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	04/28/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review and interview, the facility failed to ensure resident rooms and equipment were clean and sanitary. This affected one resident (#27) of 19 residents sampled. The census was 44. Findings include: Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including anxiety disorder, depression, malnutrition, and adult failure to thrive. Review of the electronic Physician Orders dated April 2025 revealed Resident #27 received enteral feedings (a method of delivering nutrition directly into the gastrointestinal tract via a tube) daily for 20 hours. The resident also had his gastrostomy tube flushed with water before and after administration of medications and tube feeding residual was also checked twice a day. On 04/24/25 at 3:12 P.M., observation of Resident #27's room revealed a splattered dried yellow substance that was splattered across the walls, the ceiling including his ceiling light and on his personal items sitting on the stand where his television was. The dried yellow substance was also observed splattered across his television screen. Observation of the tube feeding pump pole revealed a dried yellow substance on the pole and the four leg base was also observed with the dried yellow substance. At the time of the observation, interview with Licensed Practical Nurse (LPN) #178 verified the above observation and stated the dried yellow substance was from the resident's tube feeding formula. LPN #178 verified the splattered areas extended across a three to four feet portion of the walls and ceiling but did not know what had caused it. LPN #178 stated she would notify housekeeping and maintenance of the observation. On 04/24/25 at 3:16 P.M., interview with Resident #27 stated when the nurses try to flush or 'unclog' his gastrostomy tube, the formula shoots out of the port and sprays everywhere. On 04/28/25 at 4:58 P.M., observation of Resident #27's room revealed the tube feeding pump pole, walls, ceiling and television screen was still splattered with dried tube feeding formula. At the time of the observation, interview with Regional Therapy Director #334 verified the observation and stated she would notify management.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and interview, the facility failed to ensure one resident's (#12) Minimum Data Set (MDS) assessments was coded accurately in the area of oxygen. This affected one resident (#12) of 16 sampled residents. The facility census was 44. Findings Include: 1. Review of the medical record for Resident #12 revealed an initial admitted [DATE] with the last readmission of 02/07/25 with the diagnoses including but not limited to metabolic encephalopathy, pneumonitis due to inhalation of food and vomit, cerebrovascular accident with right sided hemiplegia, epilepsy, diabetes mellitus, dysphagia, anemia, age related physical debility, obesity, hypoxemia, sepsis, severe protein calorie malnutrition, hypertension, hyperlipidemia, altered mental status and acute respiratory failure with hypoxia. Review of the resident's plan of care revealed no care plan addressing the resident's oxygen use. Review of the resident's monthly physician orders for April 2025 identified ordered dated 02/12/25 oxygen two liters per nasal cannula continuously, and 04/21/25 change oxygen tubing monthly on the first of the month. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was not utilizing oxygen. Review of the resident's April 2025 Treatment Administration Record (TAR) revealed the resident utilized oxygen at two liters per nasal cannula. On 04/22/25 at 9:57 A.M., observation of the resident revealed she had oxygen in place at two liters per nasal cannula. On 04/24/25 at 10:22 A.M., an interview with Registered Nurse (RN) #255 confirmed the MDS was not coded accurately to reflect the resident's use of oxygen.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure an admission PASRR screen was completed accurately to reflect all known mental illness diagnoses. This affected one (Resident #26) of one residents reviewed for PASRR. The facility census was 44. Findings include: Review of Resident #26's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included an unspecified (affective) mood disorder and anxiety disorder. Review of Resident #26's PASRR identification screen dated 08/24/24 revealed the resident was being screened for a preadmission screening (PAS) for an admission from the community. Section (E.) of the PAS was to include all known diagnoses of any of the mental disorders listed in that section. Mental disorders in that section included mood disorder and panic or other severe anxiety disorder among the seven that were listed. The PAS did not have mood disorder or a severe anxiety disorder marked despite the resident admitting to the facility with those diagnoses. Review of Resident #26's PASRR result notice dated 08/24/24 revealed, as a result of the PAS that had been completed on 08/24/24, the resident did not have any indications of a serious mental illness and did not require a referral for a Level II evaluation to determine if he needed any specialized services to address any mental illness diagnoses. On 04/24/25 at 9:16 A.M., an interview with Social Service Director (SSD) #148 revealed she was not the facility's social service director at the time Resident #26's PASRR was completed upon his admission to the facility on [DATE]. She reported she did not take over that position until January 2025. She acknowledged Resident #26's PASRR completed on 08/24/24 was not accurate as it did not reflect his known mental illness diagnoses of an affective mood disorder or anxiety.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, interview and facility policy review, the facility failed to develop a comprehensive plan of care to address resident needs and conditions as required. This affected four (#1, #12, #27, #37) of 16 residents. The facility census was 44. Findings Include: 1. Review of the medical record for Resident #12 revealed an initial admitted [DATE] with the last readmission of 02/07/25 with the diagnoses including but not limited to metabolic encephalopathy, pneumonitis due to inhalation of food and vomit, cerebrovascular accident with right sided hemiplegia, epilepsy, diabetes mellitus, dysphagia, anemia, age related physical debility, obesity, hypoxemia, sepsis, severe protein calorie malnutrition, hypertension, hyperlipidemia, altered mental status and acute respiratory failure with hypoxia. Review of the resident's plan of care revealed no care plan addressing the resident's oxygen use. Review of the resident's monthly physician orders for April 2025 identified ordered dated 02/12/25 oxygen two liters per nasal cannula continuously, and 04/21/25 change oxygen tubing monthly on the first of the month. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was not utilizing oxygen. Review of the resident's April 2025 Treatment Administration Record (TAR) revealed the resident utilized oxygen at two liters per nasal cannula. On 04/22/25 at 9:57 A.M., observation of the resident revealed she had oxygen in place at two liters per nasal cannula. On 04/24/25 at 10:22 A.M., an interview with Registered Nurse (RN) #255 confirmed the resident had no care plan addressing the resident's use of oxygen. 2. Review of the medical record for Resident #37 revealed an initial admitted [DATE] with the diagnoses including but not limited to metabolic encephalopathy, acute respiratory failure with hypoxia, cerebral infarct, atherosclerotic heart disease, obesity, obstructive and reflux uropathy, retention of urine, diabetes mellitus, obstructive sleep apnea, hypertension, low back pain, benign prostatic hyperplasia, pulmonary embolism, contusion of spleen and encounter for surgical aftercare. Review of the resident's monthly physician orders for April 2025 identified orders dated 02/09/25 change oxygen tubing monthly on the first day of the month, clean external concentrator filter every two weeks, oxygen at six liters per nasal cannula continuously every shift and monitor oxygen saturation rates every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident had not received oxygen therapy. Review of the resident's February 2025 Treatment Administration Record (TAR) revealed the resident utilized oxygen at six liters per nasal cannula. On 04/21/25 at 2:26 P.M., observation of the resident revealed he was quiet at bedrest with eyes closed with a non-invasive ventilation device (Bi-pap) with oxygen in place. On 04/24/25 at 10:22 A.M., an interview with RN #255 confirmed the resident had no care plan addressing the resident's use of oxygen. 28704 3. Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including constipation, history of fecal impaction, anemia, contractures and cerebellar stroke. Review of the electronic Physician Order Sheet dated April 2025 revealed the resident was ordered medications for constipation and anemia included the following: senna-S (laxative) 8.6-50 milligrams (mg) twice a day, miralax (laxative) 17 grams daily as needed and ferrous sulfate 300 (mg) twice a day. Review of the Medication Administration Record dated April 2025 revealed Resident #27 received senna-S and ferrous sulfate as ordered. Review of the record revealed no evidence of a care plan for constipation or anemia for Resident #27. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #27 had functional limitations of upper and lower extremities on one side. Review of the Occupational Therapy Evaluation & Plan of Treatment dated 04/21/25 through 05/20/25 revealed diagnoses included contractures of muscle, right and left hand since 12/14/21. On 04/23/25 at 3:41 P.M., interview with Resident #27 revealed he was dependent on staff for all care due to his hands/fingers and right elbow were unable to bend and were stiff. Resident #27 was observed to be unable to bend his fingers or [NAME] a fist with either hand, was unable to extend his right arm much farther than 90 degrees and was unable to raise his right arm above his shoulder. Review of the medical record revealed no care plan to address Resident #27's functional limitations of the upper extremities or identified elbow/hand contractures. On 04/28/25 at 12:01 P.M., interview with Regional MDS Coordinator #331 verified there were no care plans developed to address anemia, constipation, upper functional limits or contractures for Resident #27. 28923 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, schizo-affective disorder, obsessive-compulsive disorder, generalized anxiety disorder, major depressive disorder, and obstructive sleep apnea. Review of Resident #1's physician's orders revealed she had an order to receive Melatonin 2 milligrams (mg) by mouth every night at bedtime related to insomnia. The order had been in place since 01/31/22. Review of Resident #1's active care plans revealed the resident did not have a care plan in place to address insomnia or the use of Melatonin as a sleep aid. Findings were verified by RN #255. On 04/28/25 at 11:40 A.M., an interview with RN #255 revealed she was the staff member that was responsible for completing the resident's comprehensive care plans. She acknowledged Resident #1 did not have a care plan in place to address her diagnosis of insomnia, or the use of Melatonin on a nightly basis as a sleep aid, since 01/31/22. Review of the facility policy titled, Comprehensive Care Plan Guideline, dated 05/22/18 revealed the 48 hour baseline care plan will be completed within 48 hours of admission and will be the temporary working care plan until the comprehensive care plan is completed. A comprehensive care plan will be developed with in seven days of completion of the admission comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 28704 Based on observation, medical record review and interview, the facility failed to ensure comprehensive care plans were revised and accurately reflected the residents' status. This affected two residents (#27 and #34) of 19 sampled reviewed for care plans. The census was 44. Findings include: 1. Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including constipation, history of fecal impaction, anemia, contractures and cerebellar stroke. Review of the electronic Medication Administration Record dated April 2025 revealed Resident #27 received the following medications for pain: Tylenol 500 milligrams (mg) twice a day, biofreeze 4 % twice a day, gabapentin 100 (mg) at bedtime and tramadol 50 (mg) three times a day for moderate to severe pain. Review of the medical record revealed as of 04/28/25 revealed no evidence the resident had a pressure injury. Review of the care plan: At Risk for Pain dated 01/17/22 revealed problem areas included a pressure injury, gastroesophageal reflux disease and impaired mobility with interventions including to administer medications as ordered and attempt non-pharmacological interventions, notify the physician of increased pain and observe/record verbal/nonverbal symptoms of pain. Further revealed revealed no individualized non-pharmacological interventions for pain. On 04/28/25 at 12:02 P.M., interview with Regional MDS Coordinator #331 verified the resident's care plan did not have individualized, non-pharmacological interventions to relieve pain, and there was no evidence the resident had a pressure injury. 2. Medical record review revealed Resident #34 was admitted on [DATE] with diagnoses including dysphagia, diabetes mellitus and metabolic encephalopathy. Review of the admission Minimum Data Set 3.0 (MDS) assessment revealed Resident #34 was cognitively intact and was edentulous. Review of Resident #34's Dental Consult dated 12/12/24 revealed the resident was edentulous, wears full upper denture well and had lost full lower denture and would like to get a new one made. Review of the quarterly MDS assessment dated [DATE] revealed Resident #34 had no broken or loosely fitting full or partial denture no pain. Review of the Dental Consult dated 04/08/25 revealed Resident #34 presented for try-in of lower complete denture. Patient accepts both speech and aesthetics. Next visit plan to deliver completed lower denture. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plans dated 10/11/24 revealed Resident #34 had the potential for mouth pain related to being edentulous with the use of top dentures. Further review of the record revealed no evidence the resident had been in the process of getting new lower dentures. On 04/21/25 at 1:08 P.M., interview and observation of Resident #34 revealed she had been waiting on a new pair of lower dentures after her granddaughter had accidentally thrown them away. Resident #34 stated it had been about six months waiting on the lower dentures. On 04/23/25 at 5:16 P.M., interview with Regional Nurse #332 verified there was no evidence of a dental care plan except potential for pain and it had not been revised to reflect her lower dentures had been lost and was in the process of replacement.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, interview and facility policy review, the facility failed to ensure routine nail care, and/or showers were provided for Resident #27, #29 and #32. This affected three residents (#27, #29 and #32) of six residents reviewed for activities of daily living (ADL). The facility census was 44. Findings Include: 1. Review of the medical record for Resident #29 revealed an initial admitted [DATE] with the diagnoses including but not limited to dysphagia, aphasia, dysarthria, atrial septal defect, asthma, atrial fibrillation, hypertensive urgency, hypertensive heart disease with heart failure, obesity, heart failure and hyperlipidemia. Review of the plan of care dated 04/05/22 revealed the resident requires staff assistance to complete ADL tasks completely and safely. Interventions included bed against the wall per resident request to increase space in room for mobility and ADL functions and safety, left side grab/enabler bars for increased mobility, allow resident sufficient time to complete all or parts of task, do not rush resident, encourage resident to do as much as safely possible for self, observe for deterioration in ADL abilities and report if occurs, provide adequate resident periods between activities, therapy evaluation and treat as needed and ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the facility's shower schedule revealed the resident was scheduled showers every Monday and Thursday. Review of the resident's February 2025 shower documentation revealed the resident had eight opportunities to receive a scheduled shower for the month of February 2025. Further review of the shower documentation revealed the resident was not provided a shower on 02/03/25, 02/06/25, 02/17/25, 02/24/25 and 02/27/25. Review of the resident's March 2025 shower documentation revealed the resident had nine opportunities to receive a scheduled shower for the month of March 2025. Further review of the shower documentation revealed the resident was not provided a shower on 03/20/25 and 03/31/25. Review of the resident's April 2025 shower documentation revealed the resident had seven opportunities to receive a scheduled shower for the month of April 2025. Further review of the shower documentation revealed the resident was not provided a shower on 04/14/25, 04/17/25 and 04/24/25. On 04/24/25 at 11:22 A.M., an interview with the Regional MDS Coordinator #331 confirmed showers were not provided as scheduled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 12/06/24 with the diagnoses including but not limited to metabolic encephalopathy, urinary tract infection, acute respiratory failure with hypoxia, bibasilar pneumonia, sepsis, myalgia, constipation, dysphagia, adult failure to thrive, duodenitis, diabetes mellitus, Alzheimer's disease, dementia, hypertension, depression, severe protein calorie malnutrition, anemia and hyperlipidemia. Review of the plan of care dated 06/26/24 revealed the resident required staff assistance to complete self-care and mobility functional tasks completely and safely. Interventions included resident requires Hoyer lift and two staff to transfer, allow resident sufficient time to complete all or parts of task, do not rush resident, encourage resident to do as much as safely possible for himself, observe for deterioration in functional abilities and report if occurs, offer facial shaving on shower days and as needed or as requested, provide adequate resident periods between activities, provide nail care on shower days and as needed and therapy evaluation and treat as needed and ordered. Review of the state optional MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident required extensive assistance for bed mobility, was dependent of two staff for transfers and toileting. On 04/23/25 at 2:40 P.M., observation of the resident's nails during the administration of the physician ordered treatment to the resident's pressure ulcer revealed his nails were with a brown substance under them. Licensed Practical Nurse (LPN) #178 verified the resident in need of nail care at the time of the observation. On 04/24/25 at 10:20 A.M., observation of the resident revealed his nails remained long and dirty with a brown substance under the nail. On 04/24/25 at 10:22 A.M., an interview with Registered Nurse (RN) #255 confirmed the resident's nails remained long and dirty with a brown substance under the nail. 28704 3. Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including anxiety disorder, depression, psychotic disorder with delusions, contractures and cerebellar stroke. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact for daily-decision making, was dependent on staff for functional abilities including showering/bathing and had functional limitations of upper and lower extremities. Review of the care plan: ADL revised 03/13/25 revealed the resident required staff assistance completing all ADL tasks completely and safely. Review of the electronic Point of Care History dated January 2025 revealed Resident #27 received one bath, on 01/28/25, during the month of January 2025. Review of the paper Shower Sheet documentation between January 2025 through March 2025 revealed no additional showers were provided for the month of January 2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Orders dated April 2025 and the unit Shower Schedule revealed Resident #27 was scheduled to receive showers on Monday and Thursday nights. On 04/24/25 at 1:11 P.M., interview with the Director of Nursing verified all bath sheets had been provided since January 2025 and there was no additional bath or refusal documentation to provide for Resident #27. Review of the facility policy titled, Guidelines for Bathing Preference, last revised 05/11/15 revealed the resident will be advised of the facility's guidelines for residents to self-determine their plan of care and schedule during their stay in the campus. The resident shall determine their preference for bathing upon admission the day of week, time of day and type of bathing. If the resident is unable to communicate their preferences this information shall be obtained from the resident representative based on known history. Bathing shall occur at least twice a week unless resident preference states otherwise.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to provide activities as needed for two residents (#27 and #42) of two residents reviewed for Activities. The census was 44. Findings include: 1. Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including major depressive disorder, anxiety disorder, contractures and cerebellar stroke. Review of the care plan: Activities dated 11/16/22 revealed it was important to engage in independent activities and meaningful 1:1 opportunities as board games, cards, country and bluegrass music, outdoors and animal related activity. Review of the activity 1:1 assessment dated [DATE] revealed this assessment was to be initiated when the need for 1:1 was identified due to lack of resident engagement. Resident #27's assessment indicated a score of eight which indicated the need of 1:1 activities once a week for 15 minutes. Reviewed of Resident #27's Activity documentation dated 01/01/25 to 04/23/25 revealed the resident was not provided a weekly 1:1 activity between 02/02/25 and 02/25/25. On 04/24/25 at 12:30 P.M., interview with Area Life Enrichment Director (ALED) #204 revealed Resident #27's activities were all electronically documented. ALED #204 stated Resident #27 was assessed to have a 1:1 visit involving meaningful activities at least once a week. ALED #204 verified there was no evidence the resident had received a weekly 1:1 activity between 02/02/25 and 02/25/25. 52020 2. Record review revealed Resident #42 was admitted to the facility on [DATE]. Pertinent diagnoses included: other toxic encephalopathy, unspecified atrial fibrillation, dehydration, strange and inexplicable behavior, generalized anxiety, repeated falls. Review of Resident #42's Minimum Data Set (MDS) assessment, dated 04/03/25, revealed a brief interview for mental status (BIMS) score of 5 out of 15 which signified severe cognitive impairment. Record review of care plan for Resident #42 dated 03/31/25 revealed resident was at risk for limited activity engagement due to physical impairments and that interests included sports, pets and inspirations. Record review revealed progress note dated 04/11/25 noting resident #42 had increased restlessness and anxiety. Physician order on 04/15/25 requested staff document number of times resident yelled out. Observation on 04/21/25 at 12:44 pm of Resident #42 laying in bed with head elevated, yelling out three times a request to go to the dining room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/22/25 at 9:51 A.M. with Resident #42 in her bedroom in which she lamented that she wished she could see more people and do anything to do with sports, especially football and basketball. She said she used to watch sports with her family but they weren't there at the facility with her. Interview on 04/22/25 at 3:25 P.M. with facility Social Worker #148 revealed Resident #42 will want to go to activities but then will quickly want to return to her room. Social worker #148 also revealed family was out of town this week. Observation on 04/23/25 3:08 P.M. of Resident #42 sitting in wheelchair in common area with staff looking at word search with her. Observation on 04/24/25 at 9:09 A.M. resident #42 was sitting in dining room in wheelchair, stating loudly that she needed to go to bedroom right now. The administrator wheeled her to her room. Observation on 04/24/25 at 09:31 A.M. of resident #42 back in dining room. Observation on 04/24/25 at 9:56 A.M. of resident #42 in dining room requesting to return to her room. Observation on 04/24/25 at 9:57 A.M. of resident yelling out from her room that she needed to go to the toilet now repeated eight times and for staff to hurry up. (Staff was donning personal protective equipment in hallway). Interview on 04/24/25 at 10:05 A.M. with Life Enrichment Director #204 revealed an awareness that resident liked sports and that she had a future plan for outing with local basketball team in two months. Record review of Resident #42 Activity department 1:1 need assessment dated [DATE] and log of activities attended by Resident #42 for the month of April revealed resident was assessed to not need one to one attention because she was noted to have attended four activities in the week prior. However, review of activity log for Resident #42 for first ten days of April 2025 noted the resident's only group activity was on 04/02/25 and the other activities for the first ten days were that a newsletter was delivered to resident's room and the resident watched television in their room. Interview on 04/24/25 at 1:25 P.M. with Life Enrichment Director #204 verified Resident #42 did not have four group activities in the week prior to the need assessment as stated on the assessment form. She noted resident did often require 1:1 attention which was not reflected in the assessment as it was scored. She said resident does not need to participate in activities if family is present with resident though noted family had not been present with resident the previous week.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, interviews and facility policy review, the facility failed to ensure two resident's (#12 and #147) pressure ulcers were comprehensively assessed on admission and weekly thereafter. Additionally, the facility failed to implement interventions to prevent the development of a pressure ulcer for one resident (#42). This affected three residents (#12, #42 and #147) of six residents reviewed for pressure ulcers. The facility census was 44. Findings Include: 1. Review of the medical record for Resident #147 revealed an initial admitted [DATE] with spinal stenosis lumbosacral region, encounter for orthopedic aftercare, cerebral infarction, diabetes mellitus with diabetic neuropathy, hypertension, retention of urine, anemia and vitamin D deficiency. Review of the wound care initial consult from the hospital summary dated 04/02/25 revealed the resident was found to have a pressure injury to the sacrum. The resident had discolored deeper darker purplish periwound on each side of sacrum and scattered areas of purple noted upper buttock area especially on the left side more than right that not blanch. The wound to the left side of the sacrococcygeal area measured 5.0 centimeters (cm) by 5.0 cm by 0.1 cm and the right side to the sacrococcygeal area measured 4.0 cm by 3.0 cm by 0.1 cm. The wound was described as mostly pink superficial with a deeper discolored red on the inner areas of left buttock. These are combination of pressure (stage 2), moisture associated skin damage (MASD), and shear force mixed etiology. The wound summary assessment was stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister) pressure injury to bilateral sacrococcygeal area with shear force involved. The treatment implemented was to apply Venelex to sacrum areas that are open red and purple do not use foam since area's are scattered and will need full coverage of ointment twice daily and as needed, keep offloading as much as possible and have staff help move her side to side. Review of the resident's hospital discharge orders dated 04/11/25 revealed wound care instructions as follows apply Venelex thin amount to sacrum areas that are open red/pink and cover with a foam dressing daily, turn and reposition every two hours, elevate heels around the clock and Venelex to heels twice daily. Review of the resident's admission assessment dated [DATE] revealed the resident had a skin impairment. Review of the Braden scale contained within the assessment revealed a score of nine indicating the resident was at very high risk for skin breakdown. Review of the occurrence progress note dated 04/11/25 at 6:23 P.M. revealed the resident was admitted with a pressure ulcer measuring 2.3 cm by 2.2 cm by 1.0 and was present on admission. The location of the pressure ulcer was documented on the buttocks, however the entry did not specify which buttocks the pressure ulcer was located on. Additionally, the pressure ulcer was not staged. Review of the progress note dated 04/11/25 at 7:33 P.M. revealed the resident had two open areas on her buttocks. The entry documented the wound was covered with a foam dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 