STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366435	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand The	4500 John Shield Pkwy Dublin, OH 43017

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on medical record review, staff interview, family interview, review of Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to ensure allegations of physical abuse were reported to Ohio Department of Health (ODH) in a timely manner. This affected two (Residents #77 and #78) of three residents reviewed for abuse. The facility census was 113 residents. Findings include: 1. Review of the medical record for Resident #77 revealed an admitted [DATE] with diagnoses including moderate dementia with behavioral disturbance, anxiety disorder, acquired absence of kidney, and atherosclerotic heart disease. Review of the (Minimum Data Set) MDS assessment for Resident #77 dated 02/13/25 revealed the resident had severe cognitive impairment. Review of a progress note for Resident #77 dated 01/29/25 timed at 7:23 P.M. per by Licensed Practical Nurse (LPN) #101 revealed the nurse heard a scream from a resident's room and upon arrival found an altercation had taken place between Resident #77 and Resident #78 with both residents sustaining bruises and scratches as a result of the altercation. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including Lewy body disease, anxiety disorder, macular degeneration, and depression. Review of a progress note for Resident #78 dated 01/29/25 timed at 7:23 P.M. per LPN #101 revealed that the nurse heard a scream in a resident's room, and upon arrival found an altercation had taken place between Resident #77 and Resident #78 with both residents sustaining bruising and a scratches as a result of the altercation. Interview on 02/24/25 at 11:29 A.M. with LPN #101 confirmed Resident #77 got into a fight with Resident #78 in Resident #78's room at the end of the shift on 01/29/25. LPN #101 confirmed Resident #78 was found on the floor with a black eye to the right face and some scratches, and Resident #77 had facial bruising and a scratch, and was found sitting on the bed. LPN #101 confirmed she reported the incident to the oncoming nurse who was supposed to report it to the Administrator. LPN #101 confirmed she did not report the potential resident-to-resident physical abuse to the Administrator. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Grand The		STREET ADDRESS, CITY, STATE, ZIP CODE 4500 John Shield Pkwy Dublin, OH 43017	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Self-Reported Incident (SRI) dated 01/30/25 timed at 12:31 P.M. revealed the facility initiated an investigation of physical abuse between Residents #77 and #78. Further review revealed the facility did not initiate the SRI involving potential resident- to-resident abuse until approximately five hours after the incident occurred. Resident #77 sustained a scratch to her left jaw and bruising to her left forearm and bruising under her left eye and Resident #78 sustained a hematoma to her left temple as result of the resident-to-resident altercation. 2. Interview on 02/25/25 at 12:23 P.M. with Resident #77's representative confirmed that on 02/11/25 two staff members came in Resident #77's room to provide incontinence care. One staff held Resident #77 down by the wrists, while the other staff flipped Resident #77 back and forth to remove the soiled clothing which caused the resident to scream out in pain. Resident #77's representative confirmed she reported the incident involving Resident #77 during a care conference on 02/19/25 with the Director of Nursing (DON), Unit Manager (UM) #54, and the hospice nurse, Registered Nurse (RN) #178. Resident #77's representative further confirmed she also reported an allegation of staff to resident abuse towards Resident #78 on 02/11/25 in which the representative allegedly witnessed two staff members drag the resident by her arms down the hallway while the resident screamed. Interview on 02/26/25 at 12:44 P.M. with the hospice nurse, RN #178 confirmed Resident #77's representative reported during a care conference on 02/19/25 that recently a staff member had held Resident #77 down by her wrists while another staff member provided incontinence care to Resident #77. RN #178 further confirmed Resident #77's representative also reported during the care conference on 02/19/25 that on 02/11/25 two staff members had dragged Resident #78 down the hallway by the resident's arms. Interview on 02/26/25 at 3:08 P.M. with UM #54 confirmed Resident #77's representative reported during the resident's care conference on 02/19/25 that on 02/11/25 she witnessed one staff member hold Resident #77 down by the