STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365077	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Care Center	3929 Hoover Road Grove City, OH 43123

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, observations, staff interviews, and review of facility policy, the facility failed to ensure adequate activities of daily living (ADL) care was provided for two residents (#77 and 87). This affected two residents out of five residents reviewed for activities of daily living. Findings Include: 1. Review of a resident record revealed that Resident #77 was admitted to the facility on [DATE] and had diagnoses that included cognitive communication deficit, need for assistance with personal care and vascular dementia. Review of Resident #77's admission photo revealed that he was clean shaven. Review of Resident #77's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that he had a Brief Interview for Mental Status score of 03, indicative of severe cognitive impairment. Resident #77 required partial to moderate assistance with personal hygiene, such as shaving. Review of Resident #77's care plan dated 05/15/26 revealed that Resident #77 had an ADL self-care deficit related to weakness and dementia. A listed goal was that Resident #77 would receive the assistance necessary to meet ADL needs. An intervention listed was that Resident #77 would be assisted by a staff member for ADLs. Observation of Resident #77 on 06/02/26 at 2:00 P.M. and 06/04/26 at 9:33 A.M. and 11:27 A.M revealed that Resident #77 had long whiskers on his chin and had a sparse mustache with long whiskers. An interview with Resident #77 on 06/04/26 at 11:27 A.M. revealed that he preferred to be clean shaven. An interview with Licensed Practical Nurse #237 on 06/04/26 at 11:34 A.M. confirmed that Resident #77 had long whiskers on his chin and above his lip and he was not clean shaven. 2. Review of a resident record revealed that Resident #87 was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's disease, cognitive communication deficit and dementia without behavioral disturbance. Review of Resident #87's MDS 3.0 assessment dated [DATE] revealed that Resident #87 had severely impaired cognitive skills for daily decision making. Resident #87 was assessed as needing partial to moderate assistance with personal hygiene. Review of Resident #87's care plan dated 12/17/25 revealed that Resident #87 had an ADL self-care deficit related to weakness and impaired cognition. A goal was that Resident #87 would receive assistance necessary to meet her ADL needs. Interventions included to assist with daily hygiene and grooming as needed and assistance from one staff member needed. Observation on 06/01/26 at 11:11 A.M. revealed that Resident #87 had facial hair approximately a half centimeter in length on her chin and above her lip. An interview with Certified Nurse Aide (CNA) #206 on 06/01/26 at 11:13 A.M. confirmed that Resident #87 had long facial hair on her chin and above her lip. Review of the facility policy titled, Activities of Daily Living, revised on 12/31/24 revealed that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal hygiene. This deficiency represents non-compliance investigated under Complaint Number 2667104.

