STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows of Ottawa The	147 Putnam Parkway Ottawa, OH 45875

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, family interview, and staff interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) care received adequate assistance with personal hygiene. This affected one (#59) of four residents reviewed for ADL care. The facility census was 80. Findings include: Review of the medical record revealed Resident #59 was admitted on [DATE]. Diagnoses included paraplegia, injury to sacral spinal cord, other front temporal neurocognitive disorder, dementia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #59 was rarely understood and dependent on staff for assistance with personal hygiene. Review of the care plan dated 10/04/22 revealed Resident #59 had paraplegia and required one person assistance with ADL care. Observation on 01/27/25 at 10:38 A.M. revealed Resident #59 had unshaven facial hair on face and neck. Interview on 01/27/25 at 10:40 A.M. with Resident #59's Resident Representative revealed the resident was a businessman and was always well kempt including shaving on a daily basis. It was reported the facility had been asked to ensure he was shaved daily. Resident #59's resident representative reported he had approximately four to five days of facial hair growth. Interview on 01/27/25 at 11:10 A.M. with Certified Nurse Assistant (CNA) #431 verified Resident #59 had unshaven facial hair with growth of approximately a few days. This deficiency represents non-compliance investigated under Master Complaint Number OH000161547, Complaint Number OH00161076, and Complaint Number OH00161078.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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** 15816 Based on observation, medical record review, staff interview, interview with wound care nurse practitioner, and facility policy review, the facility failed to ensure wound monitoring and physician prescribed wound treatments were administered as ordered. Actual Harm occurred when Resident #71 fell from his wheelchair and sustained a laceration to the head which compromised a preexisting head wound. Resident #71 was evaluated at the hospital and returned to the facility with a hemostatic bandage dressing in place. The dressing remained in place for seven days without being changed or evaluated. The dressing was discovered to be severely adhered to the scalp, required debridement to remove embedded dressings and found to have a large amount of foul-smelling drainage between layers of dressings and wound with exposed bone. This affected one (#71) of three residents reviewed for the application of wound treatments in a facility census of 80. Findings include: Review of Resident #71's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included squamous cell carcinoma right lower limb, malignant neoplasm of scalp and neck, hypotension, laceration to scalp, peripheral vascular disease, lymphedema, non-pressure chronic ulcers to left and right lower legs, type II diabetes mellitus, anemia, hypertensive heart disease, moderate protein calorie malnutrition, disorder of kidney and ureter, coronary artery disease, and repeated falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had intact cognition, ability to make needs known, lower extremity range of motion impairment, utilized a wheelchair for mobility, and required partial to moderate assistance with activities of daily living. Resident #71 was at risk for pressure ulcer development, admitted with one unstageable pressure ulcer (slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar), three venous or arterial ulcers, open lesion on foot, open lesions other than ulcers, rashes or cuts, and skin tears. Review of the hospital discharge instructions dated 11/25/24 revealed Resident #71 admitted with treatments to a head wound identified as trauma/cancer. Treatments included cleanse with Dakin's solution and gauze. Apply non-adhering (Vaseline) dressing to wound. cover with Abdominal Dressing (ABD). Secure with stockinet. Change dressing twice daily. Wound description traumatic wound injury to head with dry eschar serosanguineous drainage, ecchymosis to peri-wound and full thickness. The medical record lacked the development of a nursing plan of care regarding treatment, care or interventions for the head wound. On 11/26/24, wound management detail report documentation identified a traumatic/cancer wound right side of head and top of head. The wound was described with a small amount of drainage, slough noted in area, peri-wound pink with no odor. Measurements were three (3.0) centimeters (cm) long by (x) seven (7.0) cm wide. Healing status was stable. On 11/26/24, the physician ordered to monitor dressing to top of head every shift and reapply dressing as needed. Three times a day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Meadows of Ottawa The		STREET ADDRESS, CITY, STATE, ZIP CODE: 147 Putnam