STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366480	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylor Springs Health Campus	748 Taylor Road Gahanna, OH 43230

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on closed record review, staff interview, and emergency room discharge instructions, the facility failed to provide care for a broken left wrist for one (Resident #10) of three residents reviewed for accidents. The facility census was 45. Findings include: Review of the closed medical record for Resident #10, revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing, age related osteoporosis without current pathological fracture, and unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 5 out of 15 which revealed severe cognitive impairment. Resident #10 was assessed to require substantial/maximal assistance with toilet hygiene, shower/bathe, lying to sitting on the side of the bed, toilet transfer and chair/bed to chair transfer with partial/moderate assistance with sit to lying, sit to stand, and supervision for roll left to right in bed. Resident #10 was also assessed to have one fall with no injury since admission and took an antipsychotic, antianxiety and an opioid medication during the last 7 days of assessment. Review of the progress note for Resident #10 dated 02/25/24 by Licensed Practical Nurse (LPN) #888 revealed the resident had an unwitnessed fall at 7:00 A.M. with pain and swelling to the left wrist with an order for an X-ray to be obtained. Review of the progress note for Resident #10 dated 02/25/24 at 2:30 P.M. by LPN #888 revealed the family wanted the resident sent to the emergency department for evaluation. Review of the after summary visit from [NAME] Health emergency room dated 02/25/24 revealed Resident #10 had a closed fracture of distal ends of left radius and ulna verified by an X-ray. Discharge instructions for the after care revealed to put an ice or cold pack on the left wrist for 10 to 20 minutes at a time. To do this every 1 to 2 hours for the next 3 days (while awake). Also, prop the wrist on pillows when sitting or lying down for the first few days to help reduce swelling. The resident also had a splint upon discharge with instructions to check the skin under the splint every day and do not take off the splint unless your doctor tells you to. (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
	366480	A. Building B. Wing	04/05/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 02/25/24 to 03/11/24 for Resident #10 revealed no documentation of the left wrist being iced, elevated, and the skin under the splint being checked. Review of the orders dated 02/25/24 to 03/11/24 for Resident #10 revealed no orders for the left wrist to be iced, elevated, and the skin under the splint being checked. Interview on 04/02/24 at 11:36 A.M. with the Director of Nursing verified no orders were placed for Resident #10 as instructed from the emergency room after summary visit and no documentation in the residents chart from dates 02/25/24 to 03/11/24 documenting those instructions were provided to the resident. This deficiency represents non-compliance investigated under Complaint Number OH00152040.

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on closed medical record review, emergency room record review, facility policy review and interview, the facility failed to develop and implement an individualized, effective and comprehensive pain management program for Resident #10 who experienced pain following a fall. Actual harm occurred on 02/25/24 at 7:30 A.M. when Resident #10 sustained a fall with swelling and complaints of pain (rated an eight on a scale of one to 10) to her left wrist. The resident was provided one dose of pain medication (at 8:16 A.M) which was noted to be ineffective following the incident but was not provided any other pain medication, pain management or transferred to the emergency room until 02/25/24 at approximately 2:00 P.M. (over six hours later). The resident was assessed to have a closed fracture of distal ends of left radius and ulna (wrist). This affected one resident (#10) of three residents reviewed for accidents. The facility census was 45. Findings Include: Review of the closed medical record for Resident #10, revealed an admitted [DATE] and a discharge date of [DATE]. Resident #10 had diagnoses including displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing, age related osteoporosis without current pathological fracture, and unspecified dementia, unspecified severity, with other behavioral disturbances. Review of physician's orders for Resident #10 dated 02/16/24 revealed an order for Ibuprofen 600 milligram (mg) 1 tablet three times a day for right displaced bicondylar fracture of right tibia that was present on admission. Further review revealed an order for Hydrocodone-Acetaminophen 5-325 mg one tablet every four hours as needed was ordered for moderate to severe pain for seven days that was ordered on 02/16/24 for right leg pain and was discontinued on 02/23/24. