STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366313	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Pointe	740 Canonby Place Columbus, OH 43223

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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 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** Based on record review, observation, policy review, resident interview, and staff interview, the facility failed to ensure residents were treated with dignity when indwelling urinary catheter collection bags were not covered when the residents were in bed and left visible from the hallway. Additionally, the facility also failed to ensure residents received non-disposable dishes during scheduled meals. This affected one resident (#31) of one resident reviewed for indwelling urinary catheters and one resident (#20) of five residents interviewed during the lunch meal. The facility census was 96. Findings Include: 1. Review of the medical record for Resident #31 revealed an initial admission date of 07/19/16 with the latest readmission of 05/10/25 with the diagnoses including but not limited to Parkinson's disease with dyskinesia, polyneuropathies, constipation, obstructive and reflux uropathy, hypertension, chronic kidney disease, chronic pain syndrome, hydrocele, psychotic disorder, restless leg syndrome, mood disorder, tachycardia, psychosis, developmental disability, gout, anemia, mood disorder, benign prostatic hyperplasia (BPH), intermittent explosive disorder, hallucinations, bladder neck obstruction, asthma, paranoid schizophrenia and borderline personality disorder. Review of the plan of care, not dated revealed the resident had a potential for alteration in urinary elimination related to obstructive uropathy, and potential inability to communicate needs, due to cognitive impairments with short term memory loss, impaired mobility, indwelling urinary catheter usage, history of BPH with obstruction, hydrocele, chronic kidney disease and recent urinary tract infection (UTI). Interventions included change indwelling urinary catheter as a whole unit every month as scheduled with prescribed size and balloon order on file and change as a unit routine or as needed, provide catheter care every shift and as needed, empty indwelling urinary catheter collection bag every shift and as needed, follow up with urology appointments as scheduled, indwelling urinary catheter irrigation of catheter as per most current physician order on file, 1500 milliliter (ml) fluid restriction non-compliance, monitor all labs as per current and routine physician orders on file, resident will allow indwelling urinary catheter collection bag cover to remain in place with the catheter itself and not remove the collection bag from the cover for it nor leave it in his room, staff to continue to monitor and remind him as appropriate, administer routine medications as per current physician order, keep call light within reach, remind resident to call for assistance. note any changes in amount, frequency, color or odor of urine, report any abnormalities to registered staff and treat UTI per physician order. (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
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter and was occasionally incontinent of bowel. Review of the resident's monthly physician orders for July 2025 identified orders dated 05/14/19 indwelling urinary catheter care every shift and as needed, 05/12/21 empty indwelling urinary catheter collection bag every shift and as needed, 03/19/24 change indwelling urinary catheter with a 14 FR, 16 FR or 18 FR [NAME] catheter with a 10 ml balloon on the fourth of each month as a whole unit, and as needed, 07/30/21 Acetic Acid Solution 0.25 % use 50 ml via irrigation every shift and 05/24/24 enhanced barrier precautions (EBP) contact precautions due to indwelling urinary catheter every shift. On 07/02/25 at 7:49 A.M., observation of the resident's indwelling urinary catheter collection bag revealed the collection bag was lying on the floor with light yellow urine visible from the hallway. Interview with Registered Nurse (RN) #165 at the time of the observation verified the resident's indwelling urinary catheter collection bag was lying on the floor and was not contained in a privacy covering leaving the urine being visible from the hallway. The facility Administrator provided the urinary catheter or urinary tract infection critical element pathway through the Department of Health and Human Resources center for Medicare and Medicaid Services. 2. Review of the medical record for Resident #20 revealed an initial admission date of 01/25/17 with the latest readmission of 04/03/17 with the diagnosis including but not limited to chronic obstructive pulmonary disease, vascular dementia with behavioral disturbances, sever morbid obesity, diabetes mellitus, obstructive sleep apnea, hypertension, insomnia, psychosis, paranoid schizophrenia, anxiety disorder, bipolar disorder, narcolepsy and schizoaffective disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. On 06/30/25 observations during the breakfast meal on the 100 hallway revealed the resident's breakfast was served in disposable Styrofoam takeout containers and disposable Styrofoam cups. On 06/30/25 at 12:06 P.M., observation of the lunch meal in the dining room revealed the resident's drinks were served in Styrofoam cups. On 06/30/25 at 12:19 P.M., interview with the Dietary Manager (DM) #111 revealed when the dietary department was short staffed disposable containers and cups are used due to the cooks inability to assist with washing dishes. DM #111 verified the facility does not have enough dishes to serve the residents and Styrofoam disposable containers/cups are utilized. On 06/30/25 at 12:21 P.M., observation of the lunch meal on the 400 hallway revealed the residents were served fluids in Styrofoam cups. On 06/30/25 at 12:23 P.M., an interview with Resident #20 revealed the dietary department always serves on disposable products. She said she prefers to eat/drink from dishes. She stated once in a while they may get a plate. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/25 during the lunch meal revealed the facility served drinks in Styrofoam cups. Review of the facility policy titled, :Dignity, dated 02/21 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well being level of satisfaction with life and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights, for example residents are provided with a dignified dining experience. This deficiency represents non-compliance investigated under Complaint Number OH00165161 and OH00167030.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a comprehensive plan of care in the area of elopement risk and activities of daily living (ADL). This affected two residents (#48 and #98) of 15 sampled residents. The facility census was 96. Findings Include: 1. Review of the closed medical record for Resident #98 revealed an initial admission date of 06/18/24 with the latest readmission of 04/25/25 with the diagnoses including but not limited to chronic obstructive pulmonary disease, heart failure, diabetes mellitus, asthma, senile degeneration of brain, acute respiratory failure with hypoxia, hypertensive heart disease with heart failure, chronic pain, bipolar disorder, chronic pain syndrome, pure hypercholesterolemia, disorganized schizophrenia, morbid obesity, osteoarthritis, psychosis, hypertension, mood disorder, gastro-esophageal reflux disease, other symbolic dysfunction, depressive episodes and epilepsy. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident was dependent on staff for toileting, bathing and dressing, personal hygiene. Review of the resident's plan of care revealed no comprehensive care plan addressing the resident's ADL needs. On 07/02/25 at 12:55 P.M., interview with DON and Registered Nurse (RN) #110 verified the resident had no plan of care addressing the resident ADL status. 2. Review of the medical record for Resident #48 revealed an initial admission date of 07/14/22 with the latest readmission date of 07/26/24 with the diagnoses including but not limited to diabetes mellitus, hypercholesterolemia, psychophysiological insomnia, urethral stricture, constipation, disorganized schizophrenia, benign neoplasm of rib, sternum and clavicle, major depressive disorder, neuromuscular dysfunction of bladder, psychosis, anemia, schizophrenia, retention of urine and blindness one eye. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident had no wandering. Review of the resident's elopement risk assessment dated [DATE] revealed the resident was at risk for elopement, however not at risk to elope at this time and placement on the elopement risk protocol was not indicated. The assessment indicated the elopement risk assessment was to be conducted on admission, within 30 days of admission, quarterly and any significant change affecting the assessment. Review of the plan of care revealed no care plan addressing the resident's elopement risk, despite the resident being identified as being at high risk for elopement by the facility. On 07/02/25 at 12:55 P.M., interview with DON and Registered Nurse (RN) #110 verified the resident had no plan of care addressing the resident elopement risk. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00165161.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, and staff interview, the facility failed to ensure those residents who were at risk for elopement were assessed and/or physician ordered interventions were implemented to prevent possible elopement from the facility. This affected three residents (#48, #53 and #68) of three residents reviewed for elopement. The facility census was 96. Findings Include: 1. Review of the medical record for Resident #53 revealed an initial admission date of 12/13/24 with the latest readmission of 05/28/25 with the diagnoses including but not limited to chronic obstructive pulmonary disease, hypertension, obstructive sleep apnea, chronic respiratory failure, congestive heart failure, diaphragmatic hernia, delusional disorder, sepsis, dependence on supplemental oxygen, schizoaffective disorder, bipolar type, psychosis, and urinary incontinence. Review of the plan of care, not dated revealed the resident was independently mobile, resident expresses a desire to leave facility unattended and at risk for elopement and injury. Interventions included resident will have her belongings and walker removed from her when she is using them as weapons towards staff or other residents momentarily, so no one gets hurt, resident carries all of her belongings with her all the time and is afraid someone will take her stuff, redirection may not be helpful when she is in this situation, resident needs to be kept safe along with staff and other residents, resident is re-directed back to her room until she calms down, if redirection is not helpful an as needed medication may need to be obtained if all non-pharmacological interventions have been looked at, deep breathing and relaxation techniques, distraction, redirection or comfort foods are a few interventions that could be offered, wander prevention device to ankle as per physician order; ensure placement and function every shift, respond promptly to alarm to ensure resident's