04/14/25 revealed the resident was at risk for skin breakdown related to reduced mobility and recent surgery. Interventions included avoid shearing skin during positioning, turning, and transferring, conduct weekly skin assessment, pay particular attention to bony prominence's, encourage and assist to turn and reposition for comfort and as needed, float heels as needed and tolerated, keep linens clean and dry, keep resident as clean and dry as possible, minimize skin exposure to moisture, observe feet during care for redness, swelling, or changes in condition, notify physician as needed, pressure reducing cushion to chair, pressure reducing mattress to bed, treatments/preventative treatments as or when ordered, use lifting device as needed for bed mobility and use moisture barrier product to perineal area as needed. Review of the wound observation history dated created on 04/16/25 at 10:46 A.M. for 04/11/25 at 10:45 A.M. revealed the resident was admitted to the facility with a pressure ulcer to the left buttocks measuring 2.3 cm by 2.2 cm by 1.0 cm. The progress note contained no staging, description of the wound or presence of exudate. Further review of the wound observation revealed on 04/23/25 at 12:15 P.M. the wound measurements for the 04/11/25 admission wound observation was changed to 5.0 cm by 4.5 cm by 0.1 cm with the explanation was updated admission measurements. Review of the wound observation history created on 04/16/25 at 10:46 A.M. for 04/11/25 at 10:51 A.M. revealed the resident was admitted to the facility with a pressure ulcer to the right buttocks measuring 4.0 centimeters (cm) by 3.0 cm by 0.1 cm. The progress note contained no staging, description of the wound or presence of exudate. Further review of the wound observation revealed on 04/23/25 at 12:25 P.M. the wound measurements for the 04/11/25 admission wound observation was changed to 4.0 cm by 3.0 cm by 0. 1 cm with the explanation was updated admission measurements. Review of the wound observation dated 04/16/25 at 11:29 A.M. revealed the pressure ulcer to the left buttocks measured 4.4 cm by 3.2 cm by 0.1 cm with the wound bed being described as granulation tissue. The wound had a light amount of serosanguineous exudate. The facility failed to determine of the wound had improved, deteriorated or remained unchanged or staging of the pressure ulcer. Review of the wound observation dated 04/16/25 at 11:27 A.M. revealed the pressure ulcer to the right buttocks measured 4.0 cm by 3.0 cm by 0.1 cm with the wound being described as granulation tissue. The wound had a light amount of serosanguineous exudate. The facility failed to determine of the wound had improved, deteriorated or remained unchanged or staging of the pressure ulcer. Review of the resident's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident was dependent on staff for toileting, transfers and substantial/moderate assistance with bed mobility. The assessment indicated the resident had an indwelling urinary catheter and was always incontinent of bowel. The assessment indicated the resident was at risk for skin breakdown and had two stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). The facility implemented the interventions pressure reducing device to bed/chair, pressure ulcer/injury care, surgical wound care and applications of ointments/medications other than to feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 04/21/25 revealed the resident had pressure ulcers to her right and left buttocks, surgical incisions to neck, mid upper back, mid lower back, right lower back and left lower back. Interventions included administer analgesics per MD order, encourage fluids unless contraindicated, low air loss mattress, observe and report the condition of skin surrounding the pressure ulcer, observe and report signs of infection (e.g., localized pain, redness, swelling, tenderness, drainage, odor, and fever), observe for and report signs of pain related to pressure ulcer, obtain dietary consult, pressure reducing cushion to chair, provide diet, supplements, vitamins and minerals as ordered, treatment per MD order. Notify MD if treatment is not effective and weekly skin assessment, measurement, and observation of the pressure ulcer and record. Review of the wound observation dated 04/22/25 at 8:23 P.M. revealed the pressure ulcer to the left buttocks measured 4.4 cm by 3.2 cm with a description of closed/resurfaced. Additionally the pressure ulcer remained without staging. The facility failed to determine of the wound had improved, deteriorated or remained unchanged. Review of the wound observation dated 04/23/25 at 8:22 P.M. revealed the pressure ulcer measured 3.0 cm by 3.0 cm by 0.1 cm with the wound being described as granulation tissue. The wound had a light amount of serosanguineous exudate. Additionally the pressure ulcer remained without staging. The facility failed to determine of the wound had improved, deteriorated or remained unchanged. Review of the wound observation dated 04/24/25 at 5:58 P.M. revealed the wound was a stage III pressure ulcer measuring 4.1 cm by 3.0 cm by 0.1 cm with the wound being described as granulation tissue. The wound edges were described as being macerated/soft. Further review revealed on 04/25/25 at 12:58 P.M. the assessment was edited to the wound bed being slough. The assessment did not indicated how much of the wound bed tissue was slough. Review of the resident's April 2025 monthly physician orders identified orders dated 04/13/25 Venelex ointment with the special instructions to apply thin/small amount to sacrum areas that are open, red or pink and cover with foam dressing daily, Venelex ointment with the special instructions to apply a thin/small amount to bilateral heels twice daily, 04/16/25 low air loss mattress and 04/23/25 cleanse bilateral buttocks with normal saline (NS), apply thin layer of Venelex ointment to open areas, apply skin prep to peri-wound and cover with foam border dressing daily. Review of the resident's April 2025 Medication Administration Record (MAR) revealed the treatment of Venelex ointment with the special instructions to apply thin/small amount to sacrum areas that are open, red or pink and cover with foam dressing daily was not implemented until 04/13/25. On 04/23/25 and 04/24/25 an attempt was made to observe the physician ordered dressing change to the stage III pressure ulcer with the resident refusing the treatment. On 04/23/25 at 10:43 A.M., interview with Regional Nurse #332 confirmed she was aware the resident's wounds were not staged. She said the wound nurse had only been in the position for the past three months and she didn't feel comfortable for the nurse doing the staging. She said with granulation tissue it would be a stage III pressure ulcer. The Regional nurse revealed the hospital documentation had the wound at a stage III. The Regional Nurse reviewed the 04/02/25 wound consult report with the surveyor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/28/25 at 10:53 A.M., interview with the Assistant Director of Health Services (ADHS) revealed she documented the measurements from a shower sheet she completed when the resident admitted to the facility on [DATE] for the 04/11/25 assessment. She verified there was no documentation of the right and left wounds until she placed the assessment in on 04/16/25. The ADHS confirmed only one wound was assessed and documented on admission. On 04/28/25 at 11:34 A.M., interview with ADHS confirmed cleansing the wound with NS and applying a foam dressing to the wound was not an appropriate treatment for a Stage III pressure ulcer. 2. Review of the medical record for Resident #12 revealed an initial admitted [DATE] with the last readmission of 02/07/25 with the diagnoses including but not limited to metabolic encephalopathy, pneumonitis due to inhalation of food and vomit, cerebrovascular accident with right sided hemiplegia, epilepsy, diabetes mellitus, dysphagia, anemia, age related physical debility, obesity, hypoxemia, sepsis, severe protein calorie malnutrition, hypertension, hyperlipidemia, altered mental status and acute respiratory failure with hypoxia. Review of the resident's admission assessment dated [DATE] revealed the resident was admitted to the facility with skin impairment. Review of the Braden scale contained in the admission assessment revealed a score of 13 indicating the resident was at moderate risk for skin breakdown. Review of the progress note dated 12/18/24 at 8:34 P.M. revealed the resident was admitted with some redness around the groin area, abrasion to right buttocks and bruises to left upper extremity. Review of the medical record revealed no assessment of the abrasion to the right buttocks. Review of the resident's readmission assessment dated [DATE] revealed the resident had no skin impairment on readmission. Review of the Braden scale contained in the admission assessment revealed a score of 13 indicating the resident was at moderate risk for skin breakdown. Review of the occurrence progress note dated 01/07/25 at 4:27 P.M. revealed the resident was readmitted to the facility with moisture associated skin damage (MASD) to buttocks. Further review revealed no documentation to which buttocks the MASD was on, measurements or description of the wound. Review of the resident's weekly wound observation dated 01/09/25 revealed the resident was readmitted to the facility with MASD to the right and left buttocks measuring 14.0 centimeters (cm) by 7.0 cm by 0.1 cm. The wound observation had no description of the wound. Review of the progress note dated 01/07/25 at 7:35 P.M. revealed the resident was readmitted to the facility with a medium size MASD measuring 14.0 centimeters (cm) by 7.0 cm on buttocks. Review of the weekly wound observation dated 01/15/25 revealed the MASD to the right and left buttocks measured 6.2 cm by 13.3 cm by 0.1 cm. The wound observation had no description of the wound. Review of the readmission assessment dated [DATE] revealed the resident was readmitted to the facility with skin impairment. Review of the Braden scale contained in the assessment revealed a score of 12 indicating the resident was at high risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 02/01/25 at 4:20 P.M. revealed the resident was readmitted to the facility from an acute care hospital. The entry documented the wound on the residents buttocks remain. Further review of the progress note revealed no location or comprehensive assessment of the wound. Review of the weekly wound observation dated 02/05/25 and effective for 02/01/25 at 12:44 P.M. revealed the resident was readmitted to facility with a pressure ulcer. Further review revealed the wound measured 7. 