

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Monarch Meadows Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 299 Commerce Dr Seaman, OH 45679	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations staff interviews, policy review, and record review, the facility failed to store and prepare foods and maintain the kitchen in a sanitary manner. This had the potential to affect 46 residents who received food from the kitchen. The facility census was 47. Findings include: Observation on 09/15/25 at 8:45 A.M. of the kitchen revealed the following concerns: In the handwashing area, the garbage container was filled with used towels and was not covered. In the walk-in refrigerator, there was an unsealed bowl of cottage cheese with no label and no date. There was a container of chopped ham with no label and dated 09/11/25 and a container of cottage cheese dated 09/11/25. There were five plates of salads with no label and no date. In the area of food preparation equipment area, there was a large build of grease around the deep fryer around all four edges with apparatus grease drips down the sides of the equipment. The microwave table had food debris drips down the sides and there was dark brown debris on the wall adjacent along the floor cove basing. Along the eight-foot-long food stream table, there were dried food drips on the front. On the front of the convection oven, there was dried brown food debris built up. On the ceiling, over the clean storage of utensils, there was brown food debris collected onto three fire ceiling detectors. The dishwasher temperature log was listed as the required rinse temperature of 180 degrees Fahrenheit (F). On the dishwasher temperature logs, dated 09/01/25, 09/02/25, 09/03/25, 09/06/25, 09/07/25, 09/08/25, 09/09/25, 09/12/25, and 09/13/25, the recorded dishwasher rinse temperature was 150 degrees F. On those dates, Dietary Aide (DA) #119 had recorded the temperatures of 150 degrees F. All the other remaining days, the temperature was within 180-degree F listed by DA #126. Interview on 09/15/25 at 8:50 A.M., Dietary Manager (DM) #159 verified foods should be labeled and dated and discarded within three days of use. DM #159 verified the food preparation equipment and area should be clean and sanitary. DM #159 stated the dishwasher temperatures during the DA #119 days of work were incorrect as DA #119 had read the dishwasher final rinse temperatures incorrectly, and she had not known of the error. Observations of 09/17/25 at 10:57 A.M. of the kitchen revealed the following concerns: [NAME] #117 was preparing the puree food in a blender. After preparing the puree chicken in the blender bowl, [NAME] #117 sanitized the blender bowl and blender blade in the dishwasher. [NAME] #117 continued to touch the dishwasher, the soiled counter, and other soiled carts in the kitchen. [NAME] #117 did not wash her hands and proceeded to remove the blender bowl and blender blade from the dishwasher and reassembled the blender bowl and blade. [NAME] #117 processed mechanical soft chicken in the blender bowl. After processing, [NAME] #117 returned the soiled blade and bowl to the dishwasher. [NAME] #117 continued to touch the dishwasher, soiled food racks and counter tops. [NAME] #117 did not wash her hands and proceeded to remove the blender bowl and blender blade and reassembled the blender bowl without sanitizing her hands. [NAME] #117 did not wash her hands during the observation. Interview on 09/17/25 at 10:57 A.M., DM #159 verified [NAME] #117 should have sanitized her hands when reassembling the food processor to prevent cross contamination. Review of the facility's undated policy titled Sanitary Conditions revealed all opened food items will be labeled and dated, all equipment will be maintained in a clean and sanitary fashion. A food temperature log of the dishwasher will be maintained, and the rinse cycle will be 180 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees Fahrenheit. Employees will be knowledgeable in proper technique for processing dirty to clean dishes. The facility policy titled Garbage Removal and Dumpster dated 12/21/21 revealed all garbage cans in the food preparation area should be covered when not in use.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure signed Do Not Resuscitate (DNR) paperwork was present in the chart for a resident who requested DNR code status. This affected one (#52) of 19 residents reviewed for advance directives. The facility census was 47. Findings include: Closed record review for Resident #51 revealed the resident was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, diabetes mellitus, Alzheimer's disease, and seizures. Review of the physician's order, dated [DATE], revealed an order for the resident to be Do Not Resuscitate - Comfort Care Arrest (DNRCCA) code status. There was no DNR paperwork found in Resident #51's medical record. The nursing progress note, dated [DATE], revealed Resident #51 became unresponsive. Writer unable to find a pulse and began chest compressions. Certified Nursing Assistant (CNA) bagged resident until Registered Nurse (RN) took over. Emergency Medical Services (EMS) arrived. Telephone interview on [DATE] at 12:30 P.M. with Licensed Practical Nurse (LPN) #150 confirmed the nurse