STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366332	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Home at Taylor's Pointe	3464 Springdale Road Cincinnati, OH 45251

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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** 44083 Based on observations, staff interviews, and record reviews, the facility failed to ensure resident's had a dignified meal experience in the dining room. This affected two (Residents #32 and #191) of 15 residents in the 300 memory care unit dining room. The facility census was 91. Findings Include: Record review of Resident #191 revealed the resident was admitted to the facility on [DATE]. Diagnoses included anxiety, dementia, multiple sclerosis, and psychotic disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #191 had impaired cognition and required supervision with feeding assistance. Record review of Resident #32 revealed the resident was admitted to the facility on [DATE] . Diagnoses included cerebral infarction, aphasia, anxiety, depressive disorder, and dementia with behavioral disturbance. Review of the MDS assessment dated [DATE] revealed Resident #32 had impaired cognition. The resident received a regular, puree consistency diet. Record review of Resident #27 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia with behavioral disturbance, anxiety, and mood disorder. Review of the MDS assessment dated [DATE] revealed Resident #27 had impaired cognition. The resident received a regular mechanical soft consistency diet. Observations on 03/19/25 at 12:12 P.M. revealed in the 300 memory care unit dining room, Resident #27 was seated in a wheelchair at a dining room table with Residents #32 and #191. Resident #27 was being fed the meal by Certified Nursing Assistant (CNA) #196. Observation on 03/19/25 at 12:30 P.M. revealed Resident #191 rocked back and forth in her wheelchair. Residents #191 and #32 had not received their lunch meal trays. CNA #178 attempted to calm Resident #191 by talking with her and told her the food was coming, which did not appear to calm Resident #191. Interview on 03/19/25 at 12:32 P.M. with CNA #178 verified Resident #191 appeared to be getting anxious by watching Resident #27 eat her lunch meal and Resident #27 should have been fed at a separate table so not to have Resident's #191 and #32 watch and become anxious. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/19/25 at 12:40 P.M. revealed Resident #27 had completed her meal. At 12:44 P.M., Residents #191 and #32 received their lunch meal trays. Interview on 03/19/25 at 12:40 P.M. with Assistant Director of Nursing (ADON) #100 verified Resident #27 needed feeding assistance and received her meal first, then the other residents' received their meal trays. ADON #100 verified Resident #27 was fed while Residents #191 and #32 watched and became anxious. ADON #100 stated Residents #191 and #32 should have received their meals when Resident #27 received her meal. This deficiency represents non-compliance investigated under Complaint Numbers OH00153044 and OH00161555.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure care conferences were held quarterly for residents and their representatives. This affected five (Residents #5, #9, #50, #51, and #63) of five residents reviewed for care conferences. The facility census was 91. Findings include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of chronic ischemic heart disease, hypertension, vascular dementia, diabetes mellitus type II, and morbid obesity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had no cognitive impairment and was always incontinent of bowel and bladder. Resident #5 required supervision with eating, moderate assistance with oral hygiene, dependent on staff for toileting, dressing and transfers and maximal assistance with bathing, personal hygiene and bed mobility. Review of the Care Conference Meeting Summary documents, as supplied by the Administrator, revealed Resident #5 did not have documented care conferences in the second quarter (April, May and June) and fourth quarter (October, November and December) of 2024. Interview on 03/20/25 at 9:50 A.M. with Resident #5 stated she could not remember the last time she had a care conference. Interview on 03/20/25 at 2:10 P.M. with Social Services Designee #132 verified the facility did not provide a care conference for Resident #95 in the second and fourth quarters of 2024. 2. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses of quadriplegia status-post motor vehicle accident, neuromuscular dysfunction of bladder, diabetes mellitus type II, major depressive disorder and moderate protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had intact cognition and had a suprapubic catheter and was always incontinent of bowel. The resident was dependent on staff for eating, oral and personal hygiene, toileting, bathing, dressing, bed mobility, and transfers. Review of the Care Conference Meeting Summary documents, as provided by the facility Administrator, revealed Resident #9 did not have documented care conferences in the first quarter (January, February and March) of 2024. Interview on 03/20/25 at 10:00 A.M. with Resident #9 stated they have no recollection of quarterly care conferences. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/20/25 at 2:10 P.M. with Social Services Designee #132 verified the facility did not provide a care conference for Resident #9 in the first quarter of 2024. 3. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE] with diagnoses of quadriplegia, end-stage renal disease with dependence on renal dialysis and neuromuscular dysfunction of bladder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had moderate cognitive impairment and had an indwelling urinary catheter and was always incontinent of bowel. The resident was dependent on staff for eating, oral and personal hygiene, toileting, bathing, dressing, bed mobility, and transfers. Review of the Care Conference Meeting Summary documents, as supplied by the Administrator, revealed Resident #50 did not have documented care conferences in the first quarter (January, February and March) and third quarter (July, August and September) of 2024. Interview on 03/20/25 at 2:10 P.M. with Social Services Designee #132 verified the facility did not provide a care conference for Resident #50 in the first and third quarters of 2024. 4. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses of dementia, major depressive disorder, anxiety disorder and diabetes mellitus type II. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition and was always continent of bowel and bladder. The resident required supervision with eating, oral and personal hygiene, toileting, dressing and transfers, moderate assistance with bathing and set up assistance with bed mobility. Review of the Care Conference Meeting Summary documents, as provided by the Administrator, revealed Resident #51 did not have documented care conferences in the first quarter (January, February and March), second quarter (April, May and June) and fourth quarter (October, November and December) of 2024. Interview on 03/20/25 at 10:10 A.M. with Resident #51 stated they have no recollection of the last care conference she had with the facility. Interview on 03/20/25 at 2:10 P.M. with Social Services Designee #132 verified the facility did not provide a care conference for Resident #9 in the first, second, and fourth quarters of 2024. 5. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, diabetes mellitus type II, chronic obstructive pulmonary disease, post-traumatic stress disorder and anxiety. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #63 had intact cognition and was always continent of bowel and bladder. The resident required supervision with eating, oral and personal hygiene, toileting, dressing, bed mobility and transfers and moderate assistance with bathing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Conference Meeting Summary documents, as supplied by the Administrator, revealed Resident #63 did not have documented care conferences in the first quarter (January, February and March) and second quarter (April, May and June) of 2024. Interview on 03/20/25 at 10:10 A.M. with Resident #63 stated they have no recollection of the last care conference she had with the facility. Interview on 03/20/25 at 2:10 P.M. with Social Services Designee #132 verified the facility did not provide a care conference for Resident #9 in the first and second quarters of 2024. Review of the policy titled Care Conference, revised 03/20/24, revealed a purpose to provide the resident and, if applicable, the resident representative of the right to participate in the resident's plan of care in a manner that facilitates his/her participation. The facility's interdisciplinary team shall periodically review the resident's care plan and make necessary revisions based on the goals, preferences and needs of the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure medications were administered according to physician's order, resulting in a medication error rate rate which exceeded five percent (%). 35 opportunities were observed with four medication errors, resulting in a 11.43% error rate. This affected one (Resident #71) of four residents reviewed for medication administration. The facility census was 91. Findings include: Review of the medical record revealed Resident #71 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II (DM), chronic obstructive pulmonary disease and hypertension. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had intact cognition. Review of the physician orders revealed Resident #71 had the following orders: an order dated 02/07/25 for Novolog pen-injector 100 unit per milliliter (ml) (Insulin Aspart), inject 10 unit subcutaneously before meals for DM, hold for finger-stick blood sugar less than 150; an order dated 04/11/23 for Metoclopramide 10 milligrams (mg) give one tablet by mouth before meals and at bedtime for hiccups; an order dated 09/12/22 for Sucralfate one gram (gm), give one tablet by mouth before meals and at bedtime related to other symbolic dysfunctions; and an order dated 05/28/22 Simethicone tablet 80 mg, give one tablet by mouth before meals and at bedtime for gastro-esophageal reflux disease. Observation on 03/19/25 at 8:40 A.M. revealed Resident #71 had completed eating his breakfast meal in his room prior to receiving his morning medications. Observation of medication administration on 03/19/25 at 8:40 A.M. revealed Registered Nurse (RN) #164 administered Resident #71 four medications that had physician orders to be administered before eating breakfast. RN #164 administered Novolog insulin 10 units subcutaneously, Metoclopimide 10 mg by mouth, Sucralfate one gm by mouth, and Simethicone 80 mg by mouth. Interview on 03/19/25 at 8:50 A.M. with RN #164 verified the Novolog insulin, Metoclopramide, Sucralfate and Simethicone should have been administered before Resident #71 consumed his breakfast. Interview on 03/19/25 at 8:52 A.M. with Assistant Director of Nursing (ADON) #114 verified Resident #71 did not receive Novolog insulin, Metoclopramide, Sucralfate, and Simethicone per the physician order which stated to be administered before breakfast. Interview on 03/19/25 at 10:19 A.M. with the Director of Nursing (DON) verified nurses are to administer medications as ordered by the physician. She verified medications ordered to be administered before breakfast should be administered before the resident consumed breakfast. Review of the policy titled General Guidelines for Medication Administration dated 06/21/17 revealed medications will be administered by legally authorized and trained persons in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44083 Based on observations, staff interviews, and facility policy review, the facility failed to maintain a sanitary kitchen to prevent cross contamination of food. This affected 81 residents who received food from the kitchen. The facility identified 10 residents who do not receive food from the kitchen. The facility total census was 91. Findings include: 1. Observation and interview on 03/17/25 at 7:53 A.M. of the kitchen with Dietary Manager (DM) #140 revealed there were 15 individually packaged desserts, one opened beef base container, nine opened containers of liquids, and approximately 30 hard boiled eggs stored undated. There was a large tray of cooked sausage patties which were stored uncovered in the refrigerator. There was an opened undated container of jelly stored in the dry storage room with a label to refrigerate after opening. DM #140 verified the undated and uncovered food in the refrigerators and unrefrigerated items. 