

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Taylor Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</p> <p>Based on interview, record review, facility self-reported incident (SRI) review, and facility policy review the facility failed to timely report an allegation of abuse by Resident #3 to the executive director and state agency in a timely manner. This affected one resident (#3) of three residents reviewed for abuse. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #3 revealed an admitted [DATE] with diagnoses including gastro-esophageal reflux disease, hypertension, osteoporosis, and diverticulosis of intestine.</p> <p>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the Resident #3 had a severe cognitive impairment.</p> <p>Review of the progress note dated 06/08/24 at 3:06 A.M. revealed Resident #3 called the police and reported that a man had come into her hotel room and had his way with her. The police verified that the complaint was unsubstantiated; therefore, they left. The resident was confused and called people to pick her up from the hotel.</p> <p>Review of the facility SRI tracking number 248492 dated 06/10/24 and timed 12:12 P.M. revealed Resident #3 reported to staff that a man came into her hotel room and had his way with her. The resident had a Brief Interview for Mental Status (BIMS) score of four of 15 indicating severe cognitive impairment. She was unable to provide any details and her family had no suspects.</p> <p>Interview on 06/13/24 at 11:08 A.M. with Registered Nurse (RN) #111 revealed Resident #3 had been increasingly confused on the night on 06/08/24. Due to the resident's agitation, RN #111 contacted the resident's daughter, who spoke with the resident. The resident told her daughter that a man had come in her room. The daughter assured her mother there was no man, and she needed to go back to sleep. Shortly after this, Resident #3 called the police. The police arrived, and Resident #3 told them a man had had his way with her. He stated he did not notify anyone but documented it in the medical record due to the nature of the allegations.</p> <p>Interview on 06/13/24 at 11:28 A.M. with Certified Resident Care Assistant (CRCA) #101 revealed she was present the night of 06/08/24 and was aware of Resident #3's allegations. She was unaware if any managers were notified.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/13/24 at 12:17 P.M. with Assistant Director of Health Services (ADHS) #120 revealed Resident 3's allegation came to management's attention on 06/10/24.</p> <p>Interview on 06/13/24 at 1:12 P.M. with the Executive Director verified she was not notified of Resident #3's allegation of sexual abuse until 06/10/24 at which point she initiated an SRI.</p> <p>Review of the facility policy titled Abuse and Neglect procedural guidelines, dated December 2023, revealed any person with knowledge of or suspicion of suspected violations should report immediately without fear of reprisal. The shift supervisor was responsible for initiating or continuing the reporting process. The executive director was to be notified immediately. Alleged violations involving abuse were to be reported immediately but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the state survey agency).</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00154739.</p>