Parkway Ottawa, OH 45875	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/13/24, Wound Center Certified Nurse Practitioner (WCCNP) #200's evaluation noted Resident #71 with a traumatic head wound right open upper wound from fall. Treatment included petroleum gauze with ABD (abdominal dressing). Measurement 16.0 cm long by 13.0 cm wide and 0.2 cm deep with slough, devitalized tissue, pale granulation tissue, and small amount of thick yellow drainage with mild odor. Recommend scalp wound treatment to clean head/hair with chlorhexidine wash and comb hair. Apply Triad paste (helps maintain a moist wound environment) to wound. Cover with dry alginate (cut to size needed) and ABD pad. Secure with stockinet/hat and change daily. Follow-up visit will be on 01/10/25 at 10:30 A.M. If the resident experiences any of the following, please call the wound care service during business hours. Increased pain, increase in drainage from the wound or a foul odor, uncontrolled swelling, need for compression bandage changes due to slippage, and/or breakthrough drainage. The Wound Management Detail Report documented on 01/02/25, a traumatic/cancer wound to head measured 15.0 cm long x 8.0 cm wide with healing and stable wound. Bright red tissue present. Small amount of bloody drainage and crusty areas present. Resident #71 denied pain in the area. Review of the Event Report Incident dated 01/04/25 at 5:54 A.M. revealed Resident #71 was observed on the floor in room. Moderate bleeding from head. Skin tear to lower left forearm and left hand under ring finger. Gentle but firm pressure applied to head wound, unsuccessful stopping bleeding. Transported to hospital for evaluation. At 1:30 P.M., Resident #71 was returned from the hospital. According to hospital emergency room (ER) discharge documentation dated 01/04/25, Resident #71 was evaluated for a fall resulting in head laceration. No documentation contained in the discharge instructions included treatment to the head wound or type of dressing applied. Review of the treatment administration records between 01/04/25 and 01/10/25 revealed nursing staff initials with parentheses indicating the head wound dressing was not administered as ordered. Nursing progress notes revealed on 01/06/25 at 4:43 P.M., Resident #71 refused to let the nurse change dressing on head. On 01/07/25 at 8:54 P.M., Resident #71 refused to let the nurse change dressings on head and arms. On 01/09/25 at 1:56 A.M., Resident #71 refused to allow Registered Nurse (RN) to change bandage on his head and bilateral arms at this time. Resident #71 stated he will get them changed at his wound care appointment. Education given to the resident on importance of dressing changes and preventing infection but he still refused at this time. At 6:46 A.M., Resident #71 refused for head bandage to be removed and changed at this time. Unable to complete measurement and treatment. At 6:50 A.M., the resident allowed for wounds and dressings to be changed except for head dressing, Resident #71 refused on multiple attempts. On 01/09/25 at 4:23 P.M., the nurse attempted to provide wound treatment to residents' head. Resident #71 declined and said that he has an appointment for it tomorrow. Further review of the medical record lacked documented evidence indicating the wound clinic specialist was notified regarding Resident #71's fall with injury to the traumatic wound to his head. No attempts to determine the underlying cause for Resident #71's wound dressing refusals were noted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/10/25, WCCNP #200's evaluation noted Resident #71 stated he had a fall on 01/04/25 that resulted in re-injury of head for which he went to the ER. Per documentation: Resident #71 found to have big head injury with active bleeding. Resident's bleeding was controlled with hemostatic bandage and was appropriately wrapped. Resident #71 presented with bulky dressing and ACE wrap sitting on top of his head. He stated the dressing had not been changed since it was applied on 01/04/25 in the ER. Review of the (hospital) discharge instructions showed recommendations to schedule follow-up appointment with WCCNP #200 in clinic within two days. Review of charting shows no calls were placed to the clinic notifying the wound clinic of new wound or requesting earlier visit. On arrival, dressing was found to be severely adhered to the scalp. Copious amounts of saline irrigation were utilized to soften dressing for removal. Unfortunately, this was unsuccessful, and debridement was required to remove embedded dressings. On removal, Resident #71 was found to have a large amount of foul-smelling drainage between layers of dressings and wound with exposed bone noted to scalp wound. The treatment was changed to apply cuticerin to bone. Cover with saline moistened gauze and ABD pad. Secure stockinet/hat. Change daily. Wound descriptions noted a head wound etiology as traumatic, wound cleansed with saline. Measurements with wound length 10. 