was passing morning medications when she was notified Resident #52 was on the floor in the bathroom. LPN #150 responded immediately and while providing care to Resident #52 the resident ceased breathing and was without a pulse. LPN #150 confirmed Cardiopulmonary Resuscitation (CPR) which included chest compressions and providing oxygen by bagging the resident was initiated until EMS personnel arrived. LPN #150 confirmed a pulse check was performed and the resident had regained a pulse and was transported to the hospital. LPN #150 confirmed CPR was initiated due to the resident not having signed DNR paperwork in the medical record. Interview on [DATE] at 1:50 P.M. with the Director of Nursing (DON) confirmed Resident #52 had a physician's order for DNRCCA code status but the facility had not ensured signed DNR paperwork was present in the medical record to prevent CPR from being initiated. This deficiency represents non-compliance investigated under Complaint Number 2602027.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to ensure the physician was notified timely of a resident's change in condition. This affected one (#5) of one resident reviewed for notification of change in condition. The facility census was 47. Findings include: Record review for Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses included respiratory failure, history of falling, difficulty walking, osteoporosis, and lack of coordination. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition. Review of the nursing notes on 05/23/25 at 5:59 A.M., Resident #5 had a witnessed fall. The resident reported pain of the right thigh. Former Licensed Practical Nurse (LPN) #200 documented to monitor the area. There was no documentation the physician was notified of Resident #5's fall and pain in the right thigh. The nursing notes revealed Resident #5 began to complain of right shoulder pain at 6:07 A.M. Former LPN #300 documented the resident was educated on possibly getting an x-ray. There was no notification to the physician regarding the complaint of right shoulder pain. Review of physician orders on 05/23/25 at 10:44 P.M. revealed a stat right shoulder x-ray was ordered by the physician. Interview on 09/17/25 at 4:27 P.M., the Director of Nursing, (DON) verified Former LPN #200 did not document in the nursing progress notes the physician had been notified of the fall and the resident presented with complaints of thigh pain. The DON verified there had been no documentation the physician had been notified of the Resident #5 change in condition until LPN #150's documentation on 05/23/25 at 10:44 P.M. obtaining an x-ray. Interview on 09/17/25 at 6:00 P.M., LPN #150 stated she notified the physician and obtained a stat x-ray order of the right shoulder and right hip for Resident #5 on 05/23/25 at approximately 8:00 P.M. and charted the order in the medical record at 10:00 P.M. LPN #150 stated she had received report from Former LPN #200, the resident had fallen on 05/23/25 at 6:00 A.M. Review of the facility's undated policy titled Status Change in Resident Condition revealed notifications will be made within twenty-four hours of a change occurring in the resident's condition or status.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately. This affected one (#4) of 19 residents reviewed for MDS assessments. The facility census was 47. Findings include:Record review for Resident #4 revealed the resident was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder, ventricular dementia, and anxiety disorder. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 07/2025 revealed Resident #4 was administered Olanzapine (an antipsychotic medication) and utilized a Wanderguard (a wander/elopement alarm) every day of the month. Review of the quarterly MDS assessment, dated 07/21/25, revealed Resident #5 did not receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever was more recent and did not utilize a wander/elopement alarm during the seven-day lookback period. Interview with Regional Clinical Nurse (RCN) #204 on 09/17/25 at 2:15 P.M. confirmed Resident #5's MDS assessment dated [DATE] was inaccurate. RCN #204 confirmed the MDS assessment dated [DATE] should have stated Resident #5 received antipsychotics and had a wander/elopement alarm.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure the resident's Pre-admission Screening and Resident Review (PASARR) were completed accurately following residents' significant changes in serious mental diagnosis. This affected three (#2, #9 and #13) of three residents reviewed for PASARR. The facility census was 47. Findings include: 1. Record review of Resident #9 revealed the resident was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had impaired cognition. Review of Resident #9's PASARR, dated 07/21/25 and signed by admission Director (AD) #165, revealed Resident #9 was assessed to have no diagnosis of any of serious mental illness with documented antipsychotic medication use. There were no other PASARR reviews provided by the facility. Review of physician orders revealed Resident #9 received a new diagnosis of schizoaffective disorder on 07/23/25. Interview on 09/17/25 at 2:18 P.M., Social Services Director (SSD) #162 verified Resident #9 had a change in serious mental diagnosis which required a new PASARR. SSD #162 stated a significant change PASARR should have been completed within 14 days after the new diagnosis for Resident #9. 