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 5 out of 15 which revealed severe cognitive impairment. Resident #10 was assessed to require substantial/maximal assistance with toilet hygiene, shower/bathe, lying to sitting on the side of the bed, toilet transfer and chair/bed to chair transfer with partial/moderate assistance with sit to lying, sit to stand, and supervision for roll left to right in bed. Resident #10 was also assessed to have one fall with no injury since admission and received an antipsychotic, antianxiety and an opioid medication during the last 7 days of assessment. Review of the progress note dated 02/25/24 at 7:30 A.M. authored by Licensed Practical Nurse (LPN) #888 revealed the resident observed sitting on the floor in room in front of wheelchair (w/c). Resident #10 stated she was attempting to go to the bathroom. LPN #888 attempted to re-educate the resident about the importance of asking for assistance. Resident #10 complained of pain in left wrist; wrist swollen. LPN #888 contacted Certified Nurse Practitioner (CNP) #4000. An order for an X-ray was obtained. The order was to be STAT (immediately), and resident's family was notified. (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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the physician's order for Resident #10 dated 02/25/24 at 7:45 A.M. revealed an x-ray ordered as routine of the left wrist for pain and edema. In addition, Hydrocodone-Acetaminophen 5-325 mg one tablet every four hours as needed was ordered for moderate to severe pain for seven days. Review of the Medication Administration Record (MAR) for Resident #10 revealed on 02/25/24 at 8:16 A.M. the administration of the Hydrocodone-Acetaminophen 5-325mg tablet for left wrist pain rated an eight out of 10 (with 10 being the worst pain) by LPN #888. Prior interventions were documented as none, and follow-up result was not effective. Review of Resident #10's progress notes after the fall on 02/25/24 at 7:30 A.M. revealed no documentation of non-pharmacological pain interventions, follow up for pain medication not being effective, assessment of the left wrist, and no communication with Certified Nurse Practitioner (CNP) #4000 regarding the pain medication not being effective. Review of the MAR for Resident #10 revealed no documentation of the Hydrocodone-Acetaminophen 5-325 mg one tablet every four hours after the 02/25/24 8:16 A.M. dose. Review of the physical therapy note for Resident #10 for 02/25/24 with an unknown encounter time, revealed the resident had a fall this morning resulting in swelling and bruising to the left upper wrist and the nurse reported putting in an x-ray order this morning. Review of progress note for Resident #10 dated 02/25/24 at 2:30 P.M. by LPN #888 revealed the x-ray technician was there to obtain the left wrist x-ray, family in the room and observed the procedure. The family informed this nurse that the left wrist was believed to be broken and wanted to take the resident to the emergency room for evaluation. CNP #8000 was notified, and the resident was transported to the local hospital emergency department. Review of the Fall Investigation Summary for Resident #10 dated 02/25/24 revealed the resident had pain, but no pain scale was documented, and the resident was sent to the emergency room at 2:35 P.M. Review of skilled nurses note for Resident #10 dated 02/25/24 at 2:40 P.M. authored by LPN #888 revealed the resident had pain in her right leg which was alleviated by medication. No assessment of the left wrist was noted. Review of the hospital emergency room documentation dated 02/25/24 at 2:49 P.M. revealed Resident #10 presented on arrival with left wrist pain, swelling, ecchymosis, and complaining of pain at the area of the distal radius and ulna (wrist). Review of the progress notes for Resident #10 dated 02/25/24 at 6:00 P.M. authored by LPN #888 revealed Resident #10 returned to the facility via family from the emergency room with a diagnosis of a closed fracture distal ends of left radius and ulna (wrist). An on call CNP was sent the information and requested pain medication for the resident and a new order for Tylenol 650 mg every six hours as needed was obtained. Review of Resident #10's care plan dated 03/04/24 revealed Resident #10 had impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, and impaired or reduced safety awareness. No care plan was noted for pain management. (continued on next page)

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	366480	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylor Springs Health Campus	748 Taylor Road Gahanna, OH 43230

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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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/02/24 at 12:40 P.M. with CNP #4000 revealed she vaguely remembered the resident but did recall ordering a stat x-ray due to her left wrist being swollen as she would do with any fall in that condition. She denied being informed that the Hydrocodone-Acetaminophen 5-325 mg ordered every four hours was ineffective after the 02/25/24 8:16 A.M. dose and it was ordered every four hours as her previous prescription and should have been administered if needed as well as non-pharmacological interventions and of those fail or the resident is having uncontrolled pain, she sends the residents to the emergency room . Interview on 04/02/24 at 2:25 P.M. via telephone with LPN #888 about Resident #10's day of events for 02/25/24 revealed she was the nurse caring for the resident. She was informed by an aide the resident was on the floor, she assessed the resident and observed swelling to the left wrist and the resident was complaining of left wrist pain with grimacing, but no pain scale was used. The resident was assisted back to her wheelchair and taken to the recreation room that was