

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  06/27/2024
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)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37100</p> <p>Based on medical record review, financial record review, staff interview, facility policy review, and review of online resources, the facility failed to implement a plan to spend down resident funds when they exceeded the Medicaid allowable limit. This affected 15 (Residents #7, #83, #15, #63, #67, #95, #20, #45, #66, #3, #41, #13, #21, #29, and #26) of 18 residents reviewed for finances. The facility also failed to convey resident personal funds to the resident's authorized representative within 30 days of the resident's discharge from the facility or death. This affected three (Residents #93, #94, and #95) of four discharge resident financial records reviewed. The facility census was 94 residents.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including type two diabetes, major depressive disorder, and peripheral vascular disease.</p> <p>Review of the monthly financial statements for Resident #7 dated 10/06/23 to 03/31/24 revealed the balance ranged from \$2,826.27 to \$3,188.11.</p> <p>Review of the resident trust account record for Resident #7 revealed on 06/25/24 the balance was \$2,592.05.</p> <p>Review of the resident trust account records for Resident #7 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>2. Review of the medical record for Resident #83 revealed an admitted [DATE] with diagnoses including type two diabetes, schizoaffective disorder, and chronic obstructive pulmonary disease.</p> <p>Review of the monthly financial statements for Resident #83 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$4,192.32 to \$4,406.26.</p> <p>Review of the resident trust account record for Resident #83 revealed on 06/25/24 the balance was \$3,632.65.</p> <p>Review of the resident trust account records for Resident #83 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>(continued on next page)</p>

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including COPD, schizophrenia, and atherosclerotic heart disease.</p> <p>Review of the monthly financial statements for Resident #15 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$2,805.23 to \$4,172.43.</p> <p>Review of the resident trust account record for Resident #15 revealed on 06/25/24 the balance was \$3,654.51.</p> <p>Review of the resident trust account records for Resident #15 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>4. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses including vascular dementia, COPD, and cerebral infarction.</p> <p>Review of the monthly financial statements for Resident #63 dated 10/26/23 to 03/31/24 revealed the balance ranged from \$2,980.84 to \$3,184.42.</p> <p>Review of the resident trust account record for Resident #63 revealed on 06/25/24 the balance was \$2,804.94.</p> <p>Review of the resident trust account records for Resident #63 revealed there was only one spend down notice sent by the facility to the resident and/or resident's representative on 12/31/23.</p> <p>5. Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including diffuse traumatic brain injury, cerebral infarction, and schizoaffective disorder.</p> <p>Review of the monthly financial statements for Resident #67 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$2,691.24 to \$3,051.60.</p> <p>Review of the resident trust account record for Resident #67 revealed on 06/25/24 the balance was \$3,139.66.</p> <p>Review of the resident trust account records for Resident #67 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>6. Review of the medical record for Resident #95 revealed an admitted [DATE] with diagnoses including osteoarthritis, bipolar disorder, and acute kidney failure with a discharge date of [DATE].</p> <p>Review of the monthly financial statements for Resident #95 dated 04/01/23 to 12/13/23 revealed the balance ranged from \$ 5,600.79 and \$10,013.32.</p> <p>Review of the resident trust account record for Resident #95 revealed on 06/25/24 the balance was \$5,600.79.</p> <p>Review of the resident trust account records for Resident #95 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, cerebral infarction, and schizoaffective disorder.</p> <p>Review of the resident trust account records for Resident #20 revealed the facility sent spend down notices on 03/31/23, 06/30/23, and 09/30/23.</p> <p>Review of the resident trust account record for Resident #20 revealed on 06/25/24 the balance was \$3,609.74.</p> <p>9. Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including type two diabetes, mood disorder, and major depressive disorder.