2. Record review of Resident #2 revealed the resident was admitted to the facility on [DATE]. Diagnoses included psychosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had moderately impaired cognition. Review of physician orders revealed Resident #2 received a new diagnosis of unspecified psychosis on 07/11/24. Review of Resident #2's PASARR dated 10/21/24 and signed by Social Service Designee (SSD) #162 revealed no diagnosis of unspecified psychosis. There were no other PASARR reviews provided by the facility for the new diagnosis of unspecified psychosis on 07/11/24. Interview on 09/17/25 at 2:18 P.M. SSD #162 verified Resident #2 had a change in serious mental diagnosis which required a new PASARR. SSD #162 stated a significant change PASARR should have been completed within 14 days after the new diagnosis for Resident #2. 3. Record review of Resident #13 revealed the resident was admitted to the facility on [DATE]. Diagnoses included delusional disorders and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had intact cognition. Review of physician orders revealed Resident #13 received a new diagnosis of delusions on 02/14/24. Review of Resident #13's PASARR, dated 05/29/24 and signed by Former Social Service Designee (FSSD) #250 revealed no diagnosis of delusions. There were no other PASARR reviews provided by the facility for the new diagnosis of delusions on 02/14/24. Interview on 09/17/25 at 2:18 P.M., Social Services Director (SSD) #162 verified Resident #13 had a change in serious mental diagnosis which required a new PASARR. SSD #162 stated a significant change PASARR should have been completed within 14 days after the new diagnosis for Resident #13. Review of the facility policy titled PAS/RR dated 01/01/19, revealed the admission Director, or designed will complete the PAS/RR when the resident has experienced a significant change in condition. All residents with newly diagnosis or possible serious mental disorder will be referred to the Ohio Department of Aging upon significant change in status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents had care plans in place for dementia care and history of severe weight loss. This affected two (#3 and #7) of 19 residents reviewed for care planning. The facility census was 47. Findings include: 1. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, disorientation, and delirium. Review of the state optional Minimum Data Set (MDS) assessment, dated 08/26/25, revealed Resident #3 had severely impaired cognition. Review of the physician orders and diagnosis list revealed Resident #3 had a recent diagnosis of severe dementia on 08/14/25. Review of Resident #3's care plan revealed there was no dementia care plan created for Resident #3. Interview with the Director of Nursing (DON) on 09/17/25 at 12:58 P.M. verified there was no care plan for dementia developed for Resident #3. 2. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dysphagia, anemia, chronic kidney disease, and constipation. Review of the state optional Minimum Data Set (MDS) assessment, dated 08/26/25, revealed Resident #7 had intact cognition. Review of the physician orders and nutritional assessments revealed Resident #7 was at risk for further weight loss as she has been identified as having a severe weight loss in the past. Review of Resident #7's care plan revealed there was no nutrition care plan created for Resident #7. Interview with the Director of Nursing (DON) on 09/17/25 at 4:28 P.M. verified there was no care for nutrition and weight loss for Resident #7.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to ensure the residents receive timely care and services during a change in condition and failed to obtain weights as physician ordered. This affected three residents (#1, #5, and #23) of four residents reviewed for changes in condition. The facility census was 47. Findings include: 1. Record review of Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses included history of falling, neuropathy, osteoporosis, and lack of coordination. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition and required maximum assistance with activity of daily living skills and supervision assistance with transfers. Review of the nursing notes on 05/23/25 at 5:59 A.M., Resident #5 had a witnessed fall. The resident reported pain of the right thigh. Former Licensed Practical Nurse (LPN) #200 documented to monitor the area. There was no documentation the physician was notified of Resident #5's fall and pain in the right thigh. The nursing notes revealed Resident #5 began to complain of right shoulder pain at 6:07 A.M. Former LPN #300 documented the resident was educated on possibly getting an x-ray. There was no notification to the physician regarding the complaint of right shoulder pain. There was no follow up noted in the medical record until 10:44 P.M. Review of the physician order dated 05/23/25 at 10:44 P.M. revealed a stat (immediately) right shoulder x-ray was ordered by the physician, initiated by LPN #150. Review of the x-ray report results dated 05/24/25 at 10:48 A.M. revealed Resident #5 had x-ray results