a closed area with windows by the dining room to be observed due to being a high fall risk and she did not want to leave her in the room alone. The LPN revealed facility staff do not sit in there with the residents and the nurse's station was not in view of the room, but staff took turns checking on them. After the fall, she elevated the resident's arm on the wheelchair and applied ice to the site, called CNP #4000 and administered the Hydrocodone-Acetaminophen 5-325 mg (one tablet) after 8:00 A.M. and followed up with it not being effective due to the resident grimacing and not allowing her to touch the left wrist by guarding it. The LPN verified throughout the day, the resident would grimace when assessed and her left wrist then started bruising and was more swollen. No nonpharmacological pain interventions were completed such as icing or elevating due to the resident not allowing staff to touch it and would grimace and moan. She stated the resident was checked on several times throughout the day and was not able to assess the left wrist any of those times due to the guarding and grimacing. LPN #888 was unsure of what Certified Nurse Aides (CNAs) checked on the resident as she was in the recreation room, and they all take turns. The LPN verified she was aware the resident was severely cognitively impaired with moments of confusion and the grimacing and not allowing the staff to touch her left wrist was an indication of pain. The LPN also verified she did not contact CNP #4000 again until 2:30 P.M. to inform her of the family's request to send the resident out to the emergency room . The LPN indicated the skilled nurse note dated 02/25/24 at 2:40 P.M. was the incorrect time and it was done sometime after 2:00 P.M. Interview on 04/02/24 at 3:10 P.M. with the Director of Nursing (DON) revealed the facility nurses were educated on pain management and she was doing reeducation on pain management follow up as well as assessing pain appropriately for residents who were severely cognitively impaired. The DON stated she was aware Resident #10 also had activities in the recreation room and attended therapy for her right leg fracture but was not aware of the continued grimacing and guarding of the left wrist after the 02/25/24 fall. The DON also verified when residents were in the recreation room, all staff check on them. Interview on 04/05/24 at 2:08 P.M. via telephone with Physical Therapist (PT) #222 regarding Resident #10's session on 02/25/24 revealed the therapist did not remember Resident #10 as she was a traveling therapist between facilities. She stated she would only complete lower body exercises and would have completed those on the resident, so her upper body was not used during the session. PT #222 was able to verify the session was after 11:00 A.M. since it was signed for 4:26 P.M. but could not verify an actual time. (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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Guidelines for Pain Observation and Management revised 05/23/17 revealed the observation should include self-report of pain or for those cognitively impaired and unable to self-report level of pain the observer shall observe the resident for pathological conditions that may cause pain and behavior (facial expressions, body movements, crying. Additionally, evaluate the effectiveness of pain management interventions and modify as indicated. This deficiency represents non-compliance discovered under Complaint Number OH00152040.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on closed medical record review and staff interviews, the facility failed to administer medication as ordered by the physician for one (Resident #10) out of three residents reviewed for medication. The facility census was 45. Findings include: Review of the medical record for Resident #10, revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing, age related osteoporosis without current pathological fracture, and unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 5 out of 15 which revealed severe cognitive impairment. Resident #10 was assessed to require substantial/maximal assistance with toilet hygiene, shower/bathe, lying to sitting on the side of the bed, toilet transfer and chair/bed to chair transfer with partial/moderate assistance with sit to lying, sit to stand, and supervision for roll left to right in bed. Resident #10 was also assessed to have one fall with no injury since admission and took an antipsychotic, antianxiety and an opioid medication during the last 7 days of assessment. Review of the physicians order dated 02/20/24 for Resident #10 revealed a diazepam administer one tablet three times a day for anxiety with the times of administration being: 6:00 A.M. - 10:00 A.M., 1:00 P.M. - 3:00 P.M. and 6:00 P.M. to 10:00 P.M. Review of the Medication Administration Record (MAR) for Resident #10 revealed the diazepam 2 milligram (mg) tablets were unavailable for administration for 02/21/24 for all three doses and doses for 02/22/24 to 02/29/24 were signed off by nurses signatures. Review of the controlled drug use record for Resident #10 of the diazepam 2 mg tablets that were received from the pharmacy on 02/22/24 with 45 tablets revealed missing doses not being signed out to be administered to the resident for the following dates and time frames: 02/23/24 for 1:00 P.M. to 3:00 P.M., 02/24/24 for 6:00 A.M. - 10:00 A.M., 1:00 P.M. - 3:00 P.M. and 6:00 P.M. to 10:00 P.M., 02/25/24 6:00 A.M. - 10:00 A.M., 02/25/24 6:00 P.M. to 6:00 P.M. to 10:00 P.M., 02/26/24 6:00 A.M. to 10:00 A.M., 02/28/24 6:00 P.M. to 10:00 P.M., and 02/29/24 1:00 P.M. to 3:00 P.M. Review of the MAR for Resident #10 revealed all doses of the diazepam 2 mg tablet were administered to the resident, with nurse signatures, for all three times of administration for the dates of 03/01/24 to 03/08/24 with the medication unavailable 03/08/24 starting with the 6:00 P.M. to 10:00 P.M. dose, missing the 03/09/24 6:00 A.M. to 10:00 A.M., 1:00 P.M. to 3:00 P.M. and 6:00 P.M. to 10:00 P.M It was not administered again to the resident until 03/10/24 for the 6:00 A.M. to 10:00 A.M. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled drug use record for Resident #10 of the diazepam 2 mg tablets that were received from the pharmacy on 02/22/24 with 45 tablets revealed missing doses not being signed out to be administered to the resident for the following the date and time frame of 03/04/24 for 6:00 A.M. to 10:00 A.M Further review revealed the last dose was given 03/06/24 for 1:00 P.M. to 3:00 P.M. No controlled drug use record for Resident #10 for the diazepam 2 mg tablets to verify doses given to the MAR for the dates of 03/10/24 until discharge on [DATE] as indicated on the MAR. Interview on 04/02/24 at 10:08 A.M. with the Director of Nursing (DON) verified the diazepam 2 mg tablets were not given where it was documented unavailable and education is being completed on the process of receiving medications and prescriptions before residents are out. Interview on 04/02/24 at 12:02 P.M. with the Director of Nursing verified the doses of diazepam 2 mg tablets were not signed out on the controlled drug record form, but were signed as given on the MARs and therefore were not administered. This deficiency represents non-complaince investigated under Complaint Number OH00152040.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on closed medical record review and interviews, the facility failed to maintain an accurate medical record for a controlled drug for one (Resident #10) out of three residents reviewed for medication. The facility census was 45. Findings include: Review of the closed medical record for Resident #10, revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing, age related osteoporosis without current pathological fracture, and unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 5 out of 15 which revealed severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with toilet hygiene, shower/bathe, lying to sitting on the side of the bed, toilet transfer and chair/bed to chair transfer with partial/moderate assistance with sit to lying, sit to stand, and supervision for roll left to right in bed. The resident was assessed also to have one fall with no injury since admission and took an antipsychotic, antianxiety and an opioid medication during the last 7 days of assessment. Review of the physicians order dated 02/20/24 for Resident #10 revealed a diazepam administer one tablet three times a day for anxiety with the times of administration being: 6:00 A.M. - 10:00 A.M., 1:00 P.M. - 3:00 P.M. and 6:00 P.M. to 10:00 P.M. Review of the Medication Administration Record (MAR) for Resident #10 revealed all doses of the diazepam 2 mg tablet were administered to the resident, with nurse signatures, for all three times of administration for the dates of 02/22/24 to 02/29/24. Review of the controlled drug use record for Resident #10 of the diazepam 2 mg tablets that were received from the pharmacy on 02/22/24 with 45 tablets revealed missing doses not being signed out to be administered to the resident for the following dates and time frames: 02/23/24 for 1:00 P.M. to 3:00 P.M., 02/24/24 for 6:00 A.M. - 10:00 A.M., 1:00 P.M. - 3:00 P.M. and 6:00 P.M. to 10:00 P.M., 02/25/24 6:00 A.M. - 10:00 A.M., 02/25/24 6:00 P.M. to 6:00 P.M. to 10:00 P.M., 02/26/24 6:00 A.M. to 10:00 A.M., 02/28/24 6:00 P.M. to 10:00 P.M., and 02/29/24 1:00 P.M. to 3:00 P.M. Review of the MAR for Resident #10 revealed all doses of the diazepam 2 mg tablet were administered to the resident, with nurse signatures, for all three times of administration for the dates of 03/01/24 to 03/08/24 with the medication unavailable 03/08/24 starting with the 6:00 P.M. to 10:00 P.M. being administered again to the resident starting 03/10/24 for the 6:00 A.M. to 10:00 A.M. time frame and the last dose being 03/11/24 6:00 A.M. to 10:00 A.M. time frame. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled drug use record for Resident #10 of the diazepam 2 mg tablets that were received from the pharmacy on 02/22/24 with 45 tablets revealed missing doses not being signed out to be administered to the resident for the following the date and time frame of 03/04/24 for 6:00 A.M. to 10:00 A.M Further review revealed the last dose was given 03/06/24 for 1:00 P.M. to 3:00 P.M. timeframe. No controlled drug use record for Resident #10 for the diazepam 2 mg tablets to verify doses given to the MAR for the dates of 03/10/24 until discharge on [DATE] as indicated on the MAR. Interview on 04/02/24 at 12:02 P.M. with the Director of Nursing verified the doses of diazepam 2 mg tablets were not signed out on the controlled drug record form, but were signed as given on the MARs and therefore were not given and are not an accurate medical record. This deficiency is an incidental finding investigated under Complaint Number OH00152040.