</p> <p>Review of the monthly financial statements for Resident #45 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$2,753.15 to \$4,331.36.</p> <p>Review of the resident trust account record for Resident #45 revealed on 06/25/24 the balance was \$2,691.70.</p> <p>Review of the resident trust account records for Resident #45 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>10. Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses including type two diabetes, hyperlipidemia, and delusional disorder.</p> <p>Review of the monthly financial statements for Resident #66 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$12,914.62 to \$15,554.54.</p> <p>Review of the resident trust account record for Resident #66 revealed on 06/25/24 the balance was \$12,769.87.</p> <p>Review of the resident trust account records for Resident #66 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>11. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including atrial fibrillation, adjustment disorder, dementia, and chronic kidney disease.</p> <p>Review of the monthly financial statements for Resident #3 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$3,971.40 to \$5,907.49.</p> <p>Review of the resident trust account record for Resident #3 revealed on 06/25/24 the balance was \$3,339.31.</p> <p>Review of the resident trust account records for Resident #3 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>12. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including diffuse traumatic brain injury, ataxia, dementia, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the monthly financial statements for Resident #41 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$9,737.83 to \$17,250.13.</p> <p>Review of the resident trust account record for Resident #41 revealed on 06/25/24 the balance was \$20,783.54.</p> <p>Review of the resident trust account records for Resident #41 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>13. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including multiple sclerosis, Parkinson's disease, and hyperlipidemia.</p> <p>Review of the monthly financial statements for Resident #13 dated 11/06/23 to 03/31/24 revealed the balance ranged from \$1,809.05 to \$4,053.09.</p> <p>Review of the resident trust account record for Resident #13 revealed on 06/25/24 the balance was \$3,921.39.</p> <p>Review of the resident trust account records for Resident #13 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>14. Review of the medical record for Resident #21 revealed an admitted [DATE]with diagnoses including encephalopathy, edema, dementia, and muscle weakness.</p> <p>Review of the monthly financial statements for Resident #21 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$21,927.71 to \$28,752.41.</p> <p>Review of the resident trust account record for Resident #21 revealed on 06/25/24 the balance was \$30,922.85.</p> <p>Review of the resident trust account records for Resident #21 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>15. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including type II diabetes, anxiety disorder, dementia, and epilepsy.</p> <p>Review of the monthly financial statements for Resident #29 dated 04/01/23 to 03/31/24 revealed the balance ranged from \$2,646.45 to \$2,885.26.</p> <p>Review of the resident trust account record for Resident #29 revealed on 06/25/24 the balance was \$2,947.35.</p> <p>Review of the resident trust account records for Resident #29 revealed there were no spend down notices sent by the facility to the resident and/or resident's representative.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/27/24 at 1:27 P.M with Business Office Manager (BOM) #106 confirmed the facility should send spend down notices to every resident and/or resident representative whose account balance was within \$200 of the Medicaid allowance amount. BOM #106 further confirmed the following 15 residents were over the resource limit and had not been notified: #7, #83, #15, #63, #67, #95, #20, #45, #66, #3, #41, #13, #21, #29, #26.</p> <p>Review of facility policy titled Accounting and Records of Resident Funds dated April 2021 revealed a representative of the business office should inform the resident/representative if the balance in his/her personal funds account reached \$200 less than the resident's supplemental security income (SSI) resource limit.</p> <p>Review of an online resource titled Supplemental Security Income (SSI) on 07/02/24 at <a href="https://www.ssa.gov/ssi/text-resources-ussi.htm">https://www.ssa.gov/ssi/text-resources-ussi.htm</a> revealed SSI was a needs-based program. The resource limit for one individual on SSI was \$2,000.</p> <p>16. Review of the medical record for Resident #93 revealed an admitted [DATE] with diagnoses including type two diabetes, sleep disorder, cognitive decline, and anorexia, and a discharge date of [DATE].