safety/whereabouts, attempt to redirect resident, attempt to find causative factors preceding resident's attempts to leave, eliminate/reduce if possible, divert attention if possible when resident becomes insistent on leaving, do not agitate, find activities of interest to resident, schedule or provide equipment/supplies preventing prolonged periods of idle time and elopement assessment upon admission, quarterly and as needed. Review of the elopement risk assessment dated [DATE] following a successful elopement from the facility revealed a score of nine indicating the resident was at risk for elopement. Review of the resident's monthly physician orders for July 2025 identified orders dated 04/02/25 wanderguard to right ankle and check function and placement every shift and as needed. On 06/30/25 at 11:19 A.M., observation of Resident #53 revealed she was wandering throughout the front lobby with her belongings stacked on her rollator walker. The resident was observed going to the front door to leave with various staff intervening. The resident had no wanderguard in place due to the system not alerting while the resident was at the door. On 06/30/25 at 1:51 P.M., an interview with the Director of Nursing (DON) verified the resident had no wanderguard in place and stated the resident would take them off and throw them away. He stated the wanderguards are expensive. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #48 revealed an initial admission date of 07/14/22 with the latest readmission date of 07/26/24 with the diagnoses including but not limited to diabetes mellitus, hypercholesterolemia, psychophysiological insomnia, urethral stricture, constipation, disorganized schizophrenia, benign neoplasm of rib, sternum and clavicle, major depressive disorder, neuromuscular dysfunction of bladder, psychosis, anemia, schizophrenia, retention of urine and blindness one eye. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident had no wandering. Review of the plan of care revealed no care plan addressing the resident's elopement risk, despite the resident being identified as being at high risk for elopement by the facility. Review of the resident's elopement risk assessment dated [DATE] revealed the resident was at risk for elopement, however not at risk to elope at this time and placement on the elopement risk protocol was not indicated. The assessment indicated the elopement risk assessment was to be conducted on admission, within 30 days of admission, quarterly and any significant change affecting the assessment. Review of the medical record revealed no elopement risk assessment had been completed since the 09/30/24 assessment was completed. On 07/02/25 at 12:55 P.M., interview with DON and Registered Nurse (RN) #110 revealed the resident had taken his entire window out to leave the facility. RN #110 stated the resident would not leave a wanderguard on so he was moved to a room the widow could not be removed and the room was closer to the nurses station. The RN verified the elopement risk assessment was to be completed quarterly and the resident had not been assessed quarterly as required. 3. Review of the medical record for Resident #68 revealed an initial admission date of 11/05/19 with the diagnoses including but not limited to chronic obstructive pulmonary disease, hypothyroidism, diabetes mellitus, traumatic brain injury, dementia with behavioral disturbances, major depressive disorder, epilepsy, anorexia, anxiety disorder, insomnia, bipolar disorder, attention and concentration deficit, schizoaffective disorder, bipolar type and asthma. Review of the plan of care, not dated revealed the resident had the potential for independently mobile resident to expresses a desire to leave facility unattended, at risk for elopement and injury related to dementia, poor safety awareness and judgment, and attention communication deficits. Interventions included all facility staff members received written e-mails ([NAME] and SNF clinic) to read and complete the mandatory door alarm in-service as soon as possible and sign for completion of the materials provided, respond promptly to alarm to ensure resident's safety/whereabouts, attempt to redirect resident when appropriate, wander guard to ankle, per physician orders, ensure placement and check function every shift, when resident is trying to elope strategically place them away from an accessible door, attempt to find causative factors preceding resident's attempts to leave, eliminate/reduce if possible, resident does like to walk around units and staff to monitor her whereabouts, divert attention if possible when resident becomes insistent on leaving, do not agitate, elopement assessment upon admission, quarterly and as needed and resident to be continued to be monitored for potential poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's latest elopement risk assessment dated [DATE] revealed the resident was at risk for elopement. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had no wandering, however displayed verbal and physical behaviors towards others. Review of the resident's monthly physician orders for July 2025 identified an order dated 06/23/25 wanderguard to right ankle, check placement and function every shift and as needed. On 07/02/25 at 12:55 P.M., interview with DON and RN #110 verified the elopement risk assessments were not being completed quarterly as required. The facility's elopement policy and elopement risk protocol had been requested from the Administrator, the DON and RN #110 however were not provided. This deficiency represents non-compliance investigated under Complaint Number OH00165161.

