

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 12/02/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, resident representative interview, medical record review, and policy review, the facility failed to provide a dignified experience when alternate communication methods were not utilized to promote and enhance a resident's quality of life. This affected one (#220) of one residents reviewed for dignity. The census was 111. Findings include: Review of Resident #220's medical record revealed an admission date of 12/29/22 with diagnoses including but not limited to Alzheimer's disease, pancreatitis, type two diabetes mellitus, hypotension, depression, gastro-esophageal reflux disease, and anxiety disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #220 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. Resident #220 required moderate assistance with showering, putting on and off footwear, and personal hygiene. Review of Resident #220's care plan dated 08/01/25 revealed Resident #220 was alert and able to make her needs known. Resident #220 spoke Russian and staff were encouraged to use a translation application (app) on their phones to communicate. Additionally, Resident #220's care plan had a focus on communication which revealed Resident #220 had impaired communication as evidenced by a language barrier and had bilateral hearing loss. As Resident #220's dementia progresses, she was speaking Russian more often. Additionally, the goal was Resident #220 would be able to make basic needs known and not be resistant to staff assistance. Furthermore, the interventions for Resident #220 included to assess for the need to use a communication board/book with pictures with Russian language, involve family in translating/communicating as necessary, use simple questions or commands, and ask open-ended questions and give Resident #220 time to respond. Observation on 12/02/25 at 9:15 A.M. revealed no communication board in Resident #220's room. Observation on 12/02/25 at 9:10 A.M. revealed Certified Nurse Aide (CNA) #280 took Resident #220's tray into her room and set it on the bedside tray. CNA #280 was observed to not speak to Resident #220. Observation on 12/02/25 at 9:11 A.M. revealed Resident #220 did not pull out her phone and use the translator app. Observation on 12/02/25 at 9:11 A.M. revealed Unit Manager (UM) #595 speaking loudly from the dining area on unit A and said, She can't hear you, in regard to Resident #220. Interview with UM #595 stated the staff use a translator app on their personal phones to communicate with Resident #220. UM #595 was unable to pull up the app on her phone and called Resident #220's daughter so Resident #220 could communicate. Interview on 12/02/25 at 9:15 A.M. with Resident #220 stated, If my comments are important, then the communication with staff isn't good. Resident #220 stated she had to use hand gestures to try to make her needs known and some of the staff are not very responsive. Additionally, Resident #220 stated, It is hard to communicate specific needs like this morning, my throat was hurting, and my nose was running and I asked for medicine, but they didn't bring it. Resident #220 revealed she was supposed to have medication before her meals, but sometimes they bring it with the meal which causes the medication to not work, and she refuses and they document she refused the medication. Furthermore, Resident #220 stated, If something isn't done right or there is a refusal of services for me, then I get very upset and it causes me a lot of stress. I feel like the communication is a struggle on a daily basis. Interview on 12/02/25 at 9:15 A.M. with Resident #220's daughter stated she had told management and staff several times to use the translator app and communicate with Resident #220, but still communication was a problem. Furthermore, Resident #220's daughter stated the staff were not assisting Resident #220 with care because of communication issues. Interview on 12/02/25 at 9:30 A.M. with Licensed Practical Nurse (LPN) #185 stated Resident #220 spoke a little English. LPN #185 stated the staff use a translator app on the phone and if that does not work, then they call Resident #220's daughter to communicate with Resident #220. Interview on 12/02/25 at 11:18 A.M. with UM #595 stated all the CNAs and nurses have the translator app on their personal phones and use it to communicate with Resident #220. Furthermore, UM #595 stated the translator access number posted in Resident #220's room was for an on-site translator which can take some time getting to the facility which was why she called Resident #220's daughter to translate that morning. Interview on 12/02/25 at 11:27 A.M. with CNA #280 stated she did not have the translator app on her phone and stated she used hand gestures and simple English phrases to communicate with Resident #220. Interview on 12/2/25 at 11:29 A.M. with LPN #185 who stated she did not have the translator app on her phone. Additionally, LPN #185 stated she takes medication to Resident #220 three times a day and stated she only uses the translator app if her simple hand gestures are not effective at</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital documentation review, review of an incident report, review of staff training documentation, staff interview, and policy review, the facility failed to ensure residents were administered antibiotic medications and insulin as ordered and within scheduled time frames which resulted in significant medication errors. This affected two (#299 and #45) of six residents reviewed for medication administration. The census was 111. Findings include: 1. Review of the medical record for Resident #299 revealed an admission date of 09/12/25 with diagnoses including pseudomonas as the cause of diseases, gastrointestinal hemorrhage, acute pyelonephritis, and presence of urogenital implants. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #299 was cognitively intact, required setup or clean-up assistance with eating, and was taking an antibiotic and intravenous (IV) medication. Review of a hospital hard script copy dated 09/08/25 and signed by a physician revealed Resident #299 had an order for the antibiotic cefepime four (4) grams intravenous (IV) daily as a continuous 24-hour infusion through 09/18/25. Review of Resident #299's hospital after visit summary dated 09/12/25, for a hospital stay between 09/02/25 and 09/12/25, revealed a medication order to start cefepime 4 grams IV continuous 24-hour infusion through 09/18/25, with the dose to be given every shift. Review of Resident #299's physician order dated 09/12/25 at 11:47 P.M., created by Licensed Practical Nurse (LPN) #720, revealed cefepime hydrogen chloride IV solution reconstituted, two (2) grams, 2 times a day at 9:00 A.M. and 9:00 P.M. was ordered. Review of an incident report dated 09/12/25 revealed Resident #299 was ordered continuous IV infusion, but it was entered as twice a day and every shift without directions to run as continuous infusion. Antibiotics were administered each shift instead of continuously. Education was provided to prevent recurrence. Review of Resident #299's physician order dated 09/13/25 revealed cefepime hydrogen chloride IV solution reconstituted, 2 grams, 2 times a day at 9:00 A.M. and 9:00 P.M. was ordered. Review of Resident #299's medication administration record (MAR) revealed cefepime hydrogen chloride IV solution reconstituted, 2 grams, 2 times a day was administered on 09/13/25 at 9:00 A.M. and 9:00 P.M., on 09/14/25 at 9:00 A.M. and 9:00 P.M., and on 09/15/25 at 9:00 A.M. Review of a physician visit document dated 09/14/25 revealed the plan for Resident #299 showed infectious disease was following and recommended continuous IV cefepime. Follow-up with infectious disease was scheduled for 09/16/25 due to a left renal abscess. Review of Resident #299's physician order dated 09/15/25, completed by Unit Manager (UM) #295, revealed cefepime hydrogen chloride IV solution reconstituted, 2 grams, 2 times a day at 9:00 A.M. and 9:00 P.M. was ordered. Review of the MAR revealed on 09/15/25 at 9:00 P.M. and on 09/16/25 at 9:00 A.M., Resident #299 received 2 doses of the antibiotic scheduled for two times a day. Review of Resident #299's physician order dated 09/16/25 revealed an appointment was scheduled with infectious disease. Review of Resident #299's infectious disease note dated 09/16/25 revealed the resident's daughter reported antibiotics were not being given as a continuous infusion as ordered. The physician contacted the extended care facility and staff were unclear why the antibiotics were entered incorrectly and signed by the physician. The plan revealed the culture was positive for a multiple drug-resistant organism (MDRO) due to pseudomonas. Cefepime was supposed to be a continuous infusion. The discharge prescription was written that way, but the facility incorrectly ordered 2 grams, 2 times per day. Review of Resident #299's progress note dated 09/16/25 at 2:43 P.M. revealed the resident returned from the appointment with new orders. Review of Resident #299's progress note dated 09/16/25 at 7:03 P.M. revealed the Power of Attorney (POA) was in the facility and was made aware that new IV antibiotic orders were in place and the pharmacy would deliver the medication. Review of Resident #299's physician order dated 09/17/25 through 09/26/25 revealed an order for cefepime hydrogen chloride 4 grams IV for a kidney infection until 09/26/25 as a continuous infusion over 24 hours. Review of Resident #299's MAR revealed cefepime hydrogen chloride 4 grams IV for kidney infection until 09/26/25 as a continuous infusion over 24 hours. The first administration was on 09/17/25 at 9:00 A.M. Interview on 12/01/25 at 2:45 P.M. with the Director of Nursing (DON) and the Administrator confirmed a medication error occurred for Resident #299 when the antibiotic (cefepime) was not administered as continuous and was only a short infusion. The error was identified on 09/16/25 after a new order was received from infectious disease. The DON and the Administrator stated education was completed with all licensed nursing staff. The DON confirmed admitting nurses are responsible for entering orders and a second nurse completed a verification. Interview on 12/02/25 at 10:35 A.M. with IIM #140</p>		