

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 12/04/2024  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
| F 0550<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51680</b></p> <p>Based on observation, medical record review, staff interview and review of an orientation checklist, the facility failed to ensure residents were treated with dignity during meals. This affected two residents (#22 and #37) of two residents reviewed for dignity. The facility census was 81.</p> <p>Findings included:</p> <p>1. Review of Resident #22's medical record revealed an admitted [DATE]. Diagnoses included gastroesophageal reflux disease (GERD), dysphagia and vascular dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/02/24, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required substantial/maximal assistance from staff for eating.</p> <p>2. Review of Resident #37's medical record revealed an admitted [DATE]. Diagnoses included cerebral infarction and dysphagia.</p> <p>Review of the quarterly MDS assessment, dated 08/01/24, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance from staff for eating.</p> <p>Observation on 09/24/24 at 11:20 A.M. revealed Licensed Practical Nurse (LPN) #5 stood beside Resident #37 while assisting the resident with their meal. Resident #37's eye level was between LPN #5's chin and shoulder area. Continuous observation revealed State tested Nursing Assistant (STNA) #14 was standing over Resident #22 while assisting the resident with their meal. Concurrent interview with LPN #5 verified she stood while providing feeding assistance and stated she stood because she was short. Coinciding interview with STNA #14 verified she stood while providing a resident with feeding assistance because she did not like to sit and had never received education that it was a dignity issue to stand while feeding a resident.</p> <p>Review of STNA #14's orientation checklist, dated 06/20/24, revealed she was educated to position self at eye level, sitting down and facing the resident, while feeding.</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                     |                                                                                             |                                                 |
| F 0550<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | Interview on 09/24/2024 at 3:23 P.M. with the Director of Nursing (DON) confirmed staff should be at the resident's eye level, and not standing, while providing eating assistance.<br><br>Interview on 09/26/2024 at 10:49 A.M. with the Administrator revealed the expectation was for staff to be seated at the resident's eye level when providing assistance with meals. |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                 |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51682</p> <p>Based on resident interview, staff interview, medical record review, review of facility investigations, review of a Self-Reported Incident (SRI) and review of the facility policy, the facility failed to thoroughly investigate an allegation of resident-to-resident abuse for Resident #12 and Resident #55 and further failed to thoroughly investigate an allegation of staff distributing an illegal substance to Resident #40. This affected three residents (#12, #55 and #40) of five residents reviewed for abuse. The facility census was 81.</p> <p>Findings included:</p> <p>1. Review of Resident #55's medical record revealed an admitted [DATE]. Diagnoses included alcohol dependence with alcohol-induced persisting dementia, seizures, psychotic disorder with delusions and hallucinations due to known physiological condition.</p> <p>Review of the annual Minimum Data Set (MD'S) assessment, dated 06/19/24, revealed Resident #55 had a Brief Interview for Mental Status (BINS) score of 9, indicating the resident had moderate cognitive impairment.</p> <p>Review of the care plan, initiated 06/28/23, revealed Resident #55 showed signs of physical aggression and verbal aggression towards other residents and staff. Interventions directed staff to allow the resident to vent, validate feelings as needed, attempt to determine what triggered the behaviors and decrease stimulation as needed.</p> <p>Review of Resident #12's medical record revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, other frontotemporal neurocognitive disorder and vascular dementia with other behavioral disturbances.</p> <p>Review of the annual MDS, dated [DATE], revealed Resident #12 had a BIMS score of 12, indicating the resident had moderate cognitive impairment.</p> <p>Review of the care plan, initiated 05/11/22, revealed Resident #12 had an alteration in mood and/or behavior that included behaviors of being intrusive of others/staff and verbal and physical aggression toward others. Interventions directed staff to allow resident to vent, validate feelings as needed, attempt to identify what triggered behaviors and decrease stimulation as needed.