STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365375	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	8211 Weller Road Cincinnati, OH 45242

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 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** 34291 Based on medical record review, observation, and staff and resident interviews, the facility failed to ensure a pressure ulcer dressing change was completed per physician orders. This affected one (#93) of three residents reviewed for pressure ulcers. The facility identified four pressure ulcers in the facility. The facility census was 99. Findings include: Review of Resident #93's medical record revealed an admitted [DATE]. Diagnoses included neurogenic bladder, peripheral vascular disease, depression, and diabetes. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/21/24, revealed Resident #93 was cognitively intact. Further review revealed Resident #93 required set-up and clean-up assistance for eating, partial/moderate assistance for toileting, and supervision/touching assistance for bed mobility. Additionally, Resident #93 was coded for a stage four pressure ulcer to her sacrum and had a colostomy. Review of the most recent care plan revealed Resident #93 had a pressure ulcer to her sacrum related to immobility. Interventions included to document treatments as ordered and follow the facility policies/protocols for prevention/treatment of skin breakdown. Additionally, if the resident refused the treatment, confer with the resident, interdisciplinary team (IDT) and family to determine why and document. Review of a physician order, dated 04/18/24, revealed to cleanse the wound to the sacrum with normal saline, pat dry, pack the wound with calcium alginate with silver and cover with a Mepilex (antimicrobial foam dressing) and change on every shift. Review of the Treatment Administration Record (TAR) dated 04/30/24 revealed Resident #93's wound care treatment was documented as completed on the night shift. Observation on 05/01/24 at 9:07 A.M. of Resident #93's wound dressing to the sacrum revealed the dressing was undated. Concurrent interview with Resident #93 revealed her dressing was not changed on 04/30/24. Resident #93 denied refusing wound care treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/24 at 10:05 A.M. with agency Licensed Practical Nurse (LPN) #131 confirmed she did not complete Resident #93's wound treatment on the night shift on 04/30/24. LPN #131 stated the resident refused the treatment but she did not document Resident #93 refused. LPN #131 verified she documented the treatment as completed even though it had not been done. This deficiency represents non-compliance investigated under Complaint Number OH00152739.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365375	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	8211 Weller Road Cincinnati, OH 45242

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure proper colostomy care was provided. This affected one (#77) of three residents reviewed for colostomy care. The facility identified three residents with colostomies. The facility census was 99. Findings include: Review of Resident #77's medical record revealed an admitted [DATE]. Diagnoses included chronic ischemic heart disease, coronary artery disease, renal insufficiency, anxiety, and depression. Review of the annual Minimum Data Set (MDS) assessment, dated 03/14/24, revealed Resident #77 was cognitively intact. Further review revealed Resident #77 required substantial/maximal assistance for toileting and partial/moderate assistance for bed mobility and transfers. Resident #77 was coded as having a colostomy. Review of the plan of care, dated 03/20/24, revealed Resident #77 required the use of a colostomy. Interventions included to provide ostomy care per order to prevent odors and keep the ostomy patent. Observation on 05/07/24 at 1:14 P.M. of colostomy care for Resident #77, with Licensed Practical Nurse (LPN) #140, revealed he washed his hands and applied gloves. LPN #140 removed the dressing and the wafer. Under the wafer there was dried feces on the resident's skin. LPN #140 proceeded to clean the stool from the resident's skin with wipes and a dry towel. LPN #140 opened the package of skin prep and applied around the area of the stoma, opened the wafer package and placed the wafer over the stoma and opened the dressing package and placed a dressing on the wafer. LPN #140 did not perform hand hygiene or change his gloves during the observation. Interview on 05/07/24 at 1:30 P.M. with LPN #140 verified he did not perform hand hygiene or change his gloves when moving from dirty to clean while performing colostomy care for Resident #77. Review of the facility policy titled Colostomy/Illestomy Care, revised October 2010, revealed the procedure included the following steps: wash and dry hands thoroughly, put on gloves, remove drainage bag, remove gloves, wash hands, put on clean gloves, cleanse skin with appropriate skin cleansing preparation, discard disposable items into designated containers, remove and discard gloves, and wash and dry hands thoroughly. This deficiency represents non-compliance investigated under Master Complaint Number OH00153494.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff interview and review of facility policy, the facility failed to ensure the attending physician completed resident visits every 60 days. This affected two (#2 and #3) of three residents reviewed for physician visits. The facility census was 99. Findings included: 1. Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included hypertension, hyperlipidemia, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/30/24, revealed Resident #2 was severely cognitively impaired. Further review of Resident #2's medical record from 12/01/23 through 05/07/24 revealed no evidence of a physician visit. 2. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnoses included hypertension, dementia, hyperlipidemia, and traumatic brain injury. Review of quarterly MDS assessment, dated 04/24/24, revealed Resident #3 was severely cognitively impaired. Further review of Resident #3's medical record from 12/01/23 through 05/07/24 revealed no evidence of a physician visit. Interview on 05/07/24 at 11:59 A.M. with Nurse Practitioner (NP) #150 revealed she visited the facility on Tuesdays and Thursdays. She stated Medical Doctor (MD) #160 only visited the facility if there was a new admission or if a resident was sick. Interview on 05/09/24 at 1:21 P.M. with MD #160 verified she had not seen Residents #2 and #3 since December 2023 and it had been an oversight on her part. Review of the policy entitled Physician Visits dated 04/01/13 revealed the attending physician must make visits in accordance with applicable state and federal regulations. Further review revealed the attending physician must visit his/her patients at least once every 30 days for the first 90 days following a resident's admission and then at least every 60 days thereafter. After the first 90 days, if the attending physician determines that a resident need not be seen by him/her every 30 days, an alternate schedule of visits may be established, but not to exceed every 60 days. A Physician Assistant or Nurse Practitioner may make alternate visits after the initial 90 days following admission, unless restricted by law or regulation. This deficiency represents non-compliance investigated under Master Complaint Number OH00153494.