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation and interviews, the facility failed to ensure sufficient support personnel to carry out the functions of the food and nutrition services. This had the potential to affect all 96 residents residing in the facility. Findings Include: On 06/30/25 observations during the breakfast meal on the 100 hallway revealed the resident's breakfast was served in disposable Styrofoam takeout containers and disposable Styrofoam cups. On 06/30/25 at 12:06 P.M., observation of the lunch meal in the dining room revealed the resident's drinks were served in Styrofoam cups. On 06/30/25 at 12:19 P.M., interview with the Dietary Manager (DM) #111 revealed when the dietary department was short staffed disposable containers and cups are used due to the cooks inability to assist with washing dishes. DM #111 verified the facility did not have sufficient staff for the food and nutrition services. On 06/30/25 at 12:21 P.M., observation of the lunch meal on the 400 hallway revealed the residents were served fluids in Styrofoam cups. On 06/30/25 at 12:23 P.M., an interview with Resident #20 revealed the dietary department always serves on disposable products. She said she prefers to eat/drink from dishes. She stated once in a while they may get a plate. On 07/02/25 during the lunch meal revealed the facility served drinks in Styrofoam cups. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation and interview, the facility failed to ensure an adequate supply of dishes to serve the residents of the facility. This had the potential to affect all 96 residents residing in the facility. Findings Include: On 06/30/25 observations during the breakfast meal on the 100 hallway revealed the resident's breakfast was served in disposable Styrofoam takeout containers and disposable Styrofoam cups. On 06/30/25 at 12:06 P.M., observation of the lunch meal in the dining room revealed the resident's drinks were served in Styrofoam cups. On 06/30/25 at 12:19 P.M., interview with the Dietary Manager (DM) #111 verified the facility does not have enough dishes to serve the residents and Styrofoam disposable containers/cups are utilized. On 06/30/25 at 12:21 P.M., observation of the lunch meal on the 400 hallway revealed the residents were served fluids in Styrofoam cups. On 06/30/25 at 12:23 P.M., an interview with Resident #20 revealed the dietary department always serves on disposable products. She said she prefers to eat/drink from dishes. She stated once in a while they may get a plate. On 07/02/25 during the lunch meal revealed the facility served drinks in Styrofoam cups. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation, record review, interviews and facility policy review, the facility failed to maintain appropriate infection control practices to prevent potential infection. Additionally, the facility also failed to implement Enhanced Barrier Precautions (EBP) during a dressing change. This affected one resident (#31) of one resident reviewed for indwelling urinary catheter care and one resident (#11) of two residents reviewed for wounds. The facility census was 96. Findings Include: 1. Review of the medical record for Resident #31 revealed an initial admission date of 07/19/16 with the latest readmission of 05/10/25 with the diagnoses including but not limited to Parkinson's disease with dyskinesia, polyneuropathies, constipation, obstructive and reflux uropathy, hypertension, chronic kidney disease, chronic pain syndrome, hydrocele, psychotic disorder, restless leg syndrome, mood disorder, tachycardia, psychosis, developmental disability, gout, anemia, mood disorder, benign prostatic hyperplasia (BPH), intermittent explosive disorder, hallucinations, bladder neck obstruction, asthma, paranoid schizophrenia and borderline personality disorder. Review of the plan of care, not dated revealed the resident had a potential for alteration in urinary elimination related to obstructive uropathy, and potential inability to communicate needs, due to cognitive impairments with short term memory loss, impaired mobility, indwelling urinary catheter usage, history of BPH with obstruction, hydrocele, chronic kidney disease and recent urinary tract infection (UTI). Interventions included change indwelling urinary catheter as a whole unit every month as scheduled with prescribed size and balloon order on file and change as a unit routine or as needed, provide catheter care every shift and as needed, empty indwelling urinary catheter collection bag every shift and as needed, follow up with urology appointments as scheduled, indwelling urinary catheter irrigation of catheter as per most current physician order on file, 1500 milliliter (ml) fluid restriction non-compliance, monitor all labs as per current and routine physician orders on file, resident will allow indwelling urinary catheter collection bag cover to remain in place with the catheter itself and not remove the collection bag from the cover for it nor leave it in his room, staff to continue to monitor and remind him as appropriate, administer routine medications as per current physician order, keep call light within reach, remind resident to call for assistance. note any changes in amount, frequency, color or odor of urine, report any abnormalities to registered staff and treat UTI per physician order. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter and was occasionally incontinent of bowel. Review of the resident's monthly physician orders for July 2025 identified orders dated 05/14/19 indwelling urinary catheter care every shift and as needed, 05/12/21 empty indwelling urinary catheter collection bag every shift and as needed, 03/19/24 change indwelling urinary catheter with a 14 FR, 16 FR or 18 FR [NAME] catheter with a 10 ml balloon on the fourth of each month as a whole unit, and as needed, 07/30/21 Acetic Acid Solution 0.25 % use 50 ml via irrigation every shift and 05/24/24 enhanced barrier precautions (EBP) contact precautions due to indwelling urinary catheter every shift. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/25 at 7:49 A.M., observation of Registered Nurse (RN) #165 provide physician ordered indwelling urinary catheter care revealed the RN donned a gown, gloves and mask for EBP. The resident's indwelling urinary catheter collection bag was lying on the floor with light yellow urine visible from the hallway. RN #165 verified the indwelling urinary catheter collection bag as lying on the floor which could potentially cause an infection. The supplies required for catheter care was set-up on the resident's bedside table. The RN obtained a disposable wipe and cleansed the tip of the resident's penis, scrotum and groins. The resident was then assisted onto his left side where the RN obtained a disposable wipe and cleansed the resident's rectal area. The resident was then assisted back onto his back and using the same gloves the RN cleansed the indwelling urinary catheter from the tip outward in a circular motion with a disposable wipe using the same gloves she utilized to cleanse the resident's rectal area. On 07/02/25 at 8:03 A.M., an interview with RN #165 verified the lack of handwashing and glove changes following the cleansing cleansing of the resident's rectal area and the indwelling urinary catheter. Review of the facility policy titled, Handwashing/Hand Hygiene, not dated revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections. All personal are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors. Hand hygiene is indicated before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. 2. Review of the medical record for Resident #11 revealed an initial admission date of 03/07/22 with the diagnoses including but not limited to diabetes mellitus, hypertension, congestive heart failure, hyperlipidemia, unspecified disorder of adult personality and behavior, constipation, blindness right eye, psychophysiologic insomnia, excoriation (skin picking) disorder, open wound of scalp, glaucoma, traumatic brain injury, anxiety disorder, psychosis, personality disorder, osteoarthritis and anxiety disorder. Review of the plan of care, not dated revealed the resident had actual/potential for alteration in skin integrity related to admitted with chronic open wound of scalp, sequela, picks at his skin dry skin of his feet. Interventions included 07/01/25 Enhanced Barrier Precautions due to chronic wound, provide medications per physician order, provide routine and as needed skin treatments per most current physician order, diet and supplements per Registered Dietician recommendation and physician order, monitor meal intake, offer alternate if intake less than 50%, encourage meal and fluid intake, pressure reducing mattress to bed, monitor wound for signs/symptoms of infection, keep bed linen clean, dry and wrinkle free, encourage resident to be out of bed as tolerated, pain assessment quarterly and as needed, skin at risk score quarterly and as needed, monitor lab values per physician orders, therapy per order and refer to podiatry for routine and as needed foot care. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the most recent weekly skin/wound assessment dated [DATE] revealed the old chemical burn to the crown of the resident's head measured 3.0 centimeters (cm) by 1.9 cm by 0.1 cm and described as being 40% epithelia tissue and 60% granulation tissue. The wound had a scant amount of serous exudate. The wound color was red and the peri-wound was pink. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366313	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Pointe	740 Canonby Place Columbus, OH 43223

