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	07/25/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, record review, staff interview, and policy review, the facility failed to ensure residents had access to call lights. This affected one (Resident #46) of five residents sampled for call lights. The facility census was 93. Findings include: Review of the medical record revealed Resident #46 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, type II diabetes, and chronic viral hepatitis C. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Review of care plan dated 11/22/2022 revealed Resident #46 had an Activities of Daily Living (ADL) self-care performance deficit related to disease process and required staff assistance to complete ADL tasks. Interventions included encourage the resident to utilize the call light for assistance as needed, keep the call light within reach, and encourage the resident to participate as possible with each interaction. Observation on 07/25/2024 at 9:08 A.M. State tested Nurse Aide (STNA) #155 sanitized hands, donned gloves, and entered Resident #46's room. The room had a sign on the door for Enhanced Barrier Precautions (EBP) which indicated gowns and glows were to be worn for high-contact patient care including incontinence care, and there was plastic bin located outside of the door in the hallway which contained Personal Protective Equipment (PPE) including boxes of gloves and individually wrapped isolation gowns. STNA #155 provided incontinence care, repositioned the resident in the bed, and placed the bedside table over the bed per the resident request. The call light was on the floor. STNA #155 doffed her gloves, washed her hands with soap and water, and exited the room. Observation on 07/25/2024 from 9:18 A.M. to 9:51 A.M. revealed no staff entered Resident #46's room. At 9:51 A.M. STNA #25 asked Resident #46 if he was finished with his breakfast and removed the dishes per his request. STNA #25 moved the tray table away from the bed and stated she would return to provide repositioning after she took the dishes to the kitchen cart. Resident #46's call light remained on the floor behind the bed. STNA #25 doffed her gown and gloves, sanitized her hands and left the room with the dishes. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/25/2024 at 9:55 A.M. STNA #25 repositioned Resident #46 in bed and clipped his call light to the top blanket. During an interview on 07/25/2024 at 10:02 AM STNA #25 verified she had not been in Resident #46's room since before breakfast and had not checked to ensure Resident #46 had access to his call light before she left the room with his breakfast dishes. STNA #25 verified Resident #46's call light had been non the floor under the bed and was out of the resident's reach. Review of policy titled Answering the Call Light dated 03/2021 revealed the call light was placed within easy reach of residents who were in bed or confined to a chair. This deficiency represents noncompliance investigated under complaint number OH00154541.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, record review, interview, and policy review, the facility failed to ensure residents received wound care as ordered. This affected one (Resident #41) of one resident of two reviewed for wounds. The facility census was 93. Findings include: Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included ataxic cerebral palsy, idiopathic gout, morbid obesity, type II diabetes, chronic diastolic heart failure, unspecified Chronic Obstructive Pulmonary Disease (COPD), and hemiplegia/hemiparesis following cerebral infarction. Review of the most recent annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Review of the care plan dated 06/27/2023 revealed Resident #41 was at increased risk for pressure ulcer development related to disease process. Interventions included, administer medications as ordered, administer treatments as ordered, and follow facility protocols for the preventions and treatment of skin breakdown. Review of progress note dated 07/20/2024 at 10:45 PM revealed Resident #41 reported he had hit his leg on the air conditioning unit causing a skin tear. Review of the medical record revealed Resident #41 had a physician order dated 07/20/2024 to cleanse skin tear to left shin with Normal Saline (NS), apply Xeroform dressing, and cover with bordered dressing every day on night shift until resolved. Observation on 07/24/2024 at 10:10 A.M. revealed Resident #41 asked Licensed Practical Nurse (LPN) #90 to look at the bandage on his left lower leg. Resident #41 stated he had bumped his leg on his air conditioning unit a few days ago and the dressing had never been changed. Resident #41 had a bordered gauze dressing with noticeable scant, dark red drainage that was dated 7/21/2024. During an interview on 07/24/2024 at 10:10 A.M. LPN #90 verified Resident #41 had a dressing on his left lower leg that was dated 07/21/2024. Review of policy titled Wound Care dated 10/2010 revealed wound care was completed as per physician's orders to promote healing. This deficiency represents noncompliance investigated under complaint number OH00154541.