negative findings for right hip and Resident #5 had a right shoulder dislocation. The nursing notes dated 05/24/25 at 12:29 P.M., Resident #5 had a x-ray completed in the morning with the results showing a dislocation of the right shoulder. The physician ordered Resident #5 to the hospital for evaluation. Review of the portable x-ray service contract with the facility dated 04/19/21, revealed the response time will be two and half or less hours for stat x-rays. Interview on 09/17/25 at 4:27 P.M., the Director of Nursing (DON) verified the stat x-ray for Resident #5 was ordered on 05/23/25 at 10:00 P.M. and the stat x-ray was not obtained and read by the physician until 05/24/25 at 10:49 A.M. The DON verified the stat x-rays should have been obtained within four hours of the physician orders. Interview on 09/17/25 at 6:00 P.M., LPN #150 verified she notified the physician and obtained a stat x-ray order of the right shoulder and right hip for Resident #5 on 05/23/25 at approximately 8:00 P.M. and charted the order in the medical record at 10:00 P.M. LPN #150 stated she had received report from Former LPN #200, the resident had fallen on 05/23/25 at 6:00 A.M. LPN #150 verified the stat x-rays were not obtained during her shift, ending on 09/24/25 at 7:00 A.M. LPN #150 stated she would have expected the stat x-ray to be obtained within three to four hours of the order. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE]. Diagnoses included heart failure and encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/13/25, revealed Resident #1 had mildly impaired cognition. Review of the physician's order, dated 06/25/25, revealed Resident #1's weight was to be obtained every Monday, Wednesday, and Friday and the physician or nurse practitioner was to be notified of weight gain of five or more pounds in one week. Review of Resident #1's Treatment Administration Record (TAR) and weights documented under the weights/vital signs tab from 08/01/25 through 09/16/25 revealed weights were not obtained or refused by the resident for 08/04/25, 08/06/25, 08/08/25, 08/11/25, 08/13/25, 08/15/25, 08/18/25, 08/20/25, 08/25/25, 08/27/25, 09/03/25, 09/05/25, or 09/10/25. Interview on 09/17/25 at 2:15 P.M. with Regional Clinical Nurse #204 confirmed weights had not been obtained as ordered for Resident #1. 3. Record review for Resident #23 revealed the resident was admitted to the facility on [DATE]. Diagnoses included heart failure and hypertension. Review of the admission Minimum Data Set (MDS) assessment, dated 08/28/25, revealed Resident #23 had mildly impaired cognition. Review of the physician's order, dated 09/03/25, revealed Resident #23's weight was to be obtained every Monday, Wednesday, and Friday and the physician or nurse practitioner was to be notified of weight gain of five or more pounds in one week. Review of Resident #23's treatment administration record (TAR) and weights documented under the weights/vital signs tab from 09/03/25 through 09/16/25 revealed weights were not obtained or refused by the resident for 09/10/25, 09/12/25, or 09/15/25. Interview on 09/17/25 at 2:15 P.M. with Regional Clinical Nurse #204 confirmed weights had not been obtained as ordered for Resident #23.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and review of facility policy, the facility failed to ensure the residents received timely assessments and treatment for pressure ulcers. This affected one (#34) of two residents reviewed for pressure ulcers. The facility census was 47. Findings include:Record review for Resident #34 revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus and protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/12/25, revealed Resident #34 had impaired cognition and was at risk for pressure ulcer development but did not have any pressure ulcers at the time of the assessment. Review of the care plan, dated 06/06/25, revealed Resident #34 was at risk for impaired skin integrity/pressure ulcers. Interventions included skin assessment as ordered, inspect skin daily during care, and treatments per order. Review of the admission Packet evaluation, dated 09/02/25, revealed Resident #34 had a healing stage one pressure ulcer (non-blanchable redness) present to the sacrum. No description of the pressure ulcer or measurements were documented. There were no treatment orders for the pressure area on the sacrum on 09/02/25 and there were no further assessments, treatment orders or documentation of the pressure area on the sacrum in Resident #34's medical record. Interview with the Director of Nursing (DON) on 09/17/25 at 2:00 P.M. confirmed the facility was not aware Resident #34 had been assessed to have a pressure ulcer present on 09/02/25 and verified there were no treatment orders for the area of pressure or further assessments of the area of pressure had been completed. Observation of Resident #34's sacrum and buttocks on 09/17/25 at 3:15 P.M. revealed no areas of pressure were currently present. Review of the facility's undated policy titled Pressure Ulcer Prevention Intervention revealed the resident's skin will be assessed and monitored on a routine basis as is outlined in the skin assessment protocols.