</p> <p>Review of the resident trust account record for Resident #93 revealed on 06/25/24 the balance was of \$13,710.32.</p> <p>17. Review of the medical record for Resident #94 revealed an admitted [DATE] with diagnoses including heart failure, hypotension, and mood disorder and a discharge date of [DATE].</p> <p>Review of the resident trust account record for Resident #94 revealed on 06/25/24 the balance was \$2,627.40.</p> <p>18. Review of the medical record for Resident #95 revealed an admitted [DATE] with diagnoses including senile degeneration of brain, muscle weakness, and anemia and a discharge date of [DATE].</p> <p>Review of the resident trust account record for Resident #95 revealed on 06/25/24 the balance was \$5,760.40</p> <p>Interview on 06/27/24 at 2:10 P.M with BOM #106 confirmed Residents #93, #94, and #95 were discharged from the facility, and the facility had not disbursed the funds remaining in their resident trust accounts within 30 days as required.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36648</p> <p>Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to notify the attending physician of a change in condition. This affected one (Resident #76) of 26 sampled residents. The facility census was 94 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including peripheral vascular disease, neuralgia, schizoaffective disorder, and bipolar disorder.</p> <p>Review of the nurse progress note for Resident #76 dated 06/10/24 timed at 9:30 A.M. revealed the Director of Nursing (DON) spoke with the resident regarding frequent leaves of absence (LOA) from the facility in which he returned in a state of alcohol intoxication. Further review of the note revealed Resident #76 admitted that he did regularly consume alcohol while on LOA but had agreed not to come back to the facility intoxicated going forward. The DON also discussed concerns with Resident #76 regarding missing medications while on LOA which potentially led to recent seizure activity. Resident #76 agreed to return to the facility on LOAs in time to take medication.</p> <p>Review of nurse progress note for Resident #76 dated 06/20/24 timed at 6:59 A.M. revealed Resident #76 returned to the facility from a LOA and was drunk and confused but took his medications.</p> <p>Review of nurse progress note for Resident #76 dated 06/21/24 timed at 10:37 P.M. revealed Resident #76 returned to the facility from a LOA and was drunk and confused but took his medications.</p> <p>Review of the Medication Administration Record (MAR) for Resident #76 dated June 2023 revealed on 06/20/24 and 06/21/24 the resident received two medications at night: Seroquel (an antipsychotic medication) 100 milligrams (mg) and Keppra (an anti-seizure medication) two 750 mg tablets.</p> <p>Interview on 06/26/24 at 2:34 P.M. with Registered Nurse (RN) #178 confirmed Resident #76 often left the building around 11:00 A.M. and did not return until late in the evening and was often intoxicated upon his return to the facility.</p> <p>Interview on 06/26/24 at 2:40 P.M. with Resident #76 confirmed he was able to sign himself out of the facility when he wanted to and was able to return later in the day. Resident #76 did not recall returning to the facility intoxicated.</p> <p>Interview on 06/26/24 at 4:00 P.M. with Licensed Practical Nurse (LPN) #160 confirmed when a resident left for an LOA they should sign out and in when they returned. If a resident was intoxicated upon return from an LOA, the nurse should document the condition of the resident and give any medications due. LPN #160 confirmed Resident #76's attending physician was not notified the resident appeared to be intoxicated and confused on 06/20/24 and 06/21/24 to ensure it was safe to administer Seroquel and Keppra.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/26/24 at 4:23 P.M. with the DON confirmed the nurse dispensed the Seroquel and Keppra to Resident #76 on 06/20/24 and 06/21/24 even though the resident appeared to be intoxicated. The DON further confirmed the nurse should have contacted the physician to ensure it was safe to dispense the medications to the intoxicated resident.</p> <p>Interview on 06/27/24 at 1:38 P.M. with LPN #127 confirmed a resident was required to sign in and out when they leave on LOA. If the resident's behavior was abnormal or they were intoxicated the nurse should notify the supervisor and call the physician prior to dispensing any medications.</p> <p>Review of the facility policy titled Change in Resident's Condition or Status dated February 2021 revealed the nurse will notify the physician on call when there has been a significant change in resident's physical, emotional, and mental condition.