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	02/24/2026

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 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** Based on record review, interviews and observations, the facility failed to ensure proper hand hygiene for two Residents #245 and Resident #290. This affected two Residents (#245 and #290) of the six residents reviewed. The facility census was 71.Findings include:1.Review of the medical record for Resident #245 revealed an admission date of 02/03/23 with diagnosis to include but not limited to cerebral infarction, depression, hypertension, hypercholesterolemia, gout, atherosclerotic heart disease, hemiplegia, presence of prosthetic heart valve, thoracic aortic aneurysm, atrial fibrillation, heart failure, obstructive sleep apnea, morbid obesity, shortness of breath, hyperlipidemia, anxiety disorder, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #245 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated no cognitive impairment. Review of the care plan dated 08/31/24 for Resident #245 revealed a care plan for activities of daily living (ADL) functional which stated Resident #245 had impaired musculoskeletal status related to osteoarthritis, gout, lack of coordination, hemiplegia, dependence on wheelchair, muscle weakness, and difficulty in walking. The interventions included administer medications as ordered.Review of the physician order for Resident #245 revealed thiamine mononitrate (vitamin B1) tablet 100 milligrams (mg), amount to administer one tablet, oral.Observation on 02/24/26 at 8:03 A.M. of Licensed Practical Nurse (LPN) #250 who removed the medications for Resident #245. LPN #250 shook out two thiamine pills into the container lid, then used her bare finger to hold one thiamine pill in the lid and shook the other thiamine pill back into the container. Interview on 02/24/26 at 8:21 A.M. with LPN #250 who confirmed she had not been wearing gloves and used her finger to hold the thiamine tablet in the pill lid. LPN #250 stated she should have thrown them out and started over.2.Review of the medical record for Resident #290 revealed an admission date of 06/04/25 with diagnoses to include but not limited to epilepsy, acute and chronic respiratory failure with hypoxia, stenosis of larynx, iron deficiency anemia, depression, obesity, anxiety disorder, dependence on respirator, unspecified lack of expected normal physiological development in childhood, borderline personality disorder, congestive heart failure, asthma, dysphagia, oropharyngeal phase, tracheostomy, difficulty in walking, gastro-esophageal reflux disease, lack of coordination, hypotension, cognitive communication deficit, and need for assistance with personal care.Review of the quarterly MDS dated [DATE] revealed a BIMS of 09 which indicated moderate cognitive impairment.Observation on 02/24/26 at 8:57 A.M. of Registered Nurse (RN) #820 who prepared medications for administration to Resident #290. RN #820 had three medication pill cups on the medication cart and put the medications into the different cups per Resident #290's preference for taking her medications. RN #820 stated Resident #290 prefers some medications crushed, takes some medications whole, and had two liquid medications. There were medications in a medication cup with two capsules, RN #820 picked up one small white pill with her bare hands and moved it to a different medication cup. Then RN #820 put on gloves, opened the two capsules and put the powder into a medication cup, (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
	366299	A. Building B. Wing	02/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then she crushed three medications and put them in the same medication cup as the capsules. Then RN #820 poured the liquid clobazam medication cup into the liquid Keppra medication cup. RN #820 took all the medications into Resident #290's room and set the medication cups on the bedside table. Then RN #820 put on gloves and a gown without washing her hands or using hand sanitizer. RN #820 gave Resident #290 the mixed liquid medications first and Resident #290 grimaced. RN #820 gave Miralax to Resident #290 to wash down the mixed liquid medications. Next, RN #820 gave Resident #290 the whole pills in one medication cup which Resident #290 swallowed followed by Miralax in water Then RN #820 gave Resident #290 the powered capsules and crushed medications with no pudding. The resident continued with the Miralax and water.Interview on 02/24/26 at 9:12 A.M. with RN #820 confirmed she had picked up a pill from one medication cup with her bare hands. RN #820 stated she should have used gloves or a spoon to remove the pill. RN #820 confirmed she did not wash her hands or use hand sanitizer before putting on gloves and a gown before administering Resident #290's medications. Resident #290 was on Enhanced Barrier Precautions.Review of the facility policy General Dose Preparation and Medication Administration dated 12/01/07 revealed prior to preparing or administering medications, authorized and competent facility staff should follow the facility's infection control policies. Appropriate hand hygiene should be performed before and after direct resident contact. Medications should not come in contact with any surface except for the medication cup. Facility staff should avoid touching the medication with bare hands when opening a bottle or unit dose package.Review of the facility Infection Prevention and Control Program Policy dated 02/18/26 revealed employees participate in performance improvement activities by promoting enhanced hand hygiene and adherence to respiratory hygiene/cough etiquette.The following deficiency is based on incidental findings discovered during the course of this complaint investigation.