</p> <p>Review of an SRI, dated 07/15/2024 at 7:20 P.M., revealed an allegation of physical abuse involving Resident #12 and Resident #55 occurred on 07/15/2024 at 6:10 P.M. The SRI indicated staff heard a noise in a common area and LPN #8 saw Resident #12 make physical contact with Resident #55's facial area, which resulted in swelling of the resident's nose and discoloration to the eye. Further review revealed the residents were immediately separated, assessed for injuries, and Resident #55 was transferred to the local emergency department (ED) for evaluation and treatment. The document indicated there were no resident witnesses.</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Interview on 09/26/24 at 1:09 P.M. with LPN #8 revealed she was assigned to care for Resident #55 and Resident #12 on 07/15/24 from 7:00 A.M. to 7:00 P.M. LPN #8 stated shortly after the residents on the unit were served their evening meal, she was at the nurses' station when she heard a commotion coming from nearby and rushed to the community dining area on the unit to find Resident #55 holding his face. LPN #8 stated there were multiple residents in the dining room. LPN #8 said she asked both residents what occurred, but Resident #55 was unable to vocalize what occurred. LPN #8 stated Resident #12 explained that Resident #55 had been yelling to either shut the bathroom door or turn off the light, although she could not recall which one was said at the time.</p> <p>Interview on 09/26/24 at 11:47 P.M. with STNA #12 revealed she was assigned to the unit where the incident occurred on 07/15/24. STNA #12 stated Resident #55 was sitting in a chair at a table directly next to the bathroom in the community dining area after they finished the evening meal. STNA #12 said she was in the hallway nearby when she overheard Resident #55 speaking to Resident #12. STNA #12 recalled Resident #55 said either shut the door or shut off the light, although she could not recall which statement Resident #12 made at the time. STNA #12 stated she witnessed Resident #12 hit Resident #55 in the face a couple times before she could separate the residents. STNA #12 stated there were other residents in the dining room at the time of the incident.</p> <p>Interview on 09/26/2024 at 4:50 P.M. with the DON revealed she expected all staff to ensure residents were safe in the event abuse occurred. The DON stated when an allegation of abuse was made, the hall nurse should collect witness statements from all staff on duty at the time of the incident and notify the Administrator, DON, physician and responsible parties for each resident involved. The nurse should then complete an aggression risk assessment, a progress note and begin the increased monitoring sheets. The DON confirmed investigations should include interviews with staff and resident witnesses.</p> <p>Interview on 09/26/2024 at 4:30 P.M. with the Administrator revealed in the event of resident-to-resident abuse, he expected staff to intervene and separate the residents involved for immediate safety. The Administrator stated he should be notified within one hour of the incident and an investigation should begin immediately, to include interviews with everyone on the unit to determine if there were any witnesses.</p> <p>46194</p> <p>2. Review of Resident #40's medical record revealed an admitted [DATE]. Diagnoses included anoxic brain damage, seizures and psychoactive substance abuse with intoxication.</p> <p>Review of the care plan, initiated 05/16/22, revealed Resident #40 had a focus area indicating the resident had an alteration in mood and/or behavior and had tested positive for tetrahydrocannabinol (THC - the active ingredient in marijuana).</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                 |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of a typed document, dated 09/05/24 and located in the facility investigation, revealed Resident #40 alleged that a nurse on the day shift provided edibles and, in the past, purchased THC vapes that had been found by staff. The typed document indicated Resident #40 identified Licensed Practical Nurse (LPN) #24 as the staff member who provided the paraphernalia. The Director of Nursing (DON) interviewed LPN #24, who denied the allegation. The typed document indicated LPN #24 was placed on a separate unit. Further review revealed, Reported to this writer that State tested Nursing Assistant (STNA) had been told by resident [Resident #40] that [their] [ex-spouse] had been providing [the resident] THC products several weeks ago. There was no clarifying information on this statement. Additionally, there were no other witness statements and/or staff or resident interviews included in the investigation documents provided by the facility.</p> <p>Interview on 09/23/2024 at 10:53 A.M. with Resident #40 revealed he tested positive for marijuana and a nurse at the facility had given him gummies that contained THC.</p> <p>Interview on 09/24/2024 at 1:50 P.M. with Registered Nurse (RN) #26 revealed she was teaching an STNA class and STNA #25 stated a resident told her their ex-spouse brought the resident THC pens and gummies (edibles). RN #26 said she felt like the resident was retaliating against the nurse who reported the resident's behaviors to the nurse practitioner.