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50008</p> <p>Based on observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure that a resident footboards were repaired as needed and in a timely manner. This affected one resident (Resident #91) of three residents reviewed for their environment. The facility census was 94.</p> <p>Findings include:</p> <p>Observation on 06/24/24 at 9:39 A.M., on 06/25/24 at 8:48 A.M. and 06/26/24 at 3:37 P.M. revealed footboard to Resident #91's bed was broken at approximately two-thirds of its length. The sharp, jagged edge of the footboard was approximately three feet from the resident's window.</p> <p>Interview on 06/24/24 at 9:39 A.M. with Resident #91 confirmed the footboard to his bed had been broken for at least a week and a half. Resident #91 further confirmed he told the Director of Nursing (DON) he wanted his footboard to be replaced because he was worried about cutting himself on the jagged edge of the footboard as he passed by his bed.</p> <p>Interview on 06/26/24 at 3:39 P.M. with the DON confirmed Resident #91 had informed him of the broken footboard soon after Resident #91's room change on 05/30/24. The DON further confirmed he informed Maintenance Director (MD) #137 of the broken footboard soon after 05/30/24.</p> <p>Interview on 06/26/24 at 3:42 P.M. with MD #137 confirmed he was aware of the broken footboard on Resident #91's bed, and he had contacted a medical bed company on 06/12/24 for a replacement footboard. He received an email from the medical bed company on 06/13/24 requesting measurements for the footboard. MD #137 confirmed he had not responded to the medical bed company with the measurements.</p> <p>Review of a facility policy titled Homelike Environment undated revealed that residents should be provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximized to the extent possible the characteristics of the facility that reflected a personalized, homelike setting. These characteristics included a clean bed and bath linens that are in good condition.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36648</p> <p>Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to develop a care plan for residents regarding unsupervised leaves of absence (LOA) from the facility. This affected one (Resident #76) of 26 sampled residents. The facility census was 94 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including peripheral vascular disease, neuralgia, schizoaffective disorder, and bipolar disorder.</p> <p>Review of the care plan for Resident #76 updated 05/23/24 revealed it did not include documentation of the resident's frequent LOAs from the facility with guidelines to ensure the safety of the resident while out of the building.</p> <p>Review of the nurse progress note for Resident #76 dated 06/10/24 timed at 9:30 A.M. revealed the Director of Nursing (DON) spoke with the resident regarding frequent leaves of absence (LOA) from the facility in which he returned in a state of alcohol intoxication. Further review of the note revealed Resident #76 admitted that he did regularly consume alcohol while on LOA but had agreed not to come back to the facility intoxicated going forward. The DON also discussed concerns with Resident #76 regarding missing medications while on LOA which potentially led to recent seizure activity. Resident #76 agreed to return to the facility on LOAs in time to take medication.</p> <p>Review of nurse progress note for Resident #76 dated 06/20/24 timed at 6:59 A.M. revealed Resident #76 returned to the facility from a LOA and was drunk and confused.</p> <p>Review of nurse progress note for Resident #76 dated 06/21/24 timed at 10:37 P.M. revealed Resident #76 returned to the facility from a LOA and was drunk and confused.</p> <p>Interview on 06/26/24 at 2:34 P.M. with Registered Nurse (RN) #178 confirmed Resident #76 often left the building around 11:00 A.M. and did not return until late in the evening and was often intoxicated upon his return to the facility.</p> <p>Interview on 06/26/24 at 2:40 P.M. with Resident #76 confirmed he was able to sign himself out of the facility when he wanted to and was able to return later in the day. Resident #76 did not recall returning to the facility intoxicated.</p> <p>Interview on 06/26/24 at 3:30 P.M. with the DON confirmed Resident #76 plan of care did not include parameters for the resident regarding frequent LOAs from the facility. The DON confirmed Resident #76's care plan should reflect the resident's frequent LOAs.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/26/27 at 4:30 P.M. with Minimum Data Set (MDS) Nurse #170 confirmed Resident #76 was alert and oriented and was able to leave the facility without supervision. MDS Nurse #170 further confirmed Resident #76's care plan last updated 05/23/24 did not include the resident's almost daily LOAs from the facility and occasional behavior of returning intoxicated.