5 cm by 11.5 cm by 0.1 cm with the wound being described as slough with a moderate amount of serous exudate. Further review of the form revealed the pressure ulcer was not staged. Review of the plan of care dated 02/05/25 revealed the resident was at risk for skin breakdown and pressure ulcer development related to reduced intake, weakness, decreased mobility, requiring assist with her bed mobility, having episodes of bowel and bladder incontinence, and having a pressure ulcer to her sacrum. Interventions included air mattress to bed, avoid shearing skin during positioning, transferring, and turning, conduct a weekly skin inspection as needed, pay particular attention to the bony prominence's, encourage and assist to turn and reposition as needed to relieve pressure, encourage fluids unless contraindicated, if incontinence occurs, provide incontinence care after each incontinent episode. Avoid hot water, and use a mild cleansing agent that minimizes irritation and dryness of the skin; avoid friction to skin, keep clean and dry as possible. Minimize skin exposure to moisture, keep linens clean and dry, observe feet during care for redness, swelling, or changes in condition; notify MD as needed, report any signs of skin breakdown, treatments/Preventative treatments as/when ordered, use lifting device as needed for bed mobility and use moisture barrier product to perineal area as needed. Review of the readmission assessment dated [DATE] revealed the resident was readmitted to the facility with skin impairment. Review of the Braden scale contained in the assessment revealed a score of 14 indicating the resident was at moderate risk for skin breakdown. Review of the progress noted dated 02/07/25 at 5:06 P.M. revealed the resident was readmitted to the facility and a wound was found to the resident's buttocks area. Review of the occurrence progress note dated 02/07/25 at 5:47 P.M. revealed the resident was readmitted to the facility with an open area. The progress note contained no location, measurements, type of open area or assessment of the wound. Review of the wound assessment dated [DATE] at 12:21 P.M. and effective for 02/01/25 at 12:46 P.M. revealed the wound measured 7.5 cm by 11.5 cm by 0.2 cm with the comments unable to to measure depth in its entirety due to presence of slough covering the wound bed. Review of the wound assessment dated [DATE] at 9:24 A.M. revealed the sacral wound measured 10.4 cm by 9.5 cm by 0.1 cm with the wound being described as being granulation tissue with a 3 cm by 1 cm area of slough. The wound had a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound assessment dated [DATE] at 9:23 A.M. revealed the sacral wound measured 9.5 cm by 9.0 cm by 0.1 cm with the wound being described as being 10% slough with a moderate amount of exudate. Further review revealed the assessment did not describe the other 90% of the wound bed or exudate. The facility determined the treatment was found to be ineffective and a new treatment order was implemented. Review of the wound assessment dated [DATE] at 5:08 P.M. revealed the sacral wound measured 8.6 cm by 7.1 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the plan of care dated 02/26/25 revealed the resident had a pressure ulcer to her sacrum. Interventions included administer analgesics per MD order, encourage fluids unless contraindicated, observe and record the condition of the skin surrounding the pressure ulcer, observe and report signs of infection, obtain a dietary consult, pressure reducing mattress, provide diet, supplements, vitamins and minerals as ordered, treatment per physician order, notify physician if treatment is not effective and weekly skin assessment, measurement, and observation of the pressure ulcer and record. Review of the wound assessment dated [DATE] at 8:57 A.M. revealed the sacral wound measured 8.6 cm by 6.5 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the wound assessment dated [DATE] at 4:11 P.M. revealed the sacral wound measured 8.0 cm by 5.5 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the wound assessment dated [DATE] at 4:11 P.M. revealed the sacral wound measured 8.5 cm by 5.0 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the wound assessment dated [DATE] at 9:44 A.M. revealed the sacral wound measured 7.3 cm by 5.0 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the wound assessment dated [DATE] at 3:25 P.M. revealed the sacral wound measured 7.3 cm by 5.0 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount exudate. The assessment did not contain the type of exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the wound assessment dated [DATE] at 9:41 A.M. revealed the sacral wound measured 4.5 cm by 6.0 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound assessment dated [DATE] at 11:20 A.M. revealed the sacral wound measured 4.4 cm by 6.0 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behavior, including rejection of care. The assessment indicated the resident's vision was adequate and she wore glasses. The assessment indicated the resident was at risk for skin breakdown and had one stage II pressure ulcer that was present on admission. The facility implemented pressure reducing device for bed, pressure ulcer/injury care, application of nonsurgical dressing and applications of ointments/medications. Review of the wound assessment dated [DATE] at 7:32 P.M. revealed the sacral wound measured 4.0 cm by 4.0 cm by 0.1 cm with the wound being described as being granulation tissue with a moderate amount of serosanguineous exudate. The facility failed to determine if the wound had improved, deteriorated or remained unchanged. Review of the wound assessment dated [DATE] at 3:42 P.M. and effective for 04/25/25 at 12:55 P.M. revealed the sacral wound was now classified as a stage III pressure ulcer measuring 1.4 cm by 0.8 cm by 0. 1 cm with the wound being described as granulation tissue with a moderate amount of exudate. The assessment did not contain what type of exudate. The facility failed to determine if the wound had improved, deteriorated or remain unchanged. Review of the resident's monthly physician orders for April 2025 identified ordered dated 01/07/25 apply barrier cream to buttocks area every shift, weekly skin assessment, new treatments and notifications for any new areas noted, encourage resident to float heels while in bed as tolerated, encourage to turn and reposition while in bed, pressure reducing cushion to wheelchair, pressure reducing mattress, 02/01/25 may see as needed audiologist, dentist, podiatrist, psychologies and optometrist, turn patient every two hours, offload heels, use a maximum of two layers of linen between resident and low air loss mattress, no depends, traps moisture and cause further breakdown, 02/10/25 low air loss mattress in place, 02/26/25 cleanse wound to sacrum with normal saline or wound cleanser, pat dry, apply calcium alginate to wound bed, cover with ABD pad, use minimal tape if needed, change daily and as needed and observe sacrum dressing to wound every shift for drainage on dressing and dislodgement every shift. On 04/23/25 and 04/24/25 an attempt was made to observe the physician ordered dressing change to the stage III pressure ulcer with the resident refusing the treatment. On 04/23/25 at 10:43 A.M., interview with Regional Nurse #332 confirmed she was aware the resident's wounds were not staged. She said the wound nurse had only been in the position for the past three months and she didn't feel comfortable for the nurse doing the staging. She said with granulation tissue it would be a stage III pressure ulcer. On 04/28/25 at 11:34 A.M., interview with ADHS confirmed the resident's pressure ulcers were not comprehensively assessed as required. 52020 (continued on next page)

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	366480	A. Building B. Wing	04/28/2025