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 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** Based on observations, record review, interviews, and review of facility policy, the facility failed to ensure a physician-ordered pressure reducing mattress was functioning as intended for Resident #131 who had multiple pressure ulcers requiring pressure relieving interventions. This affected one (Resident #131) out of four residents reviewed for pressure ulcers. Findings Include:Review of the medical record for Resident #131 revealed an admission date of 05/22/26. Diagnoses included cognitive communication deficit, disorder of muscle, rhabdomyolysis, chronic pain syndrome, spinal stenosis of the lumbar region without neurogenic claudication, peripheral vascular disease, osteoarthritis, other specified disorders of bone density and structure, idiopathic scoliosis, and macular degeneration.Review of the admission skin assessments revealed the resident was admitted with multiple areas of skin impairment. Documentation identified a Stage III pressure ulcer to the left gluteus present on admission, a Stage III pressure ulcer to the right gluteus present on admission, and an unstageable pressure ulcer to the left heel present on admission. Documentation also identified a left elbow wound which later resolved.Review of the Braden Scale assessment completed upon admission revealed a score of 16, indicating the resident was at risk for the development of pressure ulcers.Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The assessment revealed the resident required moderate assistance with bed mobility and transfers and was dependent upon staff for toilet transfers. Additionally, it identified the resident had two unhealed Stage III pressure ulcers, he utilized a pressure reducing device for the bed and received pressure ulcer dressings.Review of the care plan dated 05/27/26 revealed the resident was at risk for alteration in skin integrity related to actual impairment to a left elbow skin tear and pressure ulcers to the right buttock, left buttock, and left heel. Interventions included administering treatments as ordered, applying barrier cream as needed, completing Braden Scale assessments per facility policy, providing diet and supplements as ordered, elevating heels, utilizing an air mattress, encouraging and assisting with turning and repositioning, providing incontinence care as needed, utilizing a low air loss mattress, and observing skin condition daily during activities of daily living care.Review of the physician order dated 06/01/26 at 7:00 A.M. revealed an order to monitor low air-loss mattress functioning and check that settings were appropriate for the resident every shift and to replace the mattress if malfunctioning.Observation and interview on 06/04/26 at 10:51 A.M. with Resident #131 revealed the low air-loss mattress pump was not operating and the electrical cord was unplugged from the wall outlet. Resident #131 stated the mattress was unplugged but she was not sure what the pump at the end of her bed was used for. Resident #131 stated she had utilized the air mattress since admission.Observation and interview on 06/04/26 at 11:03 A.M. with Registered Nurse (RN) #207 confirmed the low air-loss mattress was unplugged and not functioning. RN #207 further confirmed the mattress was utilized for the resident's buttock pressure ulcers. RN #207 further confirmed the resident had no history of unplugging the mattress.Interview on 06/04/26 at 11:50 A.M., revealed Resident #131 stated she never unplugged or tampered with the low air-loss mattress.Review of the facility policy titled Skin and Wound Guidelines, dated 03/05/24, revised 03/20/24, and reviewed 02/04/26, revealed the policy was intended to describe the process required for identification of residents at risk for pressure injuries and the interventions used to assist with management of pressure injuries and skin alterations. The policy indicated treatment options were selected based on the type of wound and resident needs and that treatments were ordered by the medical practitioner.This deficiency represents non-compliance investigated under Complaint Numbers 2725964

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy, the facility failed to ensure fall prevention interventions were implemented and maintained following a fall for two (Resident #07 and #84) out of two residents reviewed for falls. The facility census was 112.Findings Include: 1. Review of the medical record for Resident #07 revealed an admission date of 11/06/25 and re-entry date of 03/11/26. Diagnoses included Alzheimer's disease, fracture of neck of left femur with routine healing following surgical repair, type 2 diabetes mellitus with diabetic neuropathy, chronic kidney disease stage 3, and syncope and collapse.Review of the significant change Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 02 indicating severe cognitive impairment. The resident required extensive assistance with most activities of daily living and was dependent for ambulation beyond short distances. The resident utilized a wheelchair and had a history of falls including a fall with major injury on 03/07/26 resulting in a left hip fracture requiring surgical intervention.Review of the fall documentation revealed on 03/07/26 at 6:47 P.M. the resident was found on the floor near his bed after attempting to self-transfer from bed to wheelchair. The resident was assisted and no injury was initially noted. The resident later sustained a skin tear to the left arm with neuro checks initiated. Further documentation on 03/07/26 at 11:00 P.M. revealed the resident had a fall out of his wheelchair in the hallway with a skin tear noted and the resident stating he was looking for his mother. Neuro checks were initiated at that time.Review of the physician imaging report dated 03/09/26 revealed an intertrochanteric fracture of the left femur with displacement. The resident was sent to the emergency department for evaluation and subsequently underwent surgical repair of the hip fracture with return to the facility for long term care.Review of interdisciplinary team documentation dated 03/12/26 at 2:16 P.M. revealed the resident had a fall from attempting to self transfer from bed to wheelchair due to wheelchair not being within close proximity to the bed. The resident was found on the floor with no injury noted. An intervention was added for wheelchair placement at bedside and grippy strips were to be placed on the floor to reduce fall risk. Review of interdisciplinary team documentation dated 03/12/26 at 4:40 P.M. revealed care plan updates following the fall with major injury and identification that the resident was typically a walker user but required wheelchair use following injury.Review of the care plan revealed fall prevention interventions including bed in low position, call light within reach, nonskid footwear, assist with transfers, and grippy strips at bedside with an initiation date of 03/09/26. Observation on 06/01/26 at 2:20 P.M. revealed grippy strips were not in place at the bedside as an implemented fall prevention intervention.Interview with Licensed Practical Nurse (LPN) #162, on 06/01/26 at 2:35 P.M. confirmed the grippy strips were not implemented at bedside.2. Review of the medical record for Resident #84 revealed an admission date of 04/29/26. Diagnoses included methicillin resistant Staphylococcus aureus infection, need for assistance with personal care, unsteadiness on feet, other abnormalities of gait and mobility.Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 indicating moderate cognitive impairment. The resident required supervision to moderate assistance with transfers and ambulation and was identified as a fall risk with at least one fall documented.Review of the fall documentation dated 05/15/26 at 3:50 A.M. revealed the resident was found on the floor next to the bed with a laceration above the eye. The resident reported attempting to retrieve glasses from the floor and sliding from the bed. The resident was assessed and sent to the emergency department for evaluation.Review of interdisciplinary documentation dated 05/20/26 revealed the resident had a fall on 05/15/26 resulting in injury and care planned interventions were updated to include grippy strips at bedside and a reacher to assist with retrieval of items to prevent future falls. The resident returned from the hospital on [DATE] at 7:26 A.M. with neuro checks initiated following repair of a head laceration.Review of the care plan (continued on next page)