2 cm x width 6.2 cm and depth 0.4 cm. Wound assessment identified exposed structure bone; granulation tissue; pale granulation tissue; pink/red slough, and moderate serosanguineous (blood tinged) drainage. Observation on 01/28/25 at 2:07 P.M. revealed Assistant Director of Nursing (ADON) #322 administered Resident #71's head wound dressing including removing the existing undated dressing. ADON #322 proceeded to cleanse the open areas to his head and cleanse his wound parameter with chlorahexine. Comb his hair, apply cuticerin dressing over bone and normal saline wet gauze to remaining open areas. Followed by covering the entire head wound with an ABD and stockinet. On 01/30/25 at 8:42 A.M., an interview with the Director of Nursing (DON), ADON #322, Regional Registered Nurse (RRN) #500, and Administrator during review of Resident #71's medical record confirmed the wound clinic and/or WCCNP #200 were not informed of Resident #71's fall with injury to his head until previously scheduled appointment on 01/10/25. Staff also confirmed the treatment for the head wound was not administered between 01/04/25 and 01/10/25, and were unaware what treatment had been applied when the resident was evaluated at the hospital emergency roiagnom on [DATE] which was left in place until the wound clinic appointment on 01/10/25. On 01/30/25 at 10:20 A.M., review of the medical record with ADON #322 and RRN #500 confirmed there was no documentation of a nursing plan of care addressing the head wound until 01/29/25. Telephone interview on 01/30/25 at 3:18 P.M. with WCCNP #200 confirmed Resident #71 was under her care regarding the wound to the head and additional wounds prior to admission to the facility. WCCNP #200 confirmed she was not contacted by the facility when Resident #71 sustained an injury to the head wound which caused an additional skin impairment to the head wound WCCNP #200 was treating. WCCNP #200 indicated they were not made aware of the injury until Resident #71 was evaluated at the wound clinic on 01/10/25. Resident #71 was observed with an ACE bandage wrapped around his head and a dressing which was not prescribed was applied to the top of his head. WCCNP #200 verified all documentation of Resident #71's wound evaluations were accurate including wound descriptions. Prior to the injury on 01/04/25, the head wound did not have an area of exposed bone. WCCNP #200 confirmed Resident #71 did not develop infection and currently wounds were improving. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meadows of Ottawa The		STREET ADDRESS, CITY, STATE, ZIP CODE 147 Putnam Parkway Ottawa, OH 45875	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Guidelines for General Wound and Skin Care policy, last revised 02/23/23, revealed nursing was to re-evaluate dressing and skin integrity every shift. Re-evaluate the wound's response to the prescribed treatment. Make recommendations for changes as needed (PRN). Inform the physician (MD) of changes in wound status. Review of the facility's Notification of Change in Condition policy, dated 12/17/24, revealed purpose was to ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with resident's physician and if known notify the residents legal representative when: An accident involving the resident which results in an injury and has the potential for requiring physician intervention. A significant change in residents' physical, mental or psychosocial status. A need to alter treatment significantly. Documentation of notification or notification attempts should be recorded in the resident electronic health record. This deficiency represents non-compliance investigated under Complaint Number OH00161547.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, resident and staff interview, and review of facility policies, the facility failed to ensure interventions for residents with pressure ulcers were applied correctly. This affected one (#75) of three residents reviewed for pressure ulcers. The facility census was 80. Findings include: Review of the medical record revealed Resident #75 was admitted on [DATE]. Diagnoses included polyosteoarthritis, fracture of second lumbar vertebra, chronic kidney disease, anorexia, muscle weakness, osteoarthritis, and retention of urine. Review of the Minimum Data Set (MDS) assessment, dated 10/31/24, revealed Resident #75 was severely cognitively impaired. The resident required substantial assistance from staff for toileting, showers, upper and lower body dressing, and personal hygiene. Review of the most recent care plan revealed Resident #75 required encouragement and assistance with turning and repositioning every two hours with heel protector moon boots on while in bed at all times. Review of the wound management detail report, dated 01/27/25, revealed Resident #75 had an unstageable left heel pressure ulcer (slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar) measuring 1.4 centimeters in length by 1.1 centimeters