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review revealed Resident #42 was admitted to the facility on [DATE]. Pertinent diagnoses included: other toxic encephalopathy, unspecified atrial fibrillation, dehydration, strange and inexplicable behavior, generalized anxiety, repeated falls. Review of wound care consult for Resident #42 dated 03/22/25 (prior to resident's admission to facility) which had pressure reducing recommendations for frequent turning and minimizing elevation of head of bed. Review of care plan for Resident #42 revealed a 03/28/25 goal of skin integrity and suggestion that resident be turned and repositioned for comfort. Review of physician orders revealed order dated 03/31/25 for pressure reducing cushion for wheelchair with frequency of three times a day. Review of Resident #42's Minimum Data Set (MDS) assessment, dated 04/03/25, revealed severe cognitive impairment and required substantial/maximum assistance for toileting hygiene, showering, lower body dressing, putting on footwear and personal hygiene. Resident #42 was assessed to need supervision or touching to roll left/right, sit to lying, lying to sitting. Further review, revealed resident was at risk for developing pressure ulcers and that resident did not have any pressure ulcers at that time. Record review revealed new physician order dated 04/24/25 for staff to offer resident to be turned and repositioned every 2 hours beginning 04/24/25 at 2:00 P.M. Record review revealed a Pressure Ulcer Documentation Report dated 04/09/25 indicated a new pressure ulcer identified on coccyx for Resident #42. Noncompliance was not noted to be an issue. There were no new interventions recommended in the document. The pressure ulcer was added to care plan on 04/21/25. Record review of pressure ulcer skin logs for Resident #42 dated 04/08/25, 04/15/25 and 04/22/25 revealed no documentation of staging of the wound and no pain assessment. Review of physician order dated 04/21/25 for resident to have low air loss mattress with air pressure to be checked once a day. Observation on 04/21/25 at 4:27 P.M. of Resident #42 laying in bed on her back with head of bed elevated approximately 60 degrees yelling out, I'm not comfortable. Observation on 04/22/25 at 4:11 P.M. of Resident #42 yelling out for somebody to help her and that she was not comfortable in bed. The head of the bed was elevated approximately 60 degrees. She yelled out that she needed to relieve the pressure. Interview on 4/23/25 at 5:17 P.M. with Licensed Practical Nurse (LPN) #178 who said she would need to review chart regarding Resident #42 before she could speak on why resident developed pressure ulcer after arriving at the facility. Observation on 04/24/25 at 07:50 A.M. of Resident #42 sleeping in bed with head elevated approximately 45 degrees. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/24/25 at 09:57 A.M. of Resident #42 yelling out from room that she needed to go to toilet. Interview on 04/24/25 at 10:57 A.M. with regional clinical support RN #332 who revealed the nurse who initially had documented the wound was new and was uncomfortable with staging. She acknowledged the wound should be staged and documented and the new nurse could have called the physician with a description of the wound to have the wound staged. Observation on 04/28/25 at 8:17 A.M. of Resident #42 sleeping in bed on her back with her head elevated approximately 70 degrees. Observation and interview on 04/28/25 at 10:33 A.M. with Resident #42 who was laying in bed with head elevated approximately 70 degrees working a word search puzzle with television on. Resident denied pain or concerns. When asked what she would do if she needed help she said she would scream bloody murder. Observation on 04/28/25 at 11:28 A.M. of Resident #42 sleeping in bed on back with head elevated approximately 70 degrees. Observation on 04/28/25 at 11:40 A.M. of RN #310 entering room of Resident #42 and resident yelling out that she didn't need to go to restroom. She said that she was alright several times. Interview on 04/28/25 at 11:42 A.M. with RN #310 who stated that resident refuses to be repositioned when she is comfortable. RN #310 said she would document refusal at end of her shift. Interview on 04/28/25 with ADON #124 at 12:24 P.M. revealed the pressure ulcer could have originally developed from resident not being turned. Review of the facility policy titled, Pressure, Stasis, Arterial, Diabetic Wound Guidelines, dated 05/17/17 revealed the purpose of the policy was to provide weekly documentation guidelines of wound measurements and condition. If skin alteration is noted upon admission, the admitting nurse should compete progress note assessment. The IDT should review this timely and wound nurse or designee compete an assessment in wound management or wound zoom. Document description of wound using length, width, depth, exudates, color, odor, wound margins, surrounding tissue and tunneling and/or undermining if applicable. Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed in progress notes and wound management or with a follow up encounter weekly in wound zoom.

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, and interview, the facility failed to timely develop and implement comprehensive and individualized interventions to address limitation in range of motion and/or prevent the onset of joint contractures (chronic loss of joint mobility) for Resident #27 and #32. Actual harm occurred beginning on 08/29/24 when the facility failed to implement services to address limitations in functional ability for Resident #32, who was cognitively impaired and dependent on staff for activity of daily living care to prevent additional deterioration and/or to prevent pain (as evidenced during observation on 04/24/25) following the resident's discharge from therapy services. The resident's plan of care failed to address range of motion limitations identified by occupational therapy (OT), risk for development/deterioration of contractures and/or an individualized range of motion program for the resident's limitations in range of motion. This affected two residents (#27 and #32) of two residents reviewed for range of motion (ROM). The facility census was 44. Findings Include: 1. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 12/06/24 with diagnoses including history of cerebrovascular accident (CVA) with residual deficits including dysphagia and hemiplegia, metabolic encephalopathy, urinary tract infection, acute respiratory failure with hypoxia, bibasilar pneumonia, sepsis, myalgia, constipation, dysphagia, adult failure to thrive, duodenitis, diabetes mellitus, Alzheimer's disease, dementia, hypertension, depression, severe protein calorie malnutrition, anemia and hyperlipidemia. Review of the resident's admission assessment dated [DATE] documented the resident had no contractures upon admission to the facility. Review of the resident's Occupational Therapy (OT) evaluation dated 06/10/24 revealed Resident #32's range of motion to his left wrist had 20-degree flexion and 40-degree extension on admission to the facility. The assessment indicated the resident had no functional limitations due to contractures as of this time. Review of the plan of care for Resident #32 revealed the plan of care did not include the resident's range of motion limitations identified by OT, risk for development of contractures and/or an individualized range of motion program for the resident's limitations in range of motion. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was dependent on staff for activities of daily living and had moderate cognitive deficit. The MDS assessment identified no functional limitations in range of motion. Review of the OT discharge summary dated 06/27/24 revealed OT services were discontinued due to the resident being discharged to the hospital. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the OT evaluation and Plan of Treatment dated 07/07/24 revealed the resident's left wrist had functional limitations at 20-degree flexion and 40- degree extension on re-admission to the facility. However, the assessment indicated the resident had no functional limitations due to contractures. Review of the OT discharge summary dated 07/17/24 revealed OT services were discontinued due to the resident being discharged to the hospital. Review of the OT evaluation and Plan of Treatment dated 07/24/24 revealed the resident's left upper extremity had impaired range of motion to the elbow, wrist, thumb, index finger, middle finger, ring finger and little finger. The resident's range of motion had declined to the resident's left wrist to 40 degrees flexion and zero degrees extension. Review of the resident's five-day MDS assessment dated [DATE] revealed the resident had impaired functional limitations to both upper extremities. Review of the plan of care for Resident #32 revealed the plan of care did not include the resident's range of motion limitations identified by OT, risk for development of contractures and/or an individualized range of motion program for the resident's limitations in range of motion. Review of the venous doppler scan results dated 08/26/24 revealed no evidence of occlusive deep vein thrombosis in the left upper extremity based on available images. Review of Resident #32's OT discharge summary dated 08/29/24 revealed the resident had a noted decline and the resident's left arm was found to be swollen and warm to touch with mild pain. The physician was contacted and a new order for a venous doppler had been obtained. The OT summary indicated discharge recommendations to encourage to be up daily for quality of life, monitor skin due to dependent positioning in bed and positioning for left upper extremity pain. However, a restorative program or maintenance program was not recommended upon discharge. Review of the medical record from 08/29/24 to 04/28/25 revealed no documented evidence the facility implemented comprehensive or individualized interventions, including range of motion to address Resident #32's identified functional limitations with range of motion and/or to prevent further limitations to the resident's left elbow, wrist and fingers. Review of the resident's monthly physician orders for April 2025 revealed an order for a Lidocaine adhesive patch 4% with the special instructions to apply one patch topically in the morning and remove in the evening, however the physician's order did not specify where to apply the patch. On 04/21/25 at 12:07 P.M., an observation of Resident #32 revealed he was in bed with his elbow resting on a large heart shaped pillow at his side. The resident's forearm was observed to be extending up towards the ceiling in a fixed position with the wrist bent at a fixed 90-degree angle without support of a device. The resident's wrist was fixed palm up towards the ceiling with his middle finger, ring finger and little finger curled inward towards the palm of his hand without support of a device. A white Lidocaine patch was observed to his wrist and back of the hand. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/21/25 at 12:07 P.M., an interview with the resident's spouse revealed the resident's arm was fixed in the position with his forearm extending up towards the ceiling in a fixed position with the wrist bent at a fixed 90-degree angle without support of a device. The resident's wrist was fixed palm up towards the ceiling with his middle finger, ring finger and little finger curled inward towards the palm of his hand without support of a device. The resident's spouse revealed she spends eight to 10 hours daily with the resident and does not see the staff provide any range of motion to the resident's left upper extremity, including the shoulder, elbow, wrist and fingers. On 04/24/25 at 10:47 A.M., an interview with Occupational Therapist (OT) #333 revealed she first saw Resident #32 on 06/10/24 and at that time the resident had impairment to both wrists, shoulders and elbows. She said the last time she saw the resident was on 08/29/24. OT #333 revealed she would have to review her notes to see if the resident's level of impairment had changed or to see if he was impaired to the degree displayed currently. On 04/24/25 at 10:58 A.M., observation of the resident's left wrist with OT #333 revealed the resident's wrist was stiff. OT #333 revealed the impairment definitely was not like that in August 2024 when he was released from therapy. OT #333 attempted to try to complete range of motion to the left wrist. The resident was observed moaning out (in pain) when the OT attempted to complete range of motion to the left wrist. On 04/24/25 at 1:29 P.M., an interview with Therapy Director #336 confirmed the resident had not been screened by OT since he was discharged from therapy on 08/27/24 and the director stated the resident would not be screened unless a change had been reported. Therapy Director #333 revealed the functional limitations to the resident's left elbow, left wrist and left fingers had not been reported by the nursing staff. However, based on the onsite investigation and information provided as part of the survey, Resident #32's condition at the time of admission, dependence on staff for care and cognitive limitation placed him at increased risk for a decline in functional mobility, risk for impaired skin integrity and/or increased pain due to contractures warranting a comprehensive and individualized plan of care utilizing an interdisciplinary approach to ensure the resident maintained his highest level of well-being. A physician note, dated 04/27/25 sent as an email revealed Resident #32 was admitted to the facility with multiple comorbid conditions including Alzheimer's Dementia, adult failure to thrive, history of CVA with residual deficits including dysphagia and hemiplegia, chronic debility and ambulatory dysfunction. The note included the resident's functional status on admission was extremely low, requiring total/full care and the resident received enteral (tube) feedings due to chronic dysphagia. The physician included the resident's chronic dementia and significant physical limitations precluded him from being able to participate in or make any functional improvement and he was unable to conceptualize the clinical issues facing him due to his cognitive impairments. Review of this physician note validated the need for timely identification as well as comprehensive, individualized and effective interventions to address the resident's functional limitations. On 04/28/25 at 2:35 P.M. an interview with the Administrator revealed the facility did not have a policy regarding ROM or therapy services. 28704 (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including anxiety disorder, depression, psychotic disorder with delusions, contractures and cerebellar stroke. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 02/03/23 revealed the resident was referred to OT due to a decline in the upper extremity range of motion (ROM) and need for contracture prevention. The resident's bilateral upper extremity ROM was impaired with functional limitations present due to contracture and declining in independence with hygiene ADL's. OT to address contracture impairment and further assess and order/fabricate an orthotic device. The focus of plan of treatment was restoration, compensation and adaptation. Review of the OT Discharge Summary dated 02/15/23 revealed the resident was discharged to the hospital. Review of the medical record revealed no evidence the resident was screened or evaluated by therapy services, received ROM services or other services/devices to prevent a potential decline in contractures between 02/15/23 (after being discharged from therapy due to a hospitalization) and 04/21/25. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact for daily decision making, was dependent on staff for functional abilities including showering/bathing, had one side functional limitations of the upper and lower extremities and was not receiving any specialized therapies or restorative nursing programs. Review of the OT Evaluation and Plan of Treatment dated 04/21/25 revealed the resident was referred to OT due to the resident having received a new power wheelchair that he wanted to use within the facility which prompted the evaluation. The last time the resident was receiving therapy was in February 2023. Review of the medical record revealed no interventions, range of motion programs or care plan to address Resident #27's upper extremity contractures or functional limitations. On 04/23/25 at 2:25 P.M., an interview with Licensed Practical Nurse (LPN) #250 revealed she was Resident #27's nurse and verified the resident had contractures of his hands and right elbow. LPN #250 stated the resident does not wear any splints and nursing does not provide any interventions that she was aware of for his upper extremities. LPN #250 stated she would have to ask therapy if he was receiving therapy services. LPN #250 stated the resident does wear specialty boots on both his feet for foot drop but that was all she was aware of. On 04/23/25 at 3:41 P.M., an interview with Resident #27 revealed he was dependent on staff for all care due to his hands/fingers and right elbow being unable to bend and being stiff. Resident #27 was observed to be unable to bend his fingers or [NAME] a fist with either hand, was unable to extend his right arm much farther than 90 degrees and was unable to raise his right arm above his shoulder. On 04/24/25 at 4:00 P.M., an interview with OT #333 revealed the resident would have to have the joystick moved to the other side of the power wheelchair due to his hand contracture. OT #333 stated the resident had not complained or requested therapy services until now, if he had reported changes in ROM, they would have screened/evaluated him to see if therapy services were needed. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the OT Treatment Encounter Note dated 04/28/25 revealed the resident stated he did not think there was anything they could do for his upper extremity limitation, he tried on own but could only go so far. The note indicated Resident #27 did not identify new limitations, problems or worsening limitations that OT should know about. The resident stated he did not think his elbow had gotten worse, but he could not straighten it and hadn't been able to for two to three years. Resident #27 was missing 65 degrees from full extension and had no digit flexion. The resident's left elbow was lacking 32 degrees extension but was functional. Barriers included limited movements of upper/lower extremities and pain. At the end of the session the resident asked if there was anything that could be done for his fingers as he could bend the right fingers at all and could only do partial grip/digit flexion with left hand. On 04/28/25 at 8:47 A.M., an interview with Physical Therapy Assistant (PTA) #336 verified there had been no screens or evaluations in the last year for Resident #27 except for this most recent evaluation for wheelchair mobility. On 04/28/25 at 9:07 A.M., an interview with PTA #336 provided the last therapy evaluation and verified it was from 2023. On 04/28/25 at 12:01 P.M., an interview with Regional MDS Coordinator #331 verified there was no comprehensive care plan to address the residents' upper extremity functional limitations. On 04/28/25 at 12:41 P.M., an interview with Resident #27 revealed he does not get range of motion from the aides or nurses and had not been on therapy for a while. He stated they did give him a squeeze ball, but he could not close his hand or squeeze it. Resident #27 could not fully extend his right arm, and he could not extend it much farther than 90 degrees. He stated now he could not even brush his hair because of his hands, and he stated he could not raise his hands over his shoulders. The resident was unable to state the timeframe of when or how long it took for his joints to deteriorate to be like this. On 04/28/25 at 2:35 P.M. an interview with the Administrator revealed the facility did not have a policy regarding ROM or therapy services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, and interviews, the facility failed to obtain a physician order and monitor a non-invasive ventilation device (Bi-pap) for Resident #37. This affected one resident (#37) of four residents reviewed for respiratory care. The facility census was 44. Findings Include: Review of the medical record for Resident #37 revealed an initial admitted [DATE] with the diagnoses including but not limited to metabolic encephalopathy, acute respiratory failure with hypoxia, cerebral infarct, atherosclerotic heart disease, obesity, obstructive and reflux uropathy, retention of urine, diabetes mellitus, obstructive sleep apnea, hypertension, low back pain, benign prostatic hyperplasia, pulmonary embolism, contusion of spleen and encounter for surgical aftercare. Review of the resident's plan of care revealed no care plan addressing the resident's use of oxygen or Bi-pap. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident had not received oxygen therapy or utilized a non-invasive ventilation device. Review of the resident's monthly physician orders for April 2025 identified orders dated 02/09/25 change oxygen tubing monthly on the first day of the month, clean external concentrator filter every two week, oxygen at six liters per nasal cannula continuously every shift and monitor oxygen saturation rates every shift. Review of the resident's discontinued orders revealed the resident had an order dated 02/08/25 and discontinued on 02/19/25 Bi-pap with settings of IPAP 12, EPAP 6 with three liters of oxygen to wear during night and as needed daily. Review of the interdisciplinary team (IDT) progress note dated 04/01/25 at 4:24 P.M. revealed the resident was non-compliant with his Bi-pap, but will wear nasal cannula with oxygen. On 04/21/25 at 2:26 P.M., observation of the resident revealed he was quiet at bedrest with eyes closed with his Bi-pap machine in place with oxygen on. On 04/22/25 at 2:28 P.M., observation of the resident revealed he was asleep in bed with his Bi-pap machine in place. On 04/22/25 at 3:22 P.M., interview with Regional Nurse #332 confirmed the resident had no physician order for the Bi-pap machine setting, application and monitoring.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and interview, the facility failed to ensure one resident's (#29) antihypertensive medication (medication used to lower the blood pressure) per the physician ordered parameters. This affected one resident (#29) of five residents reviewed for unnecessary medications. The facility census was 44. Findings Include: Review of the medical record for Resident #29 revealed an initial admitted [DATE] with the diagnoses including but not limited to dysphagia, aphasia, dysarthria, atrial septal defect, asthma, atrial fibrillation, hypertensive urgency, hypertensive heart disease with heart failure, obesity, heart failure and hyperlipidemia. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the monthly physician orders for April 2025 identified an order dated 12/26/23 Metoprolol 25 milligrams (mg) by mouth twice daily with the special instructions to hold if systolic blood pressure (SBP) was less than 110 or heart rate (HR) was less than 60. Review of the resident's January 2025 Medication Administration Record (MAR) revealed the medication Metoprolol was administered on 01/05/25 when the resident's pulse was 58 and on 01/22/25 when the resident's pulse was 57. Review of the resident's February 2025 MAR revealed the medication Metoprolol was administered on 02/04/25 when the resident's pulse was 52 and on 02/05/25 when the resident's pulse was 55. Review of the resident's March 2025 MAR revealed the medication Metoprolol was administered on 03/26/25 when the resident's pulse was 59. On 04/23/25 at 2:35 P.M., interview with the Regional Nurse #332 confirmed the resident was administered the antihypertensive medication outside the physician ordered parameters.

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	366480	A. Building B. Wing	04/28/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, interviews, and facility policy review, the facility failed to ensure one resident (#29) received emergent and/or routine dental care. This affected one resident (#29) of two residents reviewed for dental services. The facility census was 44. Findings Include: Review of the medical record for Resident #29 revealed an initial admitted [DATE] with the diagnoses including but not limited to dysphagia, aphasia, dysarthria, atrial septal defect, asthma, atrial fibrillation, hypertensive urgency, hypertensive heart disease with heart failure, obesity, heart failure and hyperlipidemia. Review of the plan of care dated 03/23/22 revealed the resident had potential for oral/dental health problems related to two broken teeth and resident reports difficulty chewing. Interventions included administer medications as ordered, monitor/document for side effects and effectiveness, coordinate arrangements for dental care, transportation as needed/as ordered, diet as ordered, consult with dietitian and change if chewing/swallowing problems are noted, encourage fluids to keep oral cavity moist, provide lip balm/ointment as needed and monitor/document/report as needed any signs and/or symptoms of oral/dental problems needing attention. Review of the resident's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no obvious or likely cavity or broken natural teeth. Review of the monthly physician orders for April 2025 identified an order dated 03/25/22 may see as needed audiologist, dentist, podiatrist, psychologies and optometrist. Review of the progress note dated 11/04/24 at 6:51 P.M. revealed the nurse asked the resident about his pain. The resident stated that he still had tooth pain especially when he eats. The nurse documented she checked his mouth and noticed that the resident had missing and broken teeth. The nurse offered the resident pain medication but the resident stated not at this time. Review of the progress noted 11/05/24 at 7:52 A.M. revealed the resident state his tooth was aching when asked. The resident denied as needed Tylenol when offered. Review of the progress note dated 11/05/24 at 2:19 P.M. revealed the emergency dentist form was sent to the dentist for appointment. The dental office was to notify the facility of the date and time of the dental appointment. The resident continued to report painful chewing but declined modified diet texture. Review of the medical record revealed no documented evidence the resident was seen or the facility followed up to obtain the resident a dental consult appointment. Review of the resident's summary of dental care from 01/01/23 to 04/23/25 revealed the last dental exam provided was on 01/25/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/21/25 at 12:20 P.M., interview with the resident revealed the resident stated, I have bad teeth. The resident revealed his teeth hurt when he ate and had asked to see a dentist multiple times. Observation of the resident's mouth revealed he had multiple missing teeth and also the remaining teeth were broken and with obvious carries. On 04/23/25 at 3:37 P.M., interview with Regional Nurse #332 verified the resident had not seen a dentist since 01/25/24. Review of the facility policy titled, Dental Services Including Repair, Replacement, dated 11/08/17 revealed it is the practice of the facility to assist residents in obtaining routine and emergency dental care per the resident request. The facility will assist by making appointments and/or by arranging for transportation to and from the dental services location. Clinical staff will assess teeth and gums upon admission, with each comprehensive assessment and as needed to identify pain, lost or broken teeth, visible signs of tooth decay and other chewing and swallowing problems. The facility will ensure the delivery of emergency dental services to meet the resident needs. Emergency dental services will include services needed to treat and episode of acute pain to teeth, gums or palate, broken or otherwise damaged teeth or any other problem of the oral cavity that requires immediate attention by a dentist.

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	04/28/2025

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, infection control log review, policy review and interview, the facility failed to administer antibiotics as ordered. This affected one resident (#27) of five residents sampled for unnecessary medications. The census was 44. Findings include: Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including anxiety disorder, depression, psychotic disorder with delusions, contractures and cerebellar stroke. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact for daily-decision making. Review of the Nurse Practitioner Progress Note Details dated 03/04/25 revealed Resident #27 was seen for evaluation of some right lower extremity (RLE) edema and mild pain. The assessment and plan revealed very mild cellulitis of the right lower extremity but the resident was insistent on the fact that his RLE was more painful and swollen, as well as, some mild erythema. Will start Resident #27 on a short course of cephalexin, continue supportive care and notify with any other issues or concerns. Review of the electronic Physician Orders dated 03/04/25 revealed to administer Cephalexin (antibiotic) 500 milligrams (mg) three times a day. Review of the electronic Medication Administration Record dated March 2025 revealed cephalexin 500 (mg) was administered between 03/05/25 and 03/10/25 for a total 18 doses instead of 15 doses. Review of the Infection Control Criteria evaluation dated 03/05/25 to 03/10/25 revealed Resident #27 met the infection criteria to be treated with cephalexin. There was no evidence the facility identified during the review of the antibiotic use that Resident #27 had received three additional doses of cephalexin. On 04/24/25 at 11:25 A.M., interview with Regional Nurse #332 verified Resident #27 received three additional doses of cephalexin than what was ordered to treat cellulitis. Review of the policy: Antibiotic Stewardship revised 12/16/24 revealed the purpose was to optimize the treatment of infections by ensuring that residents who require an antibiotic were prescribed the appropriate antibiotic and reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use. Encompass a facility-wide system to monitor the use of antibiotics.