</p> <p>Review of the facility policy titled Care Planning undated revealed the facility interdisciplinary team would develop and implement person-centered care plans based on resident assessments.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50008</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to assist dependent residents with activities of daily living (ADL) care. This affected one (Resident #53) of two residents reviewed for ADL care. The facility census was 94 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including schizoaffective disorder bipolar type, polyosteoarthritis, and chronic pain syndrome.</p> <p>Review of the comprehensive care plan for Resident #53 revealed the resident had the potential for a self-care deficit in grooming related to impaired ability to groom self and a lack of fine motor skills. The goal on Resident #53's care plan was that the resident would be well groomed. The intervention listed was that Resident #53 would be cued and prompted to participate in grooming and that the resident would be assisted to complete the task.</p> <p>Observation on 06/24/24 at 7:59 A.M. and 06/25/24 at 7:50 A.M. revealed Resident #53's chin hairs were approximately one inch long and were unkempt.</p> <p>Interview on 06/25/24 at 3:54 P.M. with Resident #53 confirmed she did not like the whiskers on her chin and that she needed assistance from staff to remove them</p> <p>Interview on 06/25/24 at 4:36 P.M. with Registered Nurse (RN) # 160 confirmed Resident #53's chin hairs were long and unkempt and resident required staff assistance with removing them.</p> <p>Review of the facility policy titled Activities of Daily Living (ADL) Supporting revealed that appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987</b></p> <p>Based on medical record review, staff interview and review of the facility policy, the facility failed to monitor residents who had fallen. This affected two (Residents #10 and #63) of four residents reviewed for falls. The facility census was 94 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including cerebrovascular disease, major depressive disorder, weakness, panic disorder, dementia, personality disorder, and disorganized schizophrenia.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 04/30/24 revealed the resident had moderate cognitive impairment and required substantial/maximal assistance with toilet hygiene, bathing, bed mobility and transfers.</p> <p>Review of the progress note for Resident #10 dated 05/11/24 revealed the resident had a fall without injuries. Further review of the progress notes revealed there was no post-fall monitoring documented for the resident on 05/12/24 and 05/13/24.</p> <p>Review of the progress note for Resident #10 dated 06/16/24 revealed the resident had a fall without injuries. Further review of the progress notes revealed there was no post-fall monitoring documented for the resident on 06/17/24 and 06/18/24.</p> <p>2. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses including abnormalities of gait and mobility, nontraumatic subarachnoid hemorrhage, vascular dementia and muscle weakness.</p> <p>Review of the MDS assessment for Resident #63 dated 04/10/24 revealed the resident was cognitively intact and required supervision or touching assistance with all aspects of care.</p> <p>Review of the progress note for Resident #63 dated 02/28/24 revealed the resident had a fall which resulted in a bruise to the left ankle. Further review of the progress notes revealed there was no post-fall monitoring documented for the resident on 02/29/24 and 03/01/24.</p> <p>Review of the progress note for Resident #63 dated 05/10/24 revealed the resident had a fall which resulted in a hematoma to the forehead. Further review of the progress notes revealed there was no post-fall monitoring documented for the resident on 05/11/24 and 05/12/24.</p> <p>Interview on 06/27/24 at 1:20 P.M. with the Director of Nursing (DON) confirmed staff should monitor and document on residents with falls and there should be documentation at least twice in the 24-hour period following the fall. The DON further confirmed the facility had not completed appropriate post-fall monitoring for Resident #10's falls on 05/11/24 and 06/16/24 and Resident #63's falls on 02/28/24 and 05/10/24.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of the facility policy titled Guidelines for Fall Documentation undated revealed nurses should monitor and document on residents every shift 72 hours after a fall.		