record (MAR) for Resident #68 for July 2025 revealed one tablet was given to Resident #68 each evening from 07/14/25 to 07/20/25 for a total of seven tablets.Review of the shift change controlled substance inventory count sheet for 07/21/25 revealed one card of thirty 5 mg tablets of Oxycodone for Resident #68 was marked as removed from cart (empty) with only one nurse signature.Review of the Medication Administration Record (MAR) for Resident #68 for July 2025 revealed that on 07/21/25 and 07/23/25 the Oxycodone was not administered with a note indicating that the medication was unavailable. On 07/24/25, the medication was not administered and the note indicated that the resident took a muscle relaxer instead. On these dates, documentation indicated Resident #68 reported his pain to be zero. Review of the pharmacy electronic emergency drug administration machine documentation for Resident #68 revealed on 07/22/25 one Oxycodone 5 milligram tablet was removed for Resident #68.Interview on 09/29/25 at 2:00 P.M. with Resident #68 revealed the resident mentioned in passing during the interview that his medication was taken by a nurse but administration took care of the situation.Interview on 11/25/25 at 5:08 P.M. with Director of Nursing (DON) confirmed Resident #68 should have had a card of with 21 pills in it on 07/21/25 when the medication was documented as not available. The DON also confirmed during the interview when a narcotic card is removed from the medication cart two nurses are required to sign the shift change controlled substance inventory count sheet when the medication card is removed. She confirmed on 07/21/25 there was only signature when the Oxycontin 5 mg for Resident #68 was removed. She said that she went through the shredder bin to find the card and found the top part of the card and the medication portion was not attached.Interview on 11/25/25 at 4:10 P.M. with the DON confirmed nurses who had cared for Resident #68 were subject to drug testing and no nurses failed the drug test. DON stated the nurse who removed the Narcotic card with only one signature from the medication cart was suspended pending investigation and subsequently resigned her position at the facility. Review of the facility policy titled, Storage and Expiration Dating of Medications and Biologicals, revised 06/30/35, stated controlled medications must be counted with another designated staff member when there is an exchange of keys.Review of the facility policy titled, Missing Medication, last revised 06/04/2021 revealed if there is a discrepancy during shift count, the off-going nurse for the cart affected should not leave until the discrepancy has been explained or until the Director of Nursing instructs them to leave.Review of the facility investigation report for Self-reported investigation control number OH2611885 revealed the corrective actions the facility took in response to the identification of the missing medication.The deficient practice was corrected on 07/25/25 when the facility implemented the following corrective actions:On 07/24/25 at 3:28 P.M. the facility reported the incident to the [NAME] County Sherriff's Department.On 07/24/25 the Quality Assurance and Performance Improvement (QAPI) committee met to discuss the incident and plan approach.On 07/24/25 the DON/designee looked at all the narcotic accountability sheets that had been signed off on to ensure that there was no diversion noted. They were unable to locate the controlled substance count sheet for the Oxycodone that was removed from the medication cart and recognized that approximately 23 tablets were missing. On 07/24/25 the DON/designee interviewed the staff who worked from 07/14/25 to 07/21/25. Interviews included asking about any unusual behaviors or if they heard any complaints from the residents about medication administration On

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of facility investigation report, review of personnel file, and review of facility policy, the facility failed to report to law enforcement an incident of staff to resident abuse. This affected one resident (#55) of four residents reviewed for facility self-reported incidents and had the potential to affect all 68 residents residing in the facility. The facility census was 68.Findings include:Resident #55 was admitted to the facility on [DATE] with pertinent diagnoses including: chronic diastolic (congestive) heart failure, need for assistance with personal care, cognitive communication deficit, restlessness and agitation, Type II Diabetes Mellitus without complications, heart disease and depression. Review of quarterly Minimum Data Set (MDS) dated [DATE] for Resident #55 revealed she was severely cognitively impaired and had physical behavioral symptoms (hitting, kicking, pushing) towards others on one to three days of the review. Resident #55 required substantial/maximal assistance for toileting, showering/bathing, upper body dressing, lower body dressing and personal hygiene, rolling left to right, moving from sitting to lying and transferring to toilet. Resident #55 used a manual wheelchair and needed partial/moderate assistance for wheeling 50 feet and was dependent for wheeling 150 feet.Review of care plan entry for Resident #55 dated 04/02/24 revealed Resident #55 had behaviors towards staff and a history of refusing care. Interventions suggested included convey an attitude of acceptance towards the resident and maintain a calm environment and approach to the resident.Review of facility investigation report for Self Reported Incident (SRI) OH261885 summary of investigation revealed On Sunday, June 22, 2025 the alleged staff Certified Nursing Assistant (CNA) perpetrator (CNA #599) went into the alleged resident victim's (Resident #55's) room to assist the resident to Activities and the resident had a bowel movement. The alleged staff perpetrator (CNA #599) went to get another CNA (CNA #611) to assist with providing the alleged resident victim (Resident #55) with incontinence care. While