</p> <p>Interview on 09/24/2024 at 1:18 P.M. with STNA #25 revealed Resident #40 told her they were getting discharged because they had THC pens. STNA #25 stated she was not interviewed related to the allegation.</p> <p>Interview on 09/24/2024 at 4:06 P.M. with LPN #24 revealed she denied supplying Resident #40 with any drug paraphernalia.</p> <p>Interview on 09/25/2024 at 11:49 A.M. with the DON revealed a complete facility investigation of abuse would include suspending the accused staff and interviewing and assessing the resident. The DON stated for the incident involving Resident #40, she interviewed the resident and the alleged perpetrator, LPN #24. The DON verified she did not interview any other staff or residents because Resident #40 stated no one else was involved and did not know anything about the paraphernalia.</p> <p>Interview on 09/25/2024 at 2:22 P.M. with the Administrator revealed a facility investigation related to abuse should include interviews with the resident/s involved, staff involved, and other residents and staff to gather additional information.</p> <p>Review of a facility policy titled Investigation of Incidents and Unusual Occurrences, revised June 2017, revealed all significant incidences and unusual occurrences will be thoroughly investigated so that measures are put in place to both address the current situation and to limit future occurrences. The policy indicated all allegations of abuse would be investigated.</p> <p>Review of a facility policy titled Abuse, Neglect, Exploitation &amp; Misappropriation of Resident Property, dated 11/21/16, revealed if a staff member was accused or suspected of abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, the facility should remove that staff member from the facility and the schedule pending the outcome of the investigation.</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51680</b></p> <p>Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure fingernail care for a dependent resident. This affected one resident (#37) of two residents reviewed for activities of daily living (ADLs). The facility census was 81.</p> <p>Findings included:</p> <p>Review of Resident #37's medical record revealed an admitted [DATE]. Diagnoses included cerebral infarction, abnormal posture, contracture of the left knee, left hip, and left elbow and vascular dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/01/24, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 8, indicating the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on staff for personal hygiene.</p> <p>Review of the care plan, initiated 03/22/22, revealed Resident #37 required assistance with ADLs. Interventions included total care for grooming (nails/shave/hair).</p> <p>Observation on 09/23/24 at 2:49 P.M. of Resident #37 revealed the resident's fingernails were cracked, had sharp edges and were approximately three-fourths of an inch past the tip of the finger.</p> <p>Interview on 09/25/24 at 3:22 P.M. with State tested Nursing Assistant (STNA) #14 revealed nail care was done during showers. STNA #14 stated if a resident's nails were too thick or she was unable to provide nail care, the nurse would be notified. STNA #14 stated she informed the nurse she was unable to provide nail care for Resident #37 because the resident stated it was painful.</p> <p>Interview on 09/25/24 at 3:38 P.M. with Licensed Practical Nurse (LPN) #6 revealed resident nail care was performed on their shower days by an STNA. LPN #6 stated she would assist with nail care if an STNA was unable to, or if a resident declined. LPN #6 denied any knowledge of Resident #37's nail condition and stated she had not been notified of any issues. Concurrent observation of Resident #37's fingernails, with LPN #6 revealed the resident's nails were long, with jagged edges. LPN #6 verified the condition of Resident #37's fingernails.</p> <p>Interview on 09/26/24 at 10:12 A.M. with LPN/ Unit Manager (UM) #7 confirmed Resident #37's fingernails were a little long and had not been done.</p> <p>Interview on 09/26/24 at 10:31 A.M. with the Director of Nursing (DON) revealed resident nail care should be done on the resident's shower days.</p> <p>Interview on 09/26/24 at 10:52 A.M. with the Administrator confirmed a resident's nails should be clean and neat.</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                     |                                                                                             |                                                 |
| F 0677<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | Review of a facility policy titled Care of Fingernails/Toenails, dated July 2006, revealed nail care included daily cleaning and regular trimming. Additionally, proper nail care can aid in the prevention of skin problems around the nail bed and trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                 |