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's monthly physician orders for July 2025 identified an order dated 05/28/25 Cleanse open areas to top of head with quarter strength Dakins solution, pat dry, apply moist to dry with Dakins (cut to size) over top of areas to the front (squeeze out extra solution) cover with derma dressing, change daily and as needed and 07/01/25 Enhanced Barrier Precautions due to chronic wound. On 07/01/25 at 10:54 A.M., observation of Registered Nurse (RN) #142 provide the physician ordered treatment to Resident #11's wounds to his head revealed the RN placed a barrier on the resident's bedside table and placed the required supplies on the barrier. The RN then washed her hands and donned a pair of gloves and removed the soiled dressing to his head dated 06/30/25. The RN sanitized her hands, donned gloves and cleansed the wounds with quarter strength Dakin's solution using 4X4's. The RN then sanitized her hands and donned gloves, cut a Dakin's solution soaked 4X4 to fit the wound and placed on the wound. The RN then covered the wound with an island dressing. The RN had not implemented any EBP for the chronic wound to the resident's head. On 07/01/25 at 11:06 A.M., an interview with the Director of Nursing (DON), who was present during the treatment verified the resident had no orders for EBP and EBP were not utilized on the resident during dressing changes. Review of the facility policy titled, Enhanced Barrier Precautions, not dated revealed EBP are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDRO) to residents. Examples of high contact resident care activities requiring the use of gown and gloves for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care (any skin opening requiring a dressing). This deficiency represents non-compliance investigated under Complaint Number OH00167030.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366313	A. Building B. Wing	07/07/2025

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview the facility failed to provide a safe, sanitary and comfortable environment for resident in the resident rooms, hallways and bathrooms. This had the potential to affect all 96 residents residing in the facility. Findings include: 1. Review of the Resident Council Minutes from 04/22/25 revealed the residents requested more deep cleaning in their rooms. Also, Resident #32 had requested repairs to bed, blinds and her sink and toilet leaked. 2. Review of the Resident Council Minutes from 05/27/25 revealed Resident #82 reported a hole under her sink in the bathroom and Resident #32 reported again her sink and toilet were leaking leaking as well as Resident #7's sink was leaking. 3. Review of the Resident Council Minutes form 06/24/25 revealed Resident #82 again reported a hole under her bathroom sink. 4. On 06/30/25 at 10:53 A.M., observation of Resident #89's room revealed multiple areas of dry wall patches on the bathroom door and the room door handle was loose making the door difficult to close. 5. On 06/30/25 at 11:30 A.M., observation of the drain covers located on the 200 and 400 hallways revealed the covers were not secured to the floor posing an accident hazard. 6. On 07/01/25 at 10:54 A.M., observation of Resident #23's room revealed the wall on the left side of the bed had a large section of the paint missing with dry wall mud in the corner of the wall. 7. On 07/02/25 at 8:30 A.M., observations of the four resident hallways revealed all the doors had a black substance on them, and resident floors as well as the hallways had a build up of a black substance. On 07/01/25 at 09:50 A.M., interview with Registered Nurse (RN) #110 she knew the building needed repairs and deep cleaned. She verified the resident's were voicing concerns during resident council for maintenance concerns and they were not being addressed. The RN verified the wall behind Resident #23's bed should be repaired with a material that cannot be picked and in fact the facility had a smooth board they would place behind the bed for those residents that pick. On 07/02/25 at 11:23 A.M. interview with the Maintenance Director #187 revealed he had been off the past 10 days with COVID but was back to work as of 07/02/25. The Maintenance Director revealed he had gone and fixed the leaking sinks. This deficiency represents non-compliance investigated under Master Complaint Number OH00167030, Complaint Number OH00166963 and OH00165161.