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	365077	A. Building B. Wing	06/04/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed fall prevention interventions including call light within reach, nonskid footwear, bed in low position, assist with transfers, and use of reacher and grippy strips at bedside with an initiation date of 05/20/26.Observation and interview on 06/01/26 at 3:51 P.M. revealed grippy strips were not in place at the bedside as ordered and the reacher was not present in the resident's room. At the time of the observation, LPN #162 confirmed grippy strips were not in place and the reacher was not in the room. The resident stated he did not receive a reacher following his prior fall. LPN #162 confirmed the reacher should have been provided per the care plan.Review of the facility policy titled Fall Management Guidelines, issued 12/13/23, revealed the purpose of the policy was to provide guidelines to assist with fall risk identification and fall management of residents in the facility. The policy defined a fall as unintentionally coming to rest on the ground, floor, or other lower level with or without injury and not as a result of an overwhelming external force. The policy indicated fall risk evaluations were to be completed upon admission, readmission, quarterly, and with a significant change in condition. The policy indicated the licensed nurse was to evaluate residents for intrinsic and extrinsic fall risk factors and that a comprehensive care plan was to be developed to include individualized interventions to address modifiable risk factors and reduce the risk of injury from falls. The policy further indicated the interdisciplinary team was to review care plans after a fall to ensure interventions were appropriate and reflective of the root cause of the fall event.This deficiency represents non-compliance investigated under Complaint Numbers 2682198, 2667104, 2666938, and 2664299.

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	365077	A. Building B. Wing	06/04/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident records, interviews and review of facility policy, the facility failed to ensure appropriate pain management medications were administered per professional standards of practice, when parameters were not in place for as needed pain medications, including opioids, for two residents. This affected two residents (#21 and #101) of three residents reviewed for pain management. Findings include: 1. Review of a resident record revealed that Resident #101 was admitted to the facility on [DATE] and had diagnoses that included bipolar disorder and chronic pain syndrome. Review of Resident #101's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #101 received scheduled and as needed pain medication. Occasionally, pain interfered with therapy and day to day activities. Review of Resident #101's care plan dated 10/14/25 revealed that Resident #101's cognition fluctuated, as she initially had a Brief Interview Score of 12, indicative of a moderate cognitive impairment. Review of Resident #101's pain care plan dated 10/21/25 revealed that Resident #101 was at risk for pain related to mental and emotional health issues, and chronic medical conditions including bilateral below the knee amputations. Interventions include to administer pain medications as ordered and to implement non-pharmacological interventions per preferences to assist with pain. Review of Resident #101's physician orders dated 10/14/25 revealed that Resident #101 was prescribed acetaminophen, a non-opioid pain reliever, 325 mg, two tablets every six hours as needed for moderate pain and on 01/30/26 Resident #101 was ordered Oxycodone HCl, an opioid pain reliever, oral tablet 10 milligrams (mg), one tablet every four hours as needed for pain. No specific parameters were identified in the orders. Review of Resident #101's Medication Administration Record (MAR) revealed: On 05/02/26 she was administered Oxycodone HCl one tablet for a pain level of 4 (on a scale of zero to 10, zero being no pain and 10 being the worst pain); On 05/03/26 at 10:00 A.M. and 05/03/26 at 6:00 P.M., Resident #101 was administered Oxycodone HCl one tablet for a pain level of 4; On 05/04/26, Resident #101 was administered Oxycodone HCl 1 tablet for a pain level of 4; On 05/16/26, she was administered Oxycodone HCl one tablet for a pain level of 2; On 05/21/26, she was administered Oxycodone HCl one tablet for a pain level of 3 on two occasions; On 05/24/26, she was administered Oxycodone HCL one tablet for a pain level of 2; On 05/25/26, she was administered Oxycodone HCl one tablet for a pain level of 2; And on 05/30/26, she was administered Oxycodone HCl one tablet for a pain level of 4. Review of Resident #101's MAR revealed that Resident #101 was administered acetaminophen on 05/12/26 for a pain level of 8. An interview with the Director of Nursing (DON) on 06/04/26 at 3:40 P.M. revealed that she would expect acetaminophen to be given for pain levels of 1 through 5 and opioids to be given for pain levels of 6 through 10. The DON confirmed that Resident #101 received acetaminophen for a pain level of 8 (continued on next page)