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of facility policy, the facility failed to ensure the appropriate fall interventions were in place to prevent falls and failed to ensure fall interventions were updated on the plan of care following a fall. This affected one (#34) of four residents reviewed for falls. The facility census was 47. Findings include: Record review for Resident #34 revealed the resident was admitted to the facility on [DATE]. Diagnoses included repeated falls, diabetes mellitus, and protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/12/25, revealed Resident #34 had impaired cognition. Review of the care plan, initiated on 03/21/25 and cancelled on 06/05/25, revealed Resident #34 was at risk for falls and potential injury. Interventions included bed stabilizers, lock bed, maintain a clear pathway, monitor for side effects of psychotropic medications, non-skid strips, provide rest periods, and have room close to the nurse's station. Dates the interventions were implemented were not provided. Review of the nursing progress note, dated 05/01/25, revealed writer alerted to resident's room due to resident on floor next to bed. Upon entering room, the resident was observed laying on the floor next to the right side of bed. Resident #34 was unable to recall what he was doing at the time of the incident due to baseline cognitive decline. Resident #34 with no complaints of pain or discomfort, noted to have an abrasion to front of right shoulder and right ear and discoloration to right side of face. Head to toe assessment completed, vital signs taken, and neuro checks initiated due to fall being unwitnessed. Immediate intervention was non-skid strips to right side of bed. Review of the facility's Fall Investigation, dated 05/01/25, revealed current fall prevention plan includes and in place at the time of the fall bed stabilizers/lock bed, common items close, clear pathway, monitor for side effects of psychotropics, and room close to nurse's station. The cause of the fall based on fall investigation was determined to be unknown what resident was doing at time of fall. The new intervention which was to be added to the plan of care and CNA (Certified Nursing Assistant) assignment sheet to prevent further falls was non-skid strips to the right side of bed. Review of the facility's Incident Report, dated 05/19/25, revealed housekeeping notified CNA that Resident #34 was laying on mat on the floor beside the bed. CNA assisted resident to wheelchair. Neuro checks started at this time. First set of vital signs were obtained. Head to toe assessment completed, no injury noted. Resident #34 unable to give description. Review of the facility's Fall Investigation, dated 05/19/25, revealed Resident #34 was unable to give description of what he was trying to do. Current fall prevention plan includes and in place at the time of the fall non-skid floor mat at bedside, low bed, bed stabilizers/lock bed, and room close to nurse's station. The cause of the fall was not documented. The new intervention which was to be added to the plan of care and CNA assignment sheet to prevent further falls was mat to right side of bed. Interview on 09/17/25 at 2:22 P.M. with Registered Nurse (RN) #165 confirmed on 05/19/25 Resident #34 was found on the floor on a mat which had been put in place beside his bed. RN #165 confirmed the resident had been known to climb out of bed so a mat had been put in place to prevent injury. RN #165 confirmed care plan interventions at the time of the fall did not include a mat to be in place but did contain an intervention for non-skid strips. RN #165 confirmed the new intervention following the resident's fall on 05/19/25 was for a fall mat to be in place by the resident's bed. RN #165 confirmed the care plan initiated on 03/21/25 and cancelled on 06/05/25 did not contain an intervention for a fall mat to be in place by the resident's bed. Review of the facility's undated policy titled Fall Management revealed if a fall occurs, the licensed nurse will assess the resident for injury from the fall immediately and initiate an investigation of the reason for the fall and implement an immediate intervention to attempt in preventing future falls. The Interdisciplinary Team will review the falls routinely to determine the most appropriate type of intervention to be implemented to attempt in prevent the future incidents from occurring. A care plan will be implemented upon admission for (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Monarch Meadows Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 299 Commerce Dr Seaman, OH 45679	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who are identified as at risk for falls with interventions to attempt to prevent further incident. The care plan will be updated routinely and with significant change in the residents condition.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Monarch Meadows Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 299 Commerce Dr Seaman, OH 45679	