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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 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** 42492 Based on record review, interview, and policy review, the facility failed to ensure residents received pain medications timely. This affected one (Resident #75) of six residents sampled for medication administration. The facility census was 93. Findings include: Review of the medical record revealed Resident #75 admitted to the facility on [DATE] with diagnoses including chronic ischemic heart disease, vitamin chronic pain disease, depression, adjustment disorder with depressed mood, pain in right hip, pain in right shoulder, anxiety disorder, and dermatitis. Resident #75 had no recorded diagnosis for Alzheimer's disease or any other form of dementia. Review of Resident #75's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired, had no behaviors, did not wander, and did not reject care. Review of care plan dated 03/24/2024 revealed Resident #75 had chronic pain related to arthritis and depression. Interventions included to administer analgesia medications per physician orders, monitor and document each pain episode, monitor/document the effects of pain medication, and notify the physician if interventions were unsuccessful or there was a significant change from the resident's experience of pain. Review of the medical record revealed Resident #75 had a physician's order for routine pain medication dated 07/02/2024 for Oxycodone (opioid) 10 milligrams (mg) by mouth four times a day and an order dated 07/16/2024 at 2:50 A.M. for Oxycodone 10 mg one tablet by mouth one time only for pain. Review of the Medication Administration Record dated July 2024 revealed Resident #75 had last had her scheduled Oxycodone 10 mg on 07/15/2024 at 9:00 P.M. and the one-time dose of Oxycodone 10 mg was not administered until 07/16/2024 at 5:21 A.M. During an interview on 07/24/2024 at 3:11 P.M. Resident #75 stated she saw a psychiatrist about a year ago who told her family she was bordering on Alzheimer's disease. She said she only took Xanax (antianxiety) and an anti-depressant but no dementia medications. Resident #75 stated the nurses never identified the medications they administered and often didn't know when you asked what they were. Resident #75 stated that one night a few weeks ago, unspecified, she looked for a nurse for three hours because she needed something for abdominal pain, and no one could find her. During an interview on 07/25/2024 at 6:46 A.M. the Director of Nursing (DON) stated there was a nurse she had terminated last week, because Resident #75 had complained she could not find her. The DON investigated Resident #75's complaint and determined a nurse had been off the floor for an undetermined amount of time on 07/15/24. The DON reveaeld the nurse said she had to run home for an unidentified reason and stated the drive one-way was approximately 30 minutes. When the DON checked the time-punch records, the nurse had only been clocked out for about 20 minutes. When asked to explain the nurse became very defensive, used profanity and disconnected the call. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/2024 at 8:07 A.M. Human Resources (HR) #115 confirmed she was present on the team telephone call when the DON questioned Licensed Practical nurse (LPN) #145. HR #115 stated LPN #145 stated she had to run home and it was a thirty-minute drive. She stated she had clocked out. They checked the punches and she had been clocked out less than thirty minutes. When they asked LPN #145 to explain she began to swear and would not let the DON get a word in. She hung up and essentially terminated her own employment. During a telephone interview on 07/25/2024 at 12:27 P.M. Registered Nurse (RN) #68 stated he had worked night shift on 07/15/2024. RN #68 stated Resident #75 came to him and stated her nurse had been gone for over an hour. RN #68 stated Resident #75 had no visible signs of distress and was complaining of pain. RN #68 stated he looked around the facility and asked staff. No one had seen LPN #145 or knew her whereabouts. I told Resident #75 that LPN #145 had not stated to any staff that she was leaving and asked her to wait an additional 15 minutes for the nurse to return. RN #68 stated that Resident #75 did not have an order for pain medication due at that time, so he called the nurse practitioner and got a one-time order for Oxycodone. LPN #145 returned in about 15 minutes. RN #68 stated he could not confirm what time LPN #145 left or how long she had been absent. RN #68 stated she reported to LPN #145 that Resident #75 needed pain medications and educated the LPN that she needed to notify staff before leaving the floor. RN #68 stated that LPN #145 put the order in for the Oxycodone right away, but he returned to his unit and did not witness the medication being administered. RN #68 stated he had been assigned to Resident #75 's care before and knew she was routinely taking Oxycodone 10 mg. RN #68 stated the medication would have been available in the med cart and there would not have been a delay in administration related to having to get authorization to pull from the emergency drug kit. During an interview on 07/16/2024 the DON confirmed that the records revealed LPN #145 had entered a physician order on 07/16/2024 at 2:50 A.M. for Resident #75 for a one-time dose of Oxycodone 10 mg and the dose was not administered until 5:21 A.M. Review of policy titled Administering Medications dated April 2019 revealed medications were administered in a timely manner in accordance with prescriber orders. This deficiency represents noncompliance investigated under complaint number OH00154541.