in width and 0.1 centimeters in depth. The wound was described as stable and had improved in size from the previous week. Observation and interview on 01/27/25 at 9:47 A.M. with Resident #75 revealed the resident was lying in bed with both feet outside of the blanket. A heel protector boot was applied but was twisted to the front of the foot revealing the heel exposed with a dressing on the heel. Resident #75 requested assistance with repositioning. Observation on 01/27/25 at 9:55 A.M. revealed Certified Nursing Assistant (CNA) #447 reposition Resident #75 and exit the room. Resident #75's heel boot remained applied incorrectly with the heel unprotected. Interview on 01/27/25 at 9:56 A.M. with CNA #447 verified Resident #75's heel boot was not applied correctly and the left heel was not protected. CNA #447 verified she should have ensured the pressure ulcer interventions (heel boot protector) was in place when repositioning Resident #75. Review of policy titled Guidelines for Pressure Prevention, dated 12/17/24, revealed care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include to elevate heels off the bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meadows of Ottawa The		STREET ADDRESS, CITY, STATE, ZIP CODE 147 Putnam Parkway Ottawa, OH 45875	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled General Wound and Skin Care, dated 12/17/24, revealed wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity including to evaluate the need for heel floats/boots. This deficiency represents non-compliance investigated under Master Complaint Number OH000161547.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on resident and staff interview, medical record review, and interview with pharmacy staff, the facility failed to ensure medications were available and administered as physician ordered. This affected one (#23) of one resident reviewed for pain management. The facility census was 80. Findings include: Review of Resident #23's medical record revealed an admitted [DATE]. Diagnoses included pinched nerve in the lumbar region, traumatic muscle injury, osteoporosis, spinal stenosis, chronic pain, chronic cluster headache, tremor, and opioid dependence with opioid induced psychotic disorder with delusions. Review of Resident #23's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #23 was cognitively intact. Resident #23 displayed no behaviors during the review period. Resident #23 received scheduled and as needed (PRN) pain medication. At the time of the review Resident #23 reported her pain was almost constant and occasionally her pain would interfere with her day to day activities. Resident #23 indicated her worst pain over the last five days was a nine on a scale of zero (no pain) to ten (worst pain). Review of Resident #23's care plan revised 01/14/25 revealed supports and interventions for risk for pain. Pain interventions included administer medications as ordered, attempt non-pharmacological interventions, observe for verbal and nonverbal signs of pain, and reposition as ordered. Review of Resident #23's physician orders revealed an order dated 01/15/25 with a start date of 01/21/25 and discontinued 01/28/25 for hydrocodone-acetaminophen 5-325 milligrams (mg) take two tablets by mouth twice a day as needed for moderate to severe pain. An order dated 01/28/25 with a start date of 01/28/25 for hydrocodone-acetaminophen 5-325 mg take two tablets by mouth twice a day as needed for moderate to severe pain of seven out of ten or greater with a maximum of four tablets per day. The order was open ended. An order dated 01/28/25 with a start date of 01/28/25 for hydrocodone-acetaminophen 5-325 mg take one tablet by mouth twice a day as needed for pain between four to six on a scale of one to ten with a maximum of four doses per day. The order was open ended. Interview on 01/27/25 at 10:17 A.M. with Resident #23 reported the facility had run out of her pain medications. Resident #23 reported she only had two pills left of her pain medication and she only got one pain pill this morning when she actually wanted two. Resident #23 stated by her taking only one there was one pill left for her to take this afternoon. Resident #23 reported she was a retired nurse and her medications should have been reordered prior to her running out so she didn't have to go with less or without. Resident #23 stated she was doing ok but she still had pain after taking the one pill. A follow-up interview on 01/27/25 at 11:38 A.M. with Resident #23 revealed her pain medication was not effective and her pain level was an eight. Resident #23 reported she had tried to walk but it hurt so she was just going to stay in bed. Interview on 01/28/25 at 7:57 A.M. with Clinical Support Registered Nurse (CSRN) #537 verified Resident #23 had run out of her pain medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Meadows of Ottawa The		STREET ADDRESS, CITY, STATE, ZIP CODE: 147 Putnam Parkway Ottawa, OH 45875	