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987</b></p> <p>Based on medical record review, observation, and staff interviews the facility failed to ensure residents received oral fluids between meals. This affected one (Resident #13) of 26 residents sampled. The facility census was 94 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including multiple sclerosis, mood disorder, and Parkinson's disease.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #13 dated 06/07/24 revealed the resident was cognitively intact and required partial/moderate assistance with eating and substantial/maximal assistance with bed mobility and was dependent on staff with oral and toilet hygiene.</p> <p>Review of the active care plan for Resident #13 revealed an intervention to encourage good fluid intake at meals and between meals due to at risk for decreased cardiac output and alternated nutritional status.</p> <p>Review of the nutritional assessments for Resident #13 dated 04/01/24 and 06/10/24 completed by the Dietician revealed the resident required 1600-1700 milliliters (ml) of fluids per day.</p> <p>Review of the Medication Administration Record (MAR) for Resident #13 dated June 2024 revealed the resident was not documented as having consumed 1600-1700 mls of fluid daily on most of the days.</p> <p>Review of the progress notes for Resident #13 dated 06/01/24 to 06/27/24 revealed the notes did not include any documented of refusals of fluids per the resident.</p> <p>Observation on 06/24/24 at 10:11 A.M. and 2:42 P.M. revealed Resident #13 did not have any oral fluids at the bedside table.</p> <p>Observation on 06/25/24 at 9:44 A.M. and 1:41 P.M. revealed Resident #13 did not have any oral fluids at the bedside table.</p> <p>Interview on 06/25/24 at 1:46 P.M. with State tested Nursing Assistant (STNA) #196 confirmed Resident #13 did not have any fluids at the bedside, could not ask for fluids, and needed assistance with oral intake.</p> <p>Observation on 06/26/24 at 8:50 A.M. and 12:59 P.M. revealed Resident #13 did not have any oral fluids at the bedside table.</p> <p>Observation on 06/27/24 at 8:25 A.M. revealed Resident #13 did not have any oral fluids at the bedside table.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/27/24 at 8:36 A.M. with Licensed Practical Nurse (LPN) #102 confirmed Resident #13 did not have any fluids at the bedside, could not ask for fluids, and needed assistance with oral intake.</p> <p>Interview on 06/27/24 at 8:50 A.M. with the Assistant Director of Nursing (ADON) confirmed the facility passed water in the morning and before lunch and before dinner and as needed. If a resident was unable to ask, the staff were still required to provide water to residents and assist them with drinking the water if that was needed.</p> <p>Interview on 06/27/24 at 9:36 A.M. with the Director of Nursing (DON) confirmed Resident #13's MAR dated June 2024 showed the resident had not received 1600-1700 ml's of fluids on the majority of days. The DON confirmed the staff were supposed to pass water to residents between meals and in the morning and at night and as needed. The DON confirmed the facility did not have a policy for hydration or water pass.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988</b></p> <p>Based on medical record review, staff interview, and review of facility policy the facility failed to adequately assess pain for residents who received pain medications. This affected one (Resident #52) of three residents reviewed for pain management. The facility census was 94.</p> <p>Findings:</p> <p>1. Review of medical record for Resident #52 revealed admitted [DATE] with diagnoses including peripheral vascular disease, major depression, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation, type two diabetes, and acute kidney failure.</p> <p>Review of the care plan for Resident #52 dated 02/13/24 revealed the resident had pain or alteration in comfort related to immobility, non-pressure ulcers. Interventions included the following: administer pain medications as per medical doctor orders and note the effectiveness, assess for nonverbal signs of pain, offer non-pharmacological interventions to manage pain such as massage reposition, gentle exercise, breathing and relaxation techniques distraction redirection music therapies or comfort foods.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #52 dated 03/22/24 revealed the resident had cognitive impairment, required assistance with activities of daily living (ADLs), received scheduled pain medications, received as needed pain medications and had pain almost constantly.</p> <p>Review of physician's orders for Resident #52 revealed an order dated 04/17/24 for oxycodone (a narcotic pain medication) 5 milligrams (mg) by mouth two times a day for moderate pain.