| F 0689<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29358</p> <p>Based on medical record review, review of a fall investigation, staff interview and review of facility policy, the facility failed to ensure a thorough investigation, to include staff interviews, was completed related to an unwitnessed fall. This affected one resident (#18) of two residents reviewed for falls. The facility census was 81.</p> <p>Findings included:</p> <p>Review of Resident #18's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease and sleep disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/18/24, revealed Resident #18 was severely cognitively impaired for daily decision making. The MDS indicated the resident required supervision or touching assistance for the ability to roll left to right, to move from a sitting to a lying position and from sit to stand. Additionally, Resident #18 experienced one fall with injury during the assessment period.</p> <p>Review of the care plan, initiated 09/06/19, revealed Resident #18 was at risk for falls related to poor judgment and safety awareness and impaired balance and gait. Interventions directed staff to encourage and remind to ask for assistance, encourage to wear non-skid footwear, have commonly used articles within easy reach, and maintain a clear pathway. Further review revealed the following revisions to fall interventions: on 10/13/22, obtain laboratory tests and urinalysis as needed; on 12/05/22, declutter bed; on 02/20/23, encourage compliance with the walker; 03/13/23 placement of a bed alarm' 12/13/23 provide therapy per physician orders; and on 09/06/24, offer the resident assistance to bed prior to 10:00 P.M.</p> <p>Review of a fall investigation, dated 09/05/24 and completed by Licensed Practical Nurse (LPN) #18, revealed on 09/05/2024 at 10:45 P.M., Resident #18 was found face down on the floor in front of a chair in the common area with their walker in front of them and had non-skid socks on. The fall investigation form indicated the resident stated they did not know what happened or what they were trying to do. Further review revealed the resident fell asleep and fell forward out of the chair. A new fall intervention was implemented to offer the resident assistance to bed prior to 10:00 P.M.</p> <p>A telephone interview on 09/25/24 at 2:46 P.M. with LPN #18 revealed part of the fall investigation process was for the nurse on duty to figure out the why and what of a fall, come up with interventions and to complete an incident report. LPN #18 stated Resident #18 had been sitting in a chair in the lobby. LPN #18 stated the resident was awake when she walked by, as she stepped off the unit for a minute. LPN #18 stated Registered Nurse (RN) #10 called her about the fall and she came back to the unit and saw Resident #18 on the floor. LPN #18 stated she put ice on the resident's forehead, completed an assessment and called emergency medical services (EMS). LPN #18 stated the resident had a knot on her head. LPN #18 stated the staff tried multiple times to assist Resident #18 to bed but the resident refused. LPN #18 stated the management team completed fall investigations and helped identify interventions. LPN #18 stated she thought the resident probably fell asleep and slid out of the chair. LPN #18 stated the resident was known for bending over and picking things up off the floor.</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A telephone interview on 09/26/24 at 10:43 A.M. with State tested Nursing Assistant (STNA) #20 revealed she was at the nurses' station with STNA #17 when she heard a noise and saw Resident #18 on the floor. STNA #20 stated the resident was lying on the floor on her belly, with her hand under her head. STNA #20 stated RN #19 talked with her about what happened, but LPN #18 did not.</p> <p>A telephone interview on 09/26/24 at 11:22 A.M. with RN #19 revealed she was the shift supervisor the night Resident #18 fell and responded to a call from an STNA about the fall. RN #19 stated Resident #18 was sitting on her bottom in front of a chair, with the resident's walker to the left. Resident #18 had a bump on her head. RN #19 stated she assessed Resident #18 and called 911. RN #19 stated she was never interviewed about the resident's fall.</p> <p>Interview on 09/26/24 at 1:33 P.M. with LPN/Unit Manager (UM) #7 revealed she tracked all falls. LPN/UM #7 stated Resident #18 had a fall in the common area, adding it was sort of late and the resident went to sleep and fell forward out of the chair. LPN/UM #7 was asked how she knew the resident went to sleep and fell out of the chair and she replied that was what was written by LPN #18 in the investigation report. LPN/UM #7 was asked how she ensured the details in the investigation report were accurate and she stated if she could not understand what was on the report, she would interview to get more information. LPN/UM #7 stated she was not aware no one saw the resident asleep in the chair and was unaware LPN #18, who completed the investigation report, was not on the unit at the time of the fall. LPN/UM #7 stated she spoke with LPN #18 regarding the fall, but had not interviewed anyone else. LPN/UM #7 further stated she now understood she should have interviewed other staff regarding the fall.