STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366446	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Grove Transitional Care	5919 Blue Star Drive Grove City, OH 43123

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** 49039 Based on observation and interview the facility failed to ensure dependent residents received assistance with activities of daily living. This affected one (Resident #79) out of two residents observed for activities of daily living. The facility census was 95. Findings include: Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses of chronic myeloid leukemia, retention of urine, hypertension, anemia, chronic diastolic heart failure, anxiety, and orthostatic hypotension. Review of minimum data set (MDS) 3.0 assessment completed 02/19/25 revealed Resident #79 had a memory problem, was severely cognitively impaired, and requires substantial to maximal assistance with showering and bathing. Review of behavior symptoms from 02/23/25 through 03/24/25 revealed no behavioral concerns or symptoms observed. Review of the care plan dated 02/23/24 revealed Resident #79 requires one to two person assistance with activities of daily living (ADLs), with expected decline due to the disease process. Interventions include providing assistance with bathing, bed mobility, dressing, grooming, toileting, and transfers. Review of care plan dated 03/17/25 revealed Resident #79 exhibits alterations in mood and/or behavior, including refusal to allow staff to shave facial hair. Interventions include distraction and redirection, encouraging visits from loved ones, and observing/reporting any changes in mental status. Observation on 03/17/25 at 2:15 P.M. of Resident #79 revealed the resident was lying in bed with facial hair, approximately 1/4 inch in length, was visible on the lower chin and upper lip. Review of shower/bath skin sheet dated 03/17/25 and 03/20/25 revealed Resident #79 received a shower, hair wash, and bed linen change. The records did not note if the resident was shaved or if shaving was refused. Observation on 03/19/25 at 6:09 A.M. of Resident #79 revealed the resident was lying in bed with facial hair present. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/20/25 at 9:35 A.M. revealed Resident #79 was lying in bed, positioned diagonally across the bed. Facial hair was still present, and the resident was wearing clothing from the previous day. Interview on 03/20/25 at 9:36 A.M. with Resident #79 shook her head yes in response to wanting to have her facial hair removed. Observation on 03/20/25 at 1:53 P.M. revealed Resident #79 was lying in bed in the same position, wearing the same gown from the previous day, which was bunched up and exposing the incontinent brief. Additionally, facial hair was still present. Observation on 03/20/25 at 1:55 P.M. with Certified Nursing Assistant (CNA) #201 noted that Resident #79 had not been changed out of night clothes. CNA #201 believed hospice was responsible for getting the resident bathed and dressed for the day, but she was unsure if hospice had visited. CNA #201 confirmed the resident was not wearing pants, had no blanket covering her and had her incontinent brief exposed to anyone walking past. The CNA also confirmed the resident had chin and upper lip hair and stated she would ask the nurse if she was allowed to shave the resident. The CNA also noted she did not know if the resident needed repositioning, so she had not repositioned her. Interview on 03/24/25 at 11:23 A.M. with the Director of Nursing confirmed that shaving needs should be evaluated by direct care staff daily and addressed if concerns arise or upon resident request. If shaving is completed, it should be marked on the shower record by direct care staff. Observation on 03/24/25 at 11:43 A.M. of Resident #79 revealed chin hair and upper lip hair were still present.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on observations, medical record review, resident interview, staff interview, and facility policy review, the facility failed to properly monitor resident fluid restrictions. This affected two (Residents #58 and #47) of two residents reviewed for hydration. Also, the facility failed to adequately monitor and address resident nutritional status. This affected three (Residents #29, #19, and #47) of four residents reviewed for nutrition. The census was 95. Findings Include: 1. Resident #58 was admitted to the facility on [DATE]. Her diagnoses were aftercare following joint replacement surgery, type II diabetes, muscle weakness, hypo-osmolality and hyponatremia, osteoarthritis, chronic kidney disease, anxiety disorder, major depressive disorder, mood disorder, hypertension, atherosclerotic heart disorder, insomnia, pneumonia, and presence of cardiac pacemaker. Review of her minimum data set (MDS) assessment, dated 03/10/25, revealed she was cognitively intact. Review of Resident #58's physician orders found she had a fluid restriction order of 2400 milliliters (mL) related to congestive heart failure, which was started on 02/21/25. The fluid restriction parameters included the following: 1080 mL for dietary, 840 mL for nursing, and 480 mL for supplements. Review of Resident #58's fluid intake records, dated 02/19/25 to 03/24/25, revealed the amount drank of the nutritional supplement was documented in the