</p> <p>Review of Medication Administration Records (MARs) dated April, May, and June 2024 for Resident #52 revealed the resident received oxycodone twice daily as ordered from 04/18/24 through 06/26/24. Further review of the MARs revealed they did not include a pain assessment prior to or after the administration of oxycodone.</p> <p>Review of the weekly pain assessments for Resident #52 dated 04/18/24 to 06/26/24 revealed no weekly pain assessments had been completed for the resident.</p> <p>Interview on 06/26/24 at 08:45 A.M. with the Director of Nursing (DON) confirmed the nurses had not weekly pain assessments for Resident #52 nor had the nurses documented completion of a pain assessment before or after administration of scheduled oxycodone to the resident.</p> <p>Review of facility policy titled Pain Clinical Protocol revised October 2022 revealed the staff would reassess the individual's pain and related consequences at regular intervals. The staff would assess resident for pain at least one time each shift for acute pain or significant change in level of chronic pain and at least weekly in stable chronic pain. Review of pain should include frequency, duration and intensity of pain, ability to perform activities of daily living, sleep patterns, mood, behavior and participation in activities. Further review revealed the nursing staff would assess each individual for pain upon admission to facility, at the quarterly review, whenever there was a significant change in condition and when there was onset of new pain or worsening of existing pain.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37100</p> <p>Based on medical record review, staff interview, and facility policy review, the facility failed to appropriately assess and monitor resident behaviors. This affected four (Residents #31, #69, #10, and #16) of five residents reviewed for behavior management. The census was 94.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including epilepsy, psychosis, major depressive disorder, schizoaffective disorder, suicidal ideations, borderline personality disorder, bipolar disorder, and anxiety disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 05/10/24 revealed the resident was cognitively intact.</p> <p>Review of the care plan for Resident #31 revealed resident had the following behaviors: suicidal ideations, malingering, socially inappropriate/disruptive behaviors. Resident #31 also had a care plan related to cognitive impairments related to the resident's mental health diagnoses which included the following: psychotic disturbance, mood disturbance, anxiety, schizoaffective disorder bipolar type, borderline personality disorder, bipolar disorder, and psychosis. The care plan did not include specific behaviors to track and monitor nor did it include staff interventions in response to the behaviors.</p> <p>Review of the physician's orders for Resident #31 dated June 2024 revealed the resident was taking the following medications: Buspar for anxiety, hydroxyzine as needed for anxiety, Vraylar for schizoaffective disorder, Lamictal for bipolar disorder and major depressive disorder, Celexa for depression and schizoaffective disorder.</p> <p>2. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, insomnia, psychosis, bipolar disorder, and major depressive disorder.</p> <p>Review of the MDS assessment for Resident #69 dated 04/16/24 revealed the resident was cognitively intact.</p> <p>Review of the care plan for Resident #69 revealed the resident had the following behaviors: physically aggressive toward staff, manic behavior, grandiosity of actions, calling 911, cursing, pulling fire alarms, trying to kick in doors, homicidal thoughts (shooting others and bomb threats), socially inappropriate/disruptive behaviors.</p> <p>Review of the medical record for Resident #69 revealed there was documentation of tracking or monitoring of resident behaviors to determine the effectiveness of the care plan.</p> <p>Interview on 06/27/24 at 9:57 A.M. with the Director of Nursing (DON) confirmed the facility did not track behaviors for Residents #31 and #69</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47987</p> <p>3. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including major depressive disorder, panic disorder, personality disorder, disorganized schizophrenia.</p> <p>Review of the MDS assessment for Resident #10 dated 04/30/24 revealed the resident had moderate cognitive impairment and required assistance with activities of daily living (ADLs.)</p> <p>Review of the active care plan for Resident #10 active care plans revealed there were target behaviors for post-trauma syndrome that included the following: nightmares, flashbacks, depression, isolation, headaches, confusion, difficulty concentrating. The care plan did not include specific target behaviors associated with the resident's diagnoses of depression, schizophrenia, and personality disorder.