

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 02/25/2025
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure a resident who was dependent on staff for eating received timely meal assistance. This affected one resident (#44) of 10 residents who required assistance at meals. The facility census was 48.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including dementia, osteoporosis, contracture of left hand, and muscle weakness.</p> <p>Review of Resident #44's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had severely impaired cognition. She was dependent on staff for eating</p> <p>Review of Resident #44's diet order dated 12/18/24 revealed an order for a puree diet.</p> <p>Review of Resident #44's profile care guide last updated 01/31/25 revealed she required physical assistance with eating.</p> <p>Observation on 02/26/25 at 8:01 A.M. revealed Resident #44 sitting in the dining room with a plate in front of her, she was not eating. At that time, only one staff member was present in the dining room. Certified Nursing Assistant (CNA) #185 was assisting three residents at another table who needed fed.</p> <p>Observation on 02/26/25 at 8:13 A.M. revealed another resident was added to the table of three residents who needed fed, there was still only one staff member. Between 8:15 A.M. and 8:27 A.M. additional staff entered the dining room to assist residents. No staff assisted Resident #44 with her meal that was sitting in front of her during this observation from 8:15 A.M. to 8:27 A.M.</p> <p>Observation and interview on 02/26/25 at 8:27 A.M. revealed Resident #44 was still sitting in the dining room with a plate in front of her, and it was untouched. At that time, CNA #185 approached the resident. CNA #185 stated they had a lot of residents who needed assistance at meals. She verified Resident #44 was dependent on staff for eating, and that her plate had been sitting in front of her for almost thirty minutes.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162840 and Complaint Number OH00161491.</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
---	-------	-----------