

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2025
NAME OF PROVIDER OR SUPPLIER Scioto Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 740 Canonby Place Columbus, OH 43223	

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 - Many	Provide and implement an infection prevention and control program. (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
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital documents, observation, Local Health Department (LHD) interview, staff interview, and review of facility policy, the facility failed to have an effective water management and legionella prevention plan and further failed to implement recommended legionella mitigation strategies to prevent the potential spread of Legionella pneumonia. This had the potential to affect all 94 residents residing in the facility. The facility census was 94. Findings include: Review of the medical record for Resident #88 (SR) revealed an admission date of 09/23/21. Diagnoses included cerebral infarct (stroke), diabetes, hemiplegia and hemiparesis, anxiety, cardiac arrhythmia, dysphagia, and weakness. Further review of the medical record revealed the resident was treated for pneumonia at the facility and sent to the hospital on [DATE] for further evaluation and treatment. Review of the hospital lab results, dated 10/03/25, revealed Resident #88 tested positive from a urinalysis test for legionella (bacteria that can cause a severe form of pneumonia). Further review of a hospital note dated 10/14/25 revealed Resident #88 was admitted with altered mental status and found to have acute respiratory failure and sepsis secondary to Legionella pneumonia. The note stated septic shock developed after admission and the hospital stay had been complicated with a diagnosis of atrial fibrillation (a-fib) with rapid ventricular response (RVR) and continued diuresis (increase production and excretion of urine) for pulmonary edema. Review of the facility policy and procedure titled, Reducing Legionella Risk and Transmission, dated June 2017, revealed legionella could cause pneumonia. It was the policy to reduce the risk of growth and spread of legionella through assessment identification, prevention, monitoring, reporting, investigating, and controlling infections and communicable diseases. The policy stated the facility should analyze and assess areas of risk with considerations of water temperatures, stagnation, no usage of disinfectants and conditions for bacteria spread. Prevention and monitoring mechanisms could include periodic disinfectants through usage of chemicals and consider testing residents for legionella when they develop pneumonia. If an infection was confirmed, the facility should complete an investigation including auditing and identification of the potential origin for the legionella. The facility should consider restricting water in the facility or other immediate control measures. Review of the Legionella Risk Assessment, dated November 2017, revealed the document was completed to reduce the growth and spread of legionella. The action plan included the weekly flushing of all faucets not in frequent use, all eye wash stations, all shower heads, and all bathtub faucets; all hot water tanks should be flushed bi-monthly; and the ice machine filter should be changed every six months. The risk assessment tool included no ranges or instructions of what to do if the measures were out of appropriate ranges. Review of the facility's Water Management Plan, undated, revealed a diagram of the water system. It stated, The diagram below shows which types of monitoring could occur at different locations within the facility water system to reduce spread of legionella. The diagram included upon entrance to the facility from [NAME] Avenue, a visual inspection and disinfectant levels should be completed; the ice machine in the dining room should have visual inspections; the water heaters for the resident rooms, the water heater for the kitchen, laundry and mechanical rooms, sinks and showers for the resident rooms and kitchen and laundry appliances should have temperature checks completed and sinks and showers should have disinfectant levels checked. Review of electronic mail (e-mail) communication between the facility Assistant Administrator (AA) #200 and the LHD revealed the facility notified the LHD on 10/06/25 of a resident with a positive legionella result. From 10/06/25 to 10/07/25, the e-mails discussed testing samples of the facility water sources. On 10/08/25, the LHD asked if facility had initiated water restrictions and asked, If yes, what specifically are you doing? The facility had no evidence this was responded to via e-mail. On 10/10/25, the LHD informed the facility they would be onsite for a consultation, stating the first priority was to protect current residents by restricting water usage or installing point of use filters. Interview on 10/14/25 at 2:20 P. M. with AA #200 revealed facility had a resident (#88) test positive for legionella while at the hospital. She reported the positive case was reported to both the LHD and the state health department (SHD). AA #200 stated the facility collected 13 samples from different areas of the facility and sent them to the lab for legionella testing. Interview on 10/14/25 at 3:00 P.M. with the Administrator revealed the facility completed flushes, monitored water temperatures, and changed the ice machine filter as outlined in the risk assessment, but they did not do chemical testing as the facility utilized city water. He also reported the facility had no bathtubs and no eye wash stations. Interview on 10/14/25 at 3:25 P.M. with the Administrator AA</p>		