</p> <p>Review of the medical record for Resident #10 revealed it did not include tracking for post-trauma syndrome behaviors or any behaviors associated with resident's mental health diagnoses.</p> <p>Interview on 06/27/24 at 8:40 A.M. with Licensed Practical Nurse (LPN) #102 confirmed they were unable to document on target behaviors for Resident #10's depression, schizophrenia and personality disorder because there care plan did not list specific target behaviors.</p> <p>Interview on 06/27/24 at 9:40 A.M. with the DON confirmed Resident #10 did not have a care plan for depression, schizophrenia and personality disorder which identified specific target behaviors. The DON confirmed the facility did not track behaviors for Resident #10.</p> <p>4. Review of the medical record for Resident #16, revealed an admitted [DATE] with diagnoses including anxiety disorder, major depressive disorder, schizoaffective disorder, mood disorder due to known physiological condition with major depressive like episode, and post-traumatic stress disorder (PTSD).</p> <p>Review of the MDS assessment for Resident #16 dated 06/05/24 revealed the resident was cognitively intact and had diagnoses including anxiety disorder, depression, schizophrenia and PTSD. The resident also had delusions and verbal behavioral symptoms directed towards others and received antipsychotic, antianxiety, and antidepressant medications.</p> <p>Review of the active care plan for Resident #16 revealed it did not include specific target behaviors associated with anxiety disorder, major depressive disorder, schizoaffective disorder, mood disorder, and PTSD.</p> <p>Review of the medical record for Resident #16 revealed it did not include tracking for PTSD or any behaviors associated with the resident's mental health diagnoses.</p> <p>Interview on 06/26/24 at 9:26 A.M. with Registered Nurse (RN) #170 confirmed she completed most of the care plans for the facility and further confirmed Resident #16 did not have a care plan for PTSD and her anxiety disorder, major depressive disorder, and schizoaffective disorder, with specific target behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/27/24 at 9:42 A.M. with the DON confirmed Resident #16 did not have a care plan for anxiety disorder, major depressive disorder, schizoaffective disorder, mood disorder and PTSD identifying specific target behaviors. The DON confirmed the facility did not track behaviors for Resident #16.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50008</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to monitor resident blood pressure prior as ordered by the physician in conjunction with administration of a diuretic medication. This affected one (Resident #55) of six residents reviewed for medications. The facility census was 94 residents.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including obsessive compulsive personality disorder, paranoid schizophrenia, polydipsia, and hyponatremia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #55 dated 04/05/24 revealed the resident had intact cognition.</p> <p>Review of the physician's orders for Resident #55 revealed an order dated 06/22/24 for Lasix 20 milligrams (mg), hold for systolic blood pressure less than 100.</p> <p>Review of the care plan for Resident #55's revealed the resident was at risk for decreased cardiac output and abnormal lab values related to polydipsia, sodium deficit hyponatremia, with a goal to take Lasix as prescribed by physician. Intervention included staff were to give the diuretic as ordered and follow parameters for medication to be held.</p> <p>Review of the Medication Administration Record (MAR) for Resident #55 dated June 2024 revealed staff administered Lasix on 06/22/23, 06/23/24, 06/25/24, and 06/26/24, but there was no blood pressure recorded prior to administration.</p> <p>Interview on 06/26/24 at 2:40 P.M. with Registered Nurse (RN) #160 confirmed staff had not taken Resident #55's blood pressure on 06/22/23, 06/23/24, 06/25/24, and 06/26/24 prior to Lasix administration as ordered by the physician.</p> <p>Interview on 06/26/24 at 2:53 P.M. with the Director of Nursing (DON) confirmed Resident #55 was ordered Lasix with parameters to hold for SBP less than 100 on 06/22/24. The DON further confirmed the staff did not obtain blood pressures prior to Lasix administration on 06/22/23, 06/23/24, 06/25/24, and 06/26/24 as ordered by the physician.</p> <p>Review of the facility policy titled Administering Medications undated revealed the nurse should check to see if vital signs are ordered prior to medication administration.</p>		