wrists while the other staff member flipped Resident #77 back and forth to remove the soiled clothing which caused the resident to scream out in pain. UM #54 confirmed that the DON was present when the incident was reported at the care conference and the incident was not reported to the Administrator. UM #54 further confirmed Resident #77's representative also reported during care conference on 02/19/25 that on 02/11/25 she witnessed two staff members dragging Resident #78 down the hallway by the resident's arms. UM #54 confirmed the DON was present at the care conference and neither of the allegations of abuse reported by Resident #77's representative were investigated. Interview on 02/26/25 at 3:09 P.M. with the DON confirmed the DON was present for a care conference held for SR #77 on 02/19/25, but the DON denied being notified of abuse allegations regarding Residents #77 and #78 and confirmed the facility had not investigated allegations of staff to resident abuse towards Residents #77 and #78 Review of the SRIs dated 02/19/25 through 02/26/25 revealed there were no SRIs initiated related to Resident #77's representative allegation of physical staff to resident abuse towards Resident #77 and no SRIs or investigation initiated regarding Resident #77's representative's allegation of staff to resident abuse towards Resident #78. Review of the SRIs dated 02/19/25 through 02/26/25 revealed there were no SRIs initiated related to Resident #77's representative allegation of physical staff to resident abuse towards Residents #77 and #78. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand The	4500 John Shield Pkwy Dublin, OH 43017

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Abuse dated 05/24/23 revealed abuse included willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The facility should educate staff on identifying abuse and possible indicators of abuse. All allegations of abuse must be immediately reported to the facility administration. The facility would report any allegations of abuse to the state survey agency in accordance with state law. This deficiency represents noncompliance investigated under Complaint Number OH00162859 and Complaint Number OH00162858.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Grand The		STREET ADDRESS, CITY, STATE, ZIP CODE 4500 John Shield Pkwy Dublin, OH 43017	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on medical record review, resident representative interview, staff interview, hospice staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to investigate allegations of staff to resident physical abuse. This affected two (Residents #77 and #78) of three residents reviewed for abuse. The facility census was 113 residents. Finding Include: Review of the medical record for Resident #77 revealed an admitted [DATE] with diagnoses including moderate dementia with behavioral disturbance, anxiety disorder, acquired absence of kidney, and atherosclerotic heart disease. Review of the (Minimum Data Set) MDS assessment for Resident #77 dated 02/13/25 revealed the resident had severe cognitive impairment. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including Lewy body disease, anxiety disorder, macular degeneration, and depression. Interview on 02/25/25 at 12:23 P.M. with Resident #77's representative confirmed that on 02/11/25 two staff members came in Resident #77's room to provide incontinence care. One staff held Resident #77 down by the wrists, while the other staff flipped Resident #77 back and forth to remove the soiled clothing which caused the resident to scream out in pain. Resident #77's representative confirmed she reported the incident involving Resident #77 during a care conference on 02/19/25 with the Director of Nursing (DON), Unit Manager (UM) #54, and the hospice nurse, Registered Nurse (RN) #178. Resident #77's representative further confirmed she also reported an allegation of staff to resident abuse towards Resident #78 on 02/11/25 in which the representative allegedly witnessed two staff members drag the resident by her arms down the hallway while the resident screamed. Interview on 02/26/25 at 12:44 P.M. with the hospice nurse, RN #178 confirmed Resident #77's representative reported during a care conference on 02/19/25 that recently a staff member had held Resident #77 down by her wrists while another staff member provided incontinence care to Resident #77. RN #178 further confirmed Resident #77's representative also reported during the care conference on 02/19/25 that on 02/11/25 two staff members had dragged Resident #78 down the hallway by the resident's arms. Interview on 02/26/25 at 3:08 P.M. with UM #54 confirmed Resident #77's representative