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/28/25 at 8:12 A.M. with Resident #23 verified she had taken her last pain pill last night. Resident #23 stated nursing had saved one pill for the evening time yesterday which was not real good for her pain, but was better than the none she had now. Resident #23 reported she was given Tylenol and a muscle relaxer this morning since they were out of her pain medication. Resident #23 stated her pain level was still an eight on a scale of one to ten, but she was feeling really sleepy and heavy from taking the muscle relaxer. Resident #23 stated she had been told her medication had been ordered this past Friday but had not arrived yet. Resident #23 stated it didn't seem right her medication was not refilled yet. Interview on 01/28/25 at 9:31 A.M. with Pharmacy Staff (PS) #580 revealed on 01/06/25, Resident #23 had 30 hydrocodone-acetaminophen dispensed and on 01/18/25, an additional 28 were dispensed. PS #580 stated there were 60 tablets available for refill but there were nothing processing at this time. A request had not been received to fill the prescription. Interview on 01/28/25 at 1:58 P.M. with Licensed Practical Nurse (LPN) #320 verified Resident #23 had run out of her Norco (hydrocodone-acetaminophen) and had been provided two Tylenol tablets and two muscle relaxers as well. LPN #320 reported she could have pulled the Norco from the contingency box but Resident #23 had reported to her she was feeling good. The muscle relaxer order was for one to two pills. Follow up interview on 01/29/25 at 9:12 A.M. with Resident #23 found her awake lying in bed. Resident #23 reported she was very very happy and felt great because they got her pain medication in and she was able to have two tablets this morning like she had wanted. Resident #23 reported she had been uncomfortable with a pain level of around eight when she had not gotten the pain medication she was supposed to, but it had not gotten in the way of her doing what she needed to do.

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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** 37451 Based on resident interview, medical record review, staff interview, and review of facility policy, the facility failed to ensure blood sugar levels were obtained and insulin was administered according to physician orders, resulting in a significant medication error. This affected one resident (#47) of one resident reviewed for blood sugar checks and insulin. The facility census was 80. Findings include: Review of Resident #47's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus and morbid obesity. Review of Resident #47's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #47 was cognitively intact. Review of Resident #47's care plan revised 01/22/25 revealed supports and interventions for the risks of hypo/hyperglycemia related to diabetes mellitus. Interventions included diet per order, monitor blood sugars as ordered and provide medications as ordered. Review of Resident #47's physician orders revealed an order dated 10/28/21 to check Resident #47's blood sugars before meals and at bedtime (6:00 A.M. to 10:00 A.M., 11:00 A.M. to 12:30 P.M., 4:00 P.M. to 5:30 P. M., 6:00 P.M. to 10:00 P.M.). On 10/15/24, there was a physician order for Humalog Insulin 100 units per milliliter, administer 18 units before meals and hold evening/dinner for blood sugar less than 130. Review of Resident #47's Medication Administration Record (MAR) revealed on 01/06/25 Resident #47's blood sugar was not taken between 4:00 P.M. to 5:30 P.M. and it read it was taken at 7:08 P.M. and read 196. It was noted Resident #47's blood sugar was taken late and was due on the previous shift. Also on 01/06/25 Resident #47's Humalog was noted to be administered at 7:08 P.M. and was also noted Resident #47's Humalog was to be administered on the prior shift and was administered late. Interview on 01/27/25 at 10:03 A.M. with Resident #47 found her to be alert and aware. Resident #47 reported she was not getting her medications on time. She stated she often ate her meals before her blood sugar was taken and her insulin was administered. Resident #47 stated she needed her blood sugar taken before she ate, but there were times the nurse was so late and she was hungry and not able to wait and her food would get cold. Observation on 01/28/25 at 8:15 A.M. of Resident #47 found her eating her breakfast of apple juice and raisin toast. Coinciding interview with Resident #47 revealed she had not received her blood sugar check or her insulin yet. Resident #47 stated her meal had been delivered about twenty minutes ago and she tried to wait to eat but couldn't wait any more. Resident #47 stated she probably would not eat all her toast. Interview on 01/28/25 at 8:19 A.M. with Licensed Practical Nurse (LPN) #320 verified Resident #47 had not yet received her medications or her blood sugar checks yet. LPN #320 reported there were issues with the computer system so they