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	365077	A. Building B. Wing	06/04/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and received as needed opioids for pain levels of less than 5. The DON further confirmed there were no parameters for the as needed pain medications. 2. Record review for Resident #21 revealed this resident was admitted to the facility on [DATE] with diagnoses including: nasal fracture, diabetes mellitus, osteoporosis, shortness of breath, dysphagia, encephalopathy, chronic kidney disease, collapsed vertebra, Review of Resident #21's pain care plan dated 03/06/26 revealed that Resident #21 was at risk for pain related to deconditioning, fatigue, malaise, uneasiness, chronic conditions including osteoporosis, aortic stenosis, seizures, asthma, osteoarthritis, dorsalgia, recent subdural hematoma, chronic obstructive pulmonary disorder, collapsed vertebra and electrolyte imbalance. Interventions include administering pain medications as ordered. Review of Resident #21's physician orders dated 04/01/26 revealed a prescription of acetaminophen, a non-opioid pain reliever, 325 mg, two tablets every six hours as needed for moderate pain. No specific parameters were identified in the order. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to be dependent for toileting hygiene, bathing and mobility. Review of Resident #21's physician orders dated 04/28/26 revealed a prescription of Hydrocodone-Acetaminophen, an opioid pain reliever, one oral tablet 7.5 milligrams (mg) every six hours as needed for pain. No specific parameters were identified in the order. Review of Resident #21's Medication Administration Record (MAR) revealed: On 05/16/26 she was administered Oxycodone HCl one tablet for a pain level of 2/10. On 05/15/26, she was administered Oxycodone HCl one tablet for a pain level of 3/10. On 04/01/26, 04/17/26, 04/18/26, 05/21/26, and 05/30/26 she was administered Oxycodone HCl one tablet for a pain level of 4/10. On 04/10/26, 04/18/26, 04/20/26, 05/02/26, 05/03/26 and 05/09/26 she was administered Oxycodone HCl one tablet for a pain level of 5/10. During an interview with the Director of Nursing (DON) on 06/03/26 at 3:05 P.M. she confirmed there were no parameters on either of Resident #21's prescribed pain medications. On 06/04/26 at 3:40 P.M. she confirmed the expectation of acetaminophen to be administered for reported pain levels of one through five and opioids to be given for pain levels of six through 10. This deficiency represents non-compliance investigated under Complaint Number 2981805.