2. Observation on 03/19/25 from 7:30 A.M. through 8:15 A.M. revealed Dietary Manager (DM) #140 with approximately 20 rope-like strands of hair hanging out of DM #140's knitted cap he was wearing. The strands of hair were approximately six inches long that was hanging out of the knitted cap. DM #140 was assisting with breakfast food preparation. Interview on 03/19/25 at 8:15 A.M. with DM #140 verified his hair extended beyond the hair cap and was not contained. DM #140 verified all hair should be contained completely under the hair restraint. Interview on 03/20/25 at 9:55 A.M. with Registered Dietitian (RD) #695 verified all hair should be contained under the hair covering. 3. Observation on 03/19/25 at 9:10 A.M. on the 300 unit nursing station revealed the resident refrigerator had two insulated bags of food unlabeled. There were two bags of fast food unlabeled. There were two partially used and opened gallon containers of liquids which were undated. Interview on 03/19/25 at 9:10 A.M. with Admission Director (AR) #190 verified the refrigerator was for storage of resident foods only and all foods should be labeled and dated. AR #190 stated the unlabeled insulated bags of foods were employee's food containers and should have been stored in the employee breakroom. AR #190 verified the two bags of foods were not labeled with a name or dated. The two gallons of liquid were undated with a opened date. 4. Observation on 03/19/25 at 9:17 A.M. on the 200 unit nursing station revealed the resident refrigerator had a sign all foods should be dated. There was a bag of foods labeled with a name but had no date. There was a Styrofoam container with no label of contents or a date. There were two opened gallon containers of liquids with no open dates. There was as partially used pitcher of liquids with no label or date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/19/25 at 9:17 A.M. with Social Service Designee (SSD) #700 verified the refrigerator was for storage of resident foods only and all foods should be labeled and dated. SSD #700 verified there were no dates on the open containers of liquids and no date on the bag of identified resident's food. Review of the facility policy titled Food Storage Labeling and Dating dated 2017 revealed all items must be dated after opening with an open and a use by date.

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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** 44083 Based on observations, staff interviews, review of facility policy, and record reviews, the facility failed to ensure hand sanitation was performed during meal service. This affected three residents (#71, #85 and #61) observed during meal service. The facility census was 91. Findings include: 1. Record review of Resident #61 revealed the resident was admitted to the facility on [DATE]. Diagnoses included sepsis and ileostomy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had severely impaired cognition. The resident had a physician order for contact isolation. Observation on 03/19/25 at 8:40 A.M. revealed there was a sign on a Resident #61's room door. The signage revealed the resident was in contact precautions and everyone must clean their hands, including before entering and when leaving the room. Certified Nursing Assistant (CNA) #117 donned gloves and gown and entered Resident #61's room with the breakfast meal tray. CNA #117 was observed to assist the resident in bed and touched other items in the room to assist in positioning the resident in bed. CNA #117 doffed the gown and gloves and did not wash or hand sanitize her hands prior to or after leaving the room. Interview on 03/19/25 at 8:45 A.M. with CNA #117 verified she had assisted Resident #61 in bed and stated she should have performed hand hygiene. She verified she did not wash her hands or use hand sanitizer when she doffed the gloves when exiting Resident #61's room. Interview on 03/19/25 at 2:40 P.M. with the Director of Nursing (DON) verified the staff should hand sanitize prior to and after delivery of meal trays. Interview on 03/20/25 at 9:30 A.M. with Unit Nurse Manager #114 verified the CNAs should be performing hand hygiene after exiting resident's rooms with contact precautions, including Resident #61's room. 2. Observations on 03/19/25 at 8:33 A.M. revealed Certified Nursing Assistant (CNA) #123 delivered a breakfast tray to Resident #19. CNA #123 was observed to touch items and assist Resident #19 in bed. CNA #123 exited the room and did not wash or sanitize her hands. CNA #123 obtained Resident #71's meal tray. CNA #123 delivered and assisted Resident #71 with the meal tray. CNA #123 exited Resident #71's room and did not wash or sanitize her hands and proceeded to obtain Resident #85's meal tray. CNA #123 delivered the meal tray and assisted Resident #85 with the meal set up and touching items in the room. CNA #123 exited the room. CNA #123 did not perform hand sanitizing or hand washing between assisting the residents and delivery of meal trays to the residents. Interview on 03/19/25 at 8:35 A.M. with CNA #123 verified she had touched items in the rooms of Residents #19, #71, and #85 and had not performed hand sanitization prior to or after delivery of the meal trays to Residents #19, #71 and #85. CNA #123 verified she should have performed hand sanitation after touching items in a resident's room and delivery of meal trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 2:40 P.M. with the Director of Nursing (DON) verified the staff should hand sanitize prior to and after delivery of meal trays. Review of the facility policy titled Infection Control Policy dated 2010 revealed all staff perform hand hygiene after handling contaminated objects.