</p> <p>Interview on 09/26/24 at 3:52 P.M. with the Director of Nursing (DON) revealed after a resident fall, the nurse on duty completed a fall investigation form and a progress note to include notifications, what happened, and interventions. The DON stated all fall investigation forms went to LPN/UM #7, who tracked all falls. The DON stated UM/LPN #7 then reviewed the fall investigation form to ensure it was completed and interventions were appropriate. The DON stated UM/LPN #7 made sure all questions about the falls were answered, interventions were in place and care plans updated with interventions. The DON stated her expectation was for fall investigations to be thorough and the interdisciplinary team (IDT) should work on the investigation.</p> <p>Interview on 09/26/24 at 4:17 P.M. with the Administrator revealed his expectation was for a thorough fall investigation to be conducted.</p> <p>Review of a facility policy titled Investigation of Incidents and Unusual Occurrences, revised June 2017, revealed all falls will be investigated and documented in the progress notes.</p> |                                                                                             |                                                 |

|                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                        | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                 |
| F 0695<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is<br>disputing this citation. | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682</b></p> <p>Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure oxygen concentrator filters were adequately maintained. This affected one resident (#25) of one resident reviewed for oxygen use. The facility census was 81.</p> <p>Findings included:</p> <p>Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 07/01/24, revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required oxygen therapy.</p> <p>Review of the care plan, initiated 04/14/20, revealed Resident #25 required supplemental oxygen due to a diagnosis of COPD. Interventions directed the staff to administer supplemental oxygen as ordered.</p> <p>Observation on 09/23/24 at 9:27 A.M. of Resident #25's oxygen concentrator revealed a thick, white fuzz covered the filter.</p> <p>Observation on 09/24/24 at 7:49 A.M. of Resident #25's oxygen concentrator revealed a thick, whitish/gray fuzz covered the filter.</p> <p>Interview on 09/24/24 at 9:20 A.M. with State tested Nursing Assistant (STNA) #1 verified the filter on the rear of Resident #25's oxygen concentrator was covered with a white/grayish, dust/fuzzy matter. STNA #1 stated she did not know who was assigned to clean the filter.</p> <p>Observation on 09/24/24 at 9:26 A.M. of Resident #25's oxygen concentrator, with Registered Nurse (RN) #2, revealed a white/grayish, dust/fuzzy matter that covered the filter. Concurrent interview with RN #2 verified the observation and stated she was not assigned to clean the filter as it was cleaned on the night shift.</p> <p>Interview on 09/24/24 at 9:35 A.M. with Licensed Practical Nurse/Unit Manager (LPN/UM) #3 revealed she was uncertain of the frequency in which the concentrator should be cleaned, but thought the filter should be cleaned when the supplemental oxygen tubing was changed every other day on the night shift.</p> <p>Interview on 09/25/24 at 2:16 P.M. with the Director of Nursing (DON) revealed the oxygen filter should be cleaned by staff any time it was dirty.</p> <p>Review of a facility policy titled Respiratory Equipment Cleaning/Disinfecting, revised 07/30/24, revealed the external surface of an oxygen concentrator should be cleaned as needed and filters cleaned weekly or as needed.</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682</b></p> <p>Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure appropriate hand hygiene was performed during wound care. This affected one resident (#14) of one resident reviewed for wound care. Additionally, the facility failed to ensure appropriate placement of biohazardous receptacles for a resident on contact and droplet precautions. This affected one resident (#18) of one resident reviewed for infection control. The facility census was 81.</p> <p>Findings included:</p> <p>1. Review of Resident #14's medical record revealed an admitted [DATE]. Diagnoses included pressure ulcer of the sacral region, type II diabetes mellitus, moderate protein-calorie malnutrition and chronic multifocal osteomyelitis (infection of the bone) of multiple sites.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 08/15/24, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #14 required substantial/maximum assistance from staff for rolling from lying to left and right side and had two unhealed pressure ulcers.</p> <p>Review of Resident #14's physician orders revealed an order dated 07/19/24 to cleanse left ischium (lower part of the hip bone) with normal saline, apply collagen, cover with silver alginate, and cover with a bordered foam dressing every night and as needed. Further review revealed an additional order, dated 09/10/24, to cleanse the right ischium with wound cleanser, pat dry, apply collagen to the wound bed, then silver calcium alginate, and cover with a foam dressing every night and as needed.