were not able to get Resident #47's medications done yet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366423	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/28/25 at 9:07 A.M. with the Director of Nursing (DON) verified it looked like on 01/06/25 Resident #47's blood sugars were taken late and Resident #47's Humalog insulin was administered late. The DON reported she would get the nurse who documented the late administration contact information to clarify what occurred. Interview on 01/28/25 at 3:06 P.M. with Licensed Practical Nurse (LPN) #315 verified on 01/06/25 Resident #47 had not received her blood sugar check before her dinner and had not received her scheduled insulin as ordered. LPN #315 reported Resident #47 had asked for her blood sugar to be taken and insulin administered so he verified with the nursing going off shift the insulin had not been administered and Resident #47's blood sugar level had not been taken. LPN #315 reported he took Resident #47's blood sugar level and found it was above 130. Had her blood sugar been below 130 her insulin was to be held. Resident #47's blood sugar was above the 130 parameter so the insulin was administered. LPN #315 reported it was documented in Resident #47's MAR as a late administration because the blood sugar was taken and insulin administered around 6:45 P.M. when it was to have been completed on the previous shift between 4:00 P.M. and 5:30 P.M. before Resident #47 had dinner. Review of the facility policy titled, Medication Administration Times Procedural Guidelines, revised 05/23/18 revealed medications ordered at a specific time shall be administered at the time designated by the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Meadows of Ottawa The		STREET ADDRESS, CITY, STATE, ZIP CODE 147 Putnam Parkway Ottawa, OH 45875	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview and facility policy, the facility failed to ensure enhanced barrier infection control precautions were implemented as ordered. This affected one (#73) of 23 residents reviewed for infection control practices in a facility census of 80. Findings include: Resident #73 admitted to the facility on [DATE] with the diagnoses including, hemiplegia and hemiparesis following non-traumatic intracranial hemorrhage, aphasia, dysphagia, acute respiratory failure, hypertension, history of tracheostomy, and percutaneous endoscopic gastrostomy tube. According to the most current Minimum Data Set assessment dated [DATE] Resident #73 was assessed with severely impaired cognition, dependent on staff for the completion of activities of daily living, received nutrition via feeding tube, and mechanically altered diet. On 01/22/25 a nursing plan of care was implemented to address Resident #73 required Enhanced Barrier Precautions (EBP) during high-contact care related to presence of a feeding tube. Care plan goal was for risk for transmission of infection to be minimized with use of EBP. Interventions included: Perform hand hygiene before and after care, per policy and as required. Don/doff and dispose of Personal Protective Equipment (PPE) systematically and appropriately, per policy. Approach: Utilize gown and gloves per EBP policy during wound care/dressing changes. Utilize gown and gloves per EBP policy during indwelling device care (e.g. central lines, urinary catheter, feeding tube, and tracheostomy). Utilize gown and gloves per EBP policy during high contact ADL care (e.g. dressing, showering/bathing, hygiene, transfers, toileting/changing briefs) and during linen changes. According to physician orders dated 09/27/24 Resident #73 received PEG (feeding tube) free water flushes of 60 milliliters three times daily and staff was ordered to use EBP, wearing a gown and gloves at minimum during high-contact care activities. On 01/27/25 at 10:25 A.M. Resident #73 was observed in therapy receiving therapy treatment and hands on transfer assistance with two therapist. Staff was not wearing PPE during resident contacts. Additional observation at 10:35 A.M. revealed Resident #73 room without signage indicating EBP or directions to wear PPE and no PPE available in the vicinity of the resident room. On 1/27/25 at 1:28 P.M. interview with Registered Nurse (RN) #303 confirmed EBP interventions were not in place for Resident #73. RN #73 confirmed facility policy indicates residents with feeding tubes require access to PPE in their room and a sign on the room door directing staff to wear PPE during resident contact. Review of facility EBP standard operating procedure revised 04/02/24 revealed EBP will be in place during high contact care activities for residents with the following conditions: All residents with indwelling devices including catheters, central lines, feeding tubes, tracheostomy tubes. Personal Protective Equipment (PPE) should be used even if blood or body fluid exposure is not anticipated. At a minimum, staff shall wear gloves and gowns during high contact care activities.