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on medical record review, and resident and staff interviews, the facility failed to ensure a resident was assessed and received trauma informed care accounting for the resident's experiences with spousal abuse. This affected one (Resident #42) of one resident reviewed for trauma informed care. The facility census was 47. Findings include: Review of the medical record for Resident #42 revealed an admission date of 07/28/25. Diagnoses included dementia. Review of the state optional Minimum Data Set (MDS) assessment, dated 08/04/25, revealed Resident #42 had intact cognition. Review of Resident #42's medical record revealed no indication Resident #42 was assessed for Post Traumatic Stress Disorder (PTSD) (a mental health condition that develops after experiencing or witnessing a traumatic event). Resident had a well-known situation of spousal abuse to the point where her husband was removed from the facility since her admission. Resident #42's medical record including a plan of care did not address if Resident #42 received trauma informed care or a PTSD assessment with a history of spousal abuse. Interview with the Director of Nursing (DON) on 09/17/25 at 1:00 P.M. verified she had the resident's spouse removed from the building due to him being abusive to Resident #42. The DON also verified there has been no assessments or plan of care for trauma or PTSD for Resident #42. Interview with Resident #42 on 09/17/25 at 1:17 P.M. stated she had an abusive marriage which caused her at one point to cut her wrists which landed her in a psychiatric facility for assessment. She stated she was then removed from her home for safety due to the abuse, and placed in this facility. Resident #42 stated she feels safe here now. Resident #42 was not aware of any staff providing trauma informed care or a PTSD assessment.		

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NAME OF PROVIDER OR SUPPLIER Monarch Meadows Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 299 Commerce Dr Seaman, OH 45679	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure residents were free from significant medication errors. This affected one (#34) of seven residents reviewed for medication administration. The facility census was 47. Findings include: Record review for Resident #34 revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/12/25, revealed Resident #34 had impaired cognition. Review of the physician's visit note, dated 09/05/25, revealed Resident #34 had diabetes mellitus and blood sugars were often elevated. The physician was going to order 10 units of Lantus (an insulin medication to lower blood sugar) at bedtime. The physician visit was signed by the physician. Review of the physician's orders revealed there was no order for 10 units of Lantus to be administered at bedtime had been initiated. Review of the resident's medication administration record from 09/05/25 to 09/16/25 revealed 10 units of Lantus at bedtime was not administered to Resident #34. Interview on 09/17/25 at 11:05 A.M. with the Director of Nursing (DON) confirmed Resident #34's physician had ordered 10 units of Lantus to be administered on 09/05/25 but the order had not been transcribed or implemented by the facility. The DON stated the facility had an issue with the physician sending over his visit notes timely to the facility and then did not realize the facility was not writing the orders from the physician's visit notes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Monarch Meadows Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 299 Commerce Dr Seaman, OH 45679	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and review of the facility's radiology contract, the facility failed to obtain stat (immediately) x-rays in a timely manner. This affected one (#5) of one resident reviewed for radiology services. The facility census was 47. Findings include:Record review of Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses included history of falling, neuropathy, osteoporosis, and lack of coordination. Review of the physician order dated 05/23/25 at 10:44 P.M. revealed a stat (immediately) right shoulder x-ray was ordered by the physician. Review of the x-ray report results dated 05/24/25 at 10:48 A.M. revealed Resident #5 had x-ray results negative findings for right hip and Resident #5 had a right shoulder dislocation. The nursing notes dated 05/24/25 at 12:29 P.M., Resident #5 had a x-ray completed in the morning with the results showing a dislocation of the right shoulder. The physician ordered Resident #5 to the hospital for evaluation. Interview on 09/17/25 at 4:27 P.M., the Director of Nursing (DON) verified the stat x-ray for Resident #5 was ordered on 05/23/25 at 10:00 P.M. and the stat x-ray was not obtained and read by the physician until 05/24/25 at 10:49 A.M. The DON verified the stat x-rays should have been obtained within four hours of the physician orders. Interview on 09/17/25 at 6:00 P.M., Licensed Practical Nurse (LPN) #150 verified she notified the physician and obtained a stat x-ray order of the right shoulder and right hip for Resident #5 on 05/23/25 at approximately 8:00 P.M. and charted the order in the medical record at 10:00 P.M. LPN #150 verified the stat x-rays were not obtained during her shift, ending on 09/24/25 at 7:00 A.M. LPN #150 stated she would have expected the stat x-ray to be obtained within three to four hours of the order. Review of the portable x-ray service contract with the facility dated 04/19/21, revealed the response time will be two and half or less hours for stat x-rays.		