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	365077	A. Building B. Wing	06/04/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, and staff interview, the facility failed to properly store medications. This affected two residents (#16 and #122) out of 28 residents in the survey sample.Findings Include: 1. Review of the medical record for Resident #131 revealed an admission date of 11/07/25. Diagnoses included type two diabetes mellitus without complications, essential (primary) hypertension, peripheral vascular disease, and acute kidney failure. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 indicating intact cognition. The assessment indicated the resident required extensive assistance with activities of daily living and medication administration. Review of physician orders revealed an active order for Losartan Potassium 100 milligrams by mouth daily for hypertension. Review of the Medication Administration Record confirmed the medication was administered on 06/01/26. Review of nursing documentation revealed no documentation of medication omission, spill, or discrepancy on 06/01/26. Review of nursing documentation dated 06/02/26 at 08:25 A.M. revealed the resident stated medications had been dropped during administration on the prior evening and were not fully recovered at that time. Observation on 06/02/26 at 8:15 A.M. revealed an unknown pill was located on the floor of Resident #131's room. Observation and interview on 06/02/26 at 8:18 A.M. Licensed Practical Nurse (LPN) #362 confirmed observation of a pill on the floor and it was identified as Losartan Potassium. The medication was observed in plain view on the floor. The Licensed Practical Nurse confirmed the resident was not approved for self-administration and confirmed the medication was disposed of after discovery. During interviews at the resident council meeting on 06/04/26 from 1:50 P.M. to 2:11 P.M., residents stated that a pill had been observed on the floor by a council member several months prior, although the resident was unable to identify the medication source or affected resident. Review of the facility policy titled Medication and Treatment Storage, dated 08/07/23, revised 02/03/26, and reviewed 10/15/25 and 02/03/26, revealed the policy was intended to ensure accurate labeling and dating of medications and treatments and to provide safe and secure storage of all medications, including controlled access to medication storage areas. The policy indicated medications were to be stored in locked compartments with access limited to authorized licensed personnel and that medications must remain under direct observation during administration or secured in a locked storage area. (continued on next page)

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	365077	A. Building B. Wing	06/04/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of a resident record revealed that Resident #122 was admitted to the facility on [DATE] and had diagnoses that included unspecified dementia, cognitive communication deficit and chronic obstructive pulmonary disease (COPD). Review of Resident #122's MDS 3.0 assessment dated [DATE] revealed that Resident #122 had a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition. Resident #122 was assessed as having no upper body impairments. Review of Resident #122's care plan dated 03/11/25 revealed that Resident #122 had altered respiratory status related to chronic obstructive pulmonary disease and interventions included to administer medication and puffers as ordered. Review of Resident #122's care plan dated 04/18/25 revealed that Resident #122 resided on a secure unit related to impaired safety awareness. Review of Resident #122's physician orders dated 12/12/25 revealed that he was prescribed Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 micrograms per activation, a combination inhaled medication, one puff inhale orally one time a day for COPD. An observation on 06/01/26 at 11:00 A.M. revealed that Resident #122 was in his bed and his Trelegy Ellipta was within reach on Resident #122's bedside table. An interview on 06/01/26 at 11:02 A.M. with Registered Nurse Manager #323 confirmed that Resident #122's Trelegy Ellipta inhaler was not properly stored, and stated that she would secure it in the medication cart. Review of the facility policy titled, Medication and Treatment Storage, dated 08/07/23 revealed that all medications and biologicals will be stored in locked compartments such as medication carts. This deficiency represents non-compliance investigated under Complaint Number 2725964.

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	365077	A. Building B. Wing	06/04/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of Centers for Disease Control (CDC) guidance, the facility failed to ensure glucometers were sanitized/disinfected between resident use. This affected one resident (#05) and had the potential to affect four residents the facility identified as residents who utilized the facility glucometer. Findings Include: Review of the medical record for Resident #69 revealed the resident was originally admitted on [DATE] with the diagnosis of diabetes type two. Review of Resident #69's physician orders revealed an order for Humalog insulin 100 units per milliliter per sliding scale (a specific dose of insulin per the residents blood glucose reading). Review of the medical record for Resident #05 revealed the resident was admitted on [DATE] with the diagnosis of diabetes mellitus. Observation on 06/04/26 at 11:15 A.M. revealed Licensed Practical Nurse (LPN) #238 used a facility owned glucometer (a small, portable electronic device used to measure how much sugar (glucose) is in the residents' blood. The process of blood glucose testing consisted of inserting a drop of blood, generally obtained via a finger prick, on a test strip and into the glucometer.) to check the blood glucose level of Resident #69. LPN #238 then did not sanitize or disinfect the glucometer and used the same glucometer to check the blood glucose level of Resident #05.During an interview with LPN #238 on 06/04/26 at 11:28 A.M. confirmed that she did not clean and disinfect the glucometer between residents and that she did use the glucometer to check the blood glucose levels of multiple residents. She stated she would disinfect the glucometer following every two residents.Review of guidance issued from the Centers for Disease Control (CDC) and Prevention effective 08/07/24 revealed facility staff must clean and disinfect blood glucose meters after every use, per the manufacturer's instructions.