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, record review, interviews, and policy review, the facility failed to ensure residents received medications as ordered and to maintain a medication error rate of less than 5%. This affected two (Residents #41 and #51) of six residents sampled for medication administration. The facility census was 93. Findings include: 1. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included ataxic cerebral palsy, idiopathic gout, morbid obesity, type II diabetes, chronic diastolic heart failure, unspecified Chronic Obstructive Pulmonary Disease (COPD), and hemiplegia/hemiparesis following cerebral infarction. Review of the most recent annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Review of the medical record revealed Resident #41 had physician orders for Cymbalta Delayed Release (antidepressant) 20 mg capsule by mouth once daily, Amlodipine (antihypertensive) 10 mg, and Pataday (allergy eye drop) ophthalmic solution 0.1% - Instill one drop in both eyes once daily. 2. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE]. Diagnoses included unspecified Parkinsonism, unspecified dementia, unspecified COPD, type II diabetes, and Barrett's esophagus without dysplasia. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Review of the care plan dated 04/01/2024 revealed Resident #51 had Parkinson's. Interventions included adaptive devices as ordered, diet as ordered, encourage daily exercise, and give medications as ordered by physician. Review of the medical record revealed Resident #51 had physician orders dated 03/19/2024 for Rytary Oral Capsule Extended Release (antiparkinsonian agent) 23.75-95 MG give one capsule by mouth two times a day for Parkinson's. Observation on 07/24/2024 from 8:57 A.M. to 10:10 A.M. of medication pass revealed Licensed Practical Nurse (LPN) #90 administered 26 out of 30 ordered medications to five residents (Residents #41, #51, #52, #73, and #64) resulting in an error rate of 13.3% . Resident #51 did not receive Rytary Extended Release (ER) 23.75-95 mg for Parkinson's, and Resident #41 did not receive Amlodipine 10 mg (hypertension), Cymbalta Delayed Release 20 mg (depression), and Pataday 0.1% ophthalmic solution (allergy)- one drop to both eyes once daily- as ordered due to the medications were unavailable. During an interview on 07/24/2024 at 10:10 A.M. LPN #90 verified Residents #41 and #51 were not administered all their prescribed medications because the medications were unavailable. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled Administering Medications dated April 2019 revealed medications were administered in accordance with prescriber orders. This deficiency represents noncompliance investigated under complaint numbers OH00154906 and OH00154541.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, record review, interview, and policy review, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) when providing high-contact care to residents in Enhance Barrier Precautions (EBP). This had the potential to affect all residents. The facility census was 93. Findings include: Review of the medical record revealed Resident # 46 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, type II diabetes, and chronic viral hepatitis C. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Review of the care plan dated 04/26/2024 revealed Resident #46 had Enhanced Barrier Precautions (EBP) secondary to increased risk for potential infection related to Candida Auris. Interventions included educating residents and caregivers regarding infection prevention, following EBP, and performing hand hygiene before and after delivery of care. Review of the medical record revealed Resident #46 had physician orders dated 05/26/2023 for Isolation: Enhanced Barrier Precautions due to Candida Auris positive. Observation on 07/25/2024 at 9:08 A.M. State tested Nurse Aide (STNA) #155 sanitized hands, donned gloves, and entered Resident #46's room. The room had a sign on the door for Enhanced Barrier Precautions (EBP) which indicated gowns and glows were to be worn for high-contact patient care including incontinence care, and there was plastic bin located outside of the door in the hallway which contained Personal Protective Equipment (PPE) including boxes of gloves and individually wrapped isolation gowns. STNA #155 provided incontinence care, repositioned the resident in the bed, and placed the bedside table over the bed per the resident request. STNA #155 doffed her gloves, washed her hands with soap and water, and exited the room. During an interview on 07/25/2024 at 9:14 A.M. STNA #155 verified she did not wear a gown while providing incontinence care. STNA State she was educated regarding general isolation precautions but did not know what Enhanced Barrier Precautions (EBP) were or why Resident #46 was in EBP. Review of policy titled Enhanced Barrier Precautions dated 08/2022 revealed gloves and gowns were applied prior to high-contact resident care to prevent the spread of multi-drug resistant organisms to residents. This deficiency represents noncompliance investigated under complaint numbers OH00154906 and OH00154541.