providing care to the alleged resident victim, the resident became combative and stated I will hit you. The alleged perpetrator (CNA #599) stated she would hit her back. The alleged resident victim spit toward the alleged staff CNA perpetrator (CNA #599) and the alleged staff CNA perpetrator (CNA #599) covered the alleged resident victim's mouth with their hand to prevent the resident from spitting on the alleged staff CNA perpetrator again. The other staff CNA (CNA #611) immediately intervened and made sure the alleged resident victim was safe, taking them out of the room to the nurse station. Review of facility investigation report for SRI OH261885 written statement by Certified Nursing Assistant (CNA) #599 dated 06/22/25 revealed CNA #599 stated that she put her hand over Resident #55's mouth in response to Resident #55 spitting. In this written statement, CNA #599 said she asked the resident not to spit on her anymore.Review of the facility investigation report for SRI OH261885 written statement completed by CNA #611 dated 06/22/25 revealed CNA #611 wrote that CNA #599 had said to Resident #55 that she would punch her in the face and when Resident #55 spit towards CNA #599, CNA #599 then grabbed Resident #55 by the face and said you do not spit on me. Review of Employee Separation Form for STNA #599 revealed STNA #599 was terminated, effective 06/22/25. The document noted the termination was involuntary and reason noted was for physical abuse to resident.Further review of SRI OH261885 revealed the facility had not notified the the police regarding the incident. Review of progress notes for Resident #55 revealed note from 06/22/25 in which the DON documented the Power of Attorney (POA) did not want police to be notified.Interview on 11/26/25 at 2:10 P.M. with the Director of Nursing (DON) confirmed CNA #599 was terminated for abuse against Resident #55 effective 06/22/25 and that they did not report the incident to police per daughter's request.Review of facility policy titled, Ohio Resident Abuse, published 07/11/24, revealed abuse includes willful infliction of injury [or] intimidation. Willful means the individual must have acted deliberately.Review of the facility policy titled, Crime Reporting, revised 03/03/25 revealed individuals are required to report any reasonable suspicion of a crime against any individual who is a resident of the nursing facility. Individuals must report to the appropriate governmental agencies and to one or more law enforcement entities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, medical record review and policy review, this facility failed to ensure a 5% or less medication error rate was maintained when five medication errors out of 26 opportunities were observed resulting in a medication error rate of 19%. This affected one (Resident # 86) of the three residents observed for medication administration. The facility census was 68.Findings include: Review of Resident # 68's medical record revealed an admission date of 10/16/25. Diagnoses included hypertension, chronic obstructive pulmonary disease, traumatic brain injury and obstructive hydrocephalus. Review of Resident # 68's current physicians orders for November 2025 revealed the following orders:-Lisinopril (for high blood pressure) tablet 10 milligrams (mg). Hold medication if systolic blood pressure (SBP) is less than 110, pulse less than 60. Give once a day.-Aspirin (anti-inflammatory) tablet chewable 81 mg-crushed; give four tablets via gastric tube once a day.-Cholecalciferol (vitamin D3) 25 micrograms (mcg) capsule; give one tablet via gastric tube once a day.-Methylphenidate HCL (a central nervous system stimulant) tablet 5mg-crushed, give one tablet via gastric tube twice a day.-Norvasc (used to lower blood pressure) tablet 5 mg. Hold medication if SBP less than 110 or pulse less than 60. Give once a day.-Propranolol (used to lower blood pressure) tablet 20mg; give one tablet via gastric tube twice a day.-Therapeutic-M (multivitamin) tablet 9 mg-iron 400 mcg; give one tablet via gastric tube once a day.- Pro-Stat (supplement); administer 30 cubic centimeters (cc) one time a day-Enteral Feeding: Tube Feeding: Free Water Special Instructions: Tube Feeding: Free Water: Administer 180 ml every four hours to equal cc/day- no total given. Flush tube with 60 cc free water before and 30 cc between medications, every shift. Observation of medication administration on 11/26/25 at 8:20 A.M. with Registered Nurse (RN) #393 revealed the nurse obtained vitals for Resident #68. Blood pressure and pulse observed as 95/56 and 92. RN #393 stated she would hold Lisinopril and Norvasc due to parameter orders and notify the physician. RN #393 began gathering all other scheduled medications for Resident #68 followed by crushing and combining all medications together and placing the Prostat liquid and crushed medications into a 120cc drinking cup. RN #393 was then observed adding approximately 90cc of water to the cup. RN #393 then checked placement and residual for Resident #68 and flushed gastric tube with approximately 30cc's of water. All medications were administered at the same time using a syringe and not separate with water flushed in between. Interview on 11/26/2025 at 8:30 A.M. with RN #393 confirmed Resident #68's medications were crushed, combined and administered all at once and a water flush was not completed between each medication. RN #393 also confirmed there was an order to crush medications but not to combine them. Review of the facility policy titled Medication Administered through an Enteral Tube, dated 10/31/16 revealed under dose administration, Medication should be prepared and given separately. Do not mix medications together in a medication syringe and Administer liquid medications first, then follow with medications requiring dilution also to Flush with at least 15 ml of water after each individual medication is administered. This deficiency represents non-compliance investigated under Complaint Number 2580250 and 1293221.