reported during the resident's care conference on 02/19/25 that on 02/11/25 she witnessed one staff member hold Resident #77 down by the wrists while the other staff member flipped Resident #77 back and forth to remove the soiled clothing which caused the resident to scream out in pain. UM #54 confirmed that the DON was present when the incident was reported at the care conference and the incident was not reported to the Administrator. UM #54 further confirmed Resident #77's representative also reported during care conference on 02/19/25 that on 02/11/25 she witnessed two staff members dragging Resident #78 down the hallway by the resident's arms. UM #54 confirmed the DON was present at the care conference and neither of the allegations of abuse reported by Resident #77's representative were investigated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Grand The		STREET ADDRESS, CITY, STATE, ZIP CODE 4500 John Shield Pkwy Dublin, OH 43017	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 3:09 P.M. with the DON confirmed the DON was present for a care conference held for SR #77 on 02/19/25, but the DON denied being notified of abuse allegations regarding Residents #77 and #78 and confirmed the facility had not investigated allegations of staff to resident abuse towards Residents #77 and #78 Review of the SRIs dated 02/19/25 through 02/26/25 revealed there were no SRIs initiated related to Resident #77's representative allegation of physical staff to resident abuse towards Resident #77 and no SRIs or investigation initiated regarding Resident #77's representative's allegation of staff to resident abuse towards Resident #78. Review of the facility policy titled Abuse dated 05/24/23 revealed the facility would investigate allegations of abuse and take the necessary actions as a result of the investigation. The facility would make efforts to ensure all residents were protected from physical and psychosocial harm during and after the investigation, including the immediate removal of the resident from contact with the alleged abuser. This deficiency represents noncompliance investigated under Complaint Number OH00162859 and Complaint Number OH00162858.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand The	4500 John Shield Pkwy Dublin, OH 43017

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, staff interview, and record review the facility failed to ensure that the medication error rate was less than five percent. The facility medication error rate was 6.89 percent (%) based on 29 medication opportunities and two medication errors. This affected one (Resident #56) of three residents reviewed for medication administration. The facility census was 113 residents. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses including cerebrovascular disease, hypertension, benign neoplasm of colon, peripheral vascular disease, and type two diabetes mellitus. Review of the physician's orders for Resident #56 revealed an order dated 11/11/24 for Aspirin 81 milligrams (mg.) chewable, give 1 tablet by mouth one time a day and an order dated 02/11/25 for Senna-S 8.6-50 mg., give one tablet by mouth twice daily. Observation of medication administration 02/25/25 at 8:45 A.M. for Resident #56 per Licensed Practical Nurse (LPN) #18 revealed the nurse administered a Senna 8.6 mg tablet and an enteric coated Aspirin tablet 81 mg. crushed in applesauce. Interview on 02/25/25 at 8:58 A.M. with LPN #18 confirmed that Aspirin was ordered in chewable form for Resident #56 and was administered in enteric coated form which was contraindicated to be crushed. LPN #18 further confirmed Resident #56 had an order for Senna-S 8.6-50 mg., but the nurse administered Senna 8.6 mg. which omitted the 50 milligram Docusate dose as ordered by the physician. Interview on 02/25/25 at 9:00 A.M. with the Director of Nursing (DON) confirmed the physician was notified of the medication errors for Resident #56 which included administration of enteric coated Aspirin in a crushed form and administration of Senna 8.6 mg tablet instead of Senna 8.6-50mg tablet. Review of a summary sheet written by the Cleveland Clinic titled Aspirin Enteric-Coated Capsules or Tablets dated 2025 revealed enteric coated Aspirin should be swallowed whole. Patients are advised not to crush, chew, or cut enteric coated Aspirin, because doing so can increase stomach distress. Review of the facility policy titled Medication Administration dated 08/07/23 revealed the facility would safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs. Medications should not be crushed when clinically contraindicated. This deficiency represents noncompliance investigated under Complaint Number OH00162882.