</p> <p>Observation on 09/25/24 at 3:00 P.M. of Resident #14's wound care, with Licensed Practical Nurse/Unit Manager (LPN/UM) #3, revealed the resident was lying in bed on their left side. LPN/UM #3 cleansed the right ischium wound with saline and patted the wound dry with gauze. Without changing gloves or sanitizing her hands, LPN/UM #3 then cleansed the left ischium wound with saline and patted the wound dry with gauze.</p> <p>Interview on 09/25/24 at 3:30 P.M. with LPN/UM #3 verified she did not change her gloves or perform hand hygiene between cleaning Resident #14's two separate wounds, further stating she should have changed gloves and performed hand hygiene between cleaning each wound.</p> <p>Interview on 09/26/24 at 4:50 P.M. with the Director of Nursing (DON) confirmed pressure ulcer care should be performed as ordered and the care of each pressure ulcer should be performed separately.</p> <p>Review of a facility policy titled Wound Assessment, dated 09/29/17, revealed to use proper hand hygiene and glove changes when performing a wound assessment.</p> <p>29358</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>2. Review of Resident #18's medical record revealed an admitted [DATE]. Diagnoses included dementia with psychotic disturbance, psychotic disorder with delusions, Alzheimer's disease and anxiety disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/18/24, revealed Resident #18 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems. The MDS indicated the resident required substantial assistance with most activities of daily living (ADLs), supervision with bed/chair/toilet transfers, supervision with walking and used a walker.</p> <p>Review of a nursing progress note dated 09/17/24 at 10:48 A.M. revealed Resident #18 tested positive for COVID-19.</p> <p>Review of physician orders revealed and order dated 09/17/24, with an end date of 09/27/24, to maintain contact and droplet precautions every shift.</p> <p>Observation on 09/23/24 at 10:18 A.M. of the memory care unit revealed Resident #18's room door had signage indicating the resident was on contact and droplet precautions. The signage identified what personal protective equipment (PPE) was needed when entering the room. An isolation cart, containing N95 masks, gowns and eye protection, was located outside the door.</p> <p>Observation on 09/23/24 at 10:24 A.M. two covered plastic trash cans with red biohazard bags lining them outside Resident #18's door. One was marked linen and the other marked trash.</p> <p>Interview on 09/23/24 at 10:25 A.M. with State tested Nursing Assistant (STNA) #22 confirmed the biohazard trash cans were for the linen and trash removed from Resident #18's room. STNA #22 further confirmed Resident #18 was on contact and droplet precautions for COVID-19. STNA #22 stated the cans were always kept outside of the door.</p> <p>Interview on 09/23/24 at 10:26 A.M. with Licensed Practical Nurse (LPN) #23 revealed the cans for biohazardous materials were always kept in the hall, outside of the resident's room.</p> <p>Observation on 09/24/24 at 11:30 A.M. revealed the biohazard trash cans with closed lids were in the hallway outside Resident #18's room.</p> <p>Observation on 09/25/24 at 8:29 A.M. revealed the biohazard trash cans were observed outside of Resident #18's room.</p> <p>Interview on 09/23/24 at 10:30 A.M. with Infection Preventionist (IP) #21 verified biohazard waste for Resident #18 was in the hall, outside of the room. IP #21 stated there was not enough space inside the room for the containers. Additionally, IP #21 stated the containers had lids.</p> <p>Interview on 09/26/24 at 4:28 P.M. with the Director of Nursing (DON) revealed the facility usually kept the biohazardous waste inside resident rooms, but Resident #18 would get into the trash so the containers were placed in the hallway.</p> <p>Interview on 09/26/24 at 4:35 P.M. with the Administrator revealed he expected the staff to follow the infection control policies.</p> <p>(continued on next page)</p> |                                                                                             |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                               |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365554                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>09/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Meadows                                                                                   |                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3472 Hamilton Mason Road<br>Hamilton, OH 45011 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                     |                                                                                             |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | Review of a facility policy titled COVID-19 Prevention, Response, and Reporting, dated 05/11/23, revealed the facility would ensure that appropriate interventions were implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. |                                                                                             |                                                 |