medication administration record (MAR). The amount of fluid intake during meals was documented in the fluid intake record. There was no documentation to confirmed the amount of fluid intake Resident #58 had been provided by nursing. Also, review of the fluid intake records for dietary, the following dates did not have fluid amounts documented or were documented after the fact: 02/21/25 (one meal), 02/28/25 (one meal), 03/04/25 (one meal), and then 03/06/25, 03/07/25, 03/12/25 and 03/13/25 (no amounts entered until after 03/18/25). Review of dietary fluid intake records, dated 02/19/25 to 03/17/25, revealed the following dates had fluid records above the ordered restricted amount of 1080 mL: 02/20/25 (1410 mL), 02/22/25 (1260 mL), 03/02/25 (2700 mL), 03/11/25 (1440 mL), 03/15/25 (1520 mL), and 03/16/25 (1380 mL). Review of Resident #58 care plan, updated 03/17/24, revealed a care area related to potential for alteration in nutrition and hydration. One intervention included for the facility to follow fluid restriction as ordered. Interview with Certified Nursing Aide (CNA) #199 on 03/20/25 at 1:36 P.M. stated those that have a fluid restriction, will have their drinks come pre-portioned from the kitchen, which is ordered by the dietitian. The drinks have a specific fluid level that is met for each resident's dietary needs. If a resident requests more fluids, she will speak with the nurse to determine if the resident can have more water. If the nurse agrees, she will get a cup and pour it from the pitcher. She does not know if the different cups have fluid sizes, she will guess the amount that the resident drinks and put it into the medical record. She confirmed she does not know how much water is in each resident glass, so when she documents the amount consumed, it is a guess. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Director of Nursing (DON) on 03/24/25 at 11:27 A.M. confirmed the aides will document the amount of fluids each resident accepted when they are on a fluid restriction. She confirmed this is to be done for each meal. She also confirmed there is no data entry for documenting the fluid tracking by the actual nurses; there is an assumption on the amount of water provided and accepted during medication administrations; no matter how many administrations a resident has throughout the day. She confirmed Resident #58 was missing some fluid intake data that should have been documented. She also confirmed there were multiple dates that the data documented, was above the approved amount for her fluid restriction. 2. Resident #29 was admitted to the facility on [DATE]. Her diagnoses were congestive heart failure, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, type II diabetes, morbid obesity, peripheral vascular disease, chronic kidney disease, anxiety disorder, depression, hypertension, hypothyroidism, gout, atrial fibrillation, hyperlipidemia, metabolic encephalopathy, polyneuropathy, gastroparesis, insomnia, and and personal history of transient ischemic attack. Review of her MDS assessment, dated 02/05/25, revealed she was cognitively intact. Review of Resident #27's physician orders revealed the facility was to collect daily weights, and the facility was to notify the medical director of weight gain of 2.5 pounds in 24 hours or 5 pounds in a week. Review of Resident #27's current nutritional care plan, which revealed she had a potential alteration in nutrition. An intervention for this care plan stated the facility is to take weights per protocol. Review of Resident #27's current non-compliance care plan, which revealed she was non-compliant with weight monitoring as ordered. The interventions included: Notify medical director or nurse practitioner of non-compliance, educate resident, family or responsible party on negative outcomes related to non-compliance and document educational attempts made with resident in relation to compliance. Review of Resident #27's weights, dated 01/30/25 to 03/19/25, revealed the following: on 02/18/25, she weighed 196.8 pounds. She refused a weight on 02/19/25, but accepted being weighed on 02/20/25, which was 186.4 pounds. There was no documentation to support the dietitian or physician was notified of the 10.4 pound weight decrease, which represented a 5.3% decline from 02/18/25 to 02/20/25. Also, Resident #27 weight was taken on 03/12/25, which was 187.9 pounds. Resident #27 refused her weights to be taken on 03/13/25 and 03/14/25, but one 03/15/25, her weight was 176.8 pounds. This represented a 11.1 pound (5. 9%) decrease from 03/12/25 to 03/15/25. There was no documentation to support the physician or dietitian were notified of the significant weight decrease. Review of Resident #27's weights, dated 01/30/25 to 03/19/25, revealed the following dates in which Resident #27 refused to be weighed: 02/11/25, 02/16/25, 02/17/25, 02/19/25, 02/22/25, 02/23/25, 02/28/25, 03/04/25, 03/08/25, 03/09/25, 03/10/25, 03/11/25, 03/13/25, 03/14/25, 03/17/25, and 03/19/25. Review of Resident #27's nutritional documentation in the electronic medical records, found no evidence to support the physician or nurse practitioner were notified of her weight refusals as required by her non-compliance care plan. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with DON on 03/24/25 at 10:14 A.M. and 11:27 A.M. revealed weights are typically taken between 3:00 P.M. and 4:00 P.M. daily, for those who are ordered to have it taken. She confirmed there were multiple weights that were refused by Resident #27, and they could not find documentation to support the physician was notified of those refusals. She confirmed that residents who are ordered daily weights, the physician should be notified if they refuse a weight. Also, she confirmed there was no evidence to support the dietitian and/or physician were notified of the significant weight decreases. Interview with Dietitian #192 on 03/24/25 at 2:17 P.M. revealed she informs the physician about any significant changes, such as notable weight loss or gain. She occasionally alerts the physician about instances where residents refuse to have their weight taken, though she is uncertain whether the nursing staff communicates these cases to the physician. She confirmed she does not record these attempts in the medical record. Review of facility Change of Condition policy, dated April 2013, revealed a change of condition is defined as deterioration in the health, mental, or psychosocial status of a resident related to a significant change in the resident's clinical condition or status. Significant changes in resident's clinical condition or status include improvement or decline in the following: unplanned weight loss (5% in 30 days, 10% in 180 days). The unit supervisor or charge nurse will notify the resident, physician, and guardian/interested family member of all changes as stated above and of any other situations requiring notification. The person doing the notification may document all notification. 50008 3. Review of Resident #47's electronic medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy and presence of a pacemaker. Review of Resident #47's Minimum Data Set (MDS) assessment on 02/04/25 revealed that she had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognitive status. Review of Resident #47's MDS assessment on 03/18/25 revealed that she had a weight loss of 10% or more in the last six months and that she was not on a prescribed weight program. Review of Resident #47's Medication Administration Record (MAR) revealed that she had orders to be weighed daily due to heart failure on every day shift, effective 02/01/25 by physician's order. Review of Resident #47's MAR for March 2025 revealed that Licensed Practical Nurse (LPN) #157 marked Resident #47's weight with the letters NA on 03/03/25, 03/08/25, 03/09/25, and 03/10/25. Interview with Resident #47 on 03/17/25 at 10:22 A.M. revealed that the facility does not monitor her weight on a daily basis, as ordered by the physician on 02/01/25. Interview with LPN #157 on 03/24/25 at 9:42 A.M. revealed that she used the letters NA on Resident #47's MAR under her daily weights on 03/03/25, 03/08/25, 03/09/25, and 03/10/25 to indicate that it was not applicable on those particular dates. LPN #157 confirmed no weight was obtained by day shift on 03/03/25, 03/08/25, 03/09/25, and 03/10/25. LPN #157 revealed when she cannot find a nursing aide to weigh Resident #47, she does not follow up and weigh the resident herself. LPN #157 revealed that it was the responsibility of the nursing aides to weigh the residents. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 03/24/25 at 10:14 A.M. revealed that if there is not a daily weight obtained by between 3:00 P.M. and 4:00 P.M., it is the responsibility of the nurse to obtain the daily weight if a nursing aide does not obtain it, as the nurse needs to notify the physician if there are any changes in the Resident's weight status. 4. Review of Resident #47's electronic medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy and presence of a pacemaker. Review of Resident #47's Minimum Data Set (MDS) assessment on 02/04/25 revealed that she had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognitive status. Review of Resident #47's March 2025 Medication Administration Record revealed that she had a physician order for a fluid restriction on every shift related to chronic systolic (congestive) heart failure consisting of 2400 milliliters (ml) per day. The order indicated that 1080 ml were to come from dietary, and 1320 ml were to come from the nursing team. Review of Resident #47's care plan revealed there was no documentation present to support the resident being responsible for tracking her own fluid restriction. Her care plan dated 07/09/24 revealed that Resident #47 was non-compliant with her fluid restriction. Review of Resident #47's progress notes revealed there was no documentation regarding the tracking and monitoring Resident #47's daily fluid restriction. Interview with Registered Nurse (RN) #175 on 03/20/25 at 1:38 P.M. revealed that there was no system for nursing to track the amount of fluids that nursing provided to Resident #47 on a daily basis. RN #175 revealed that it was the responsibility of Resident #47 to track her fluid restriction herself. Interview with Certified Nursing Aide (CNA) #199 on 03/20/25 revealed that Resident #47 keeps track of her own fluid restriction, and CNA #199 did not track how much fluid Resident #47 consumed on a daily basis. Interview with Licensed Practical Nurse (LPN) #157 on 03/24/25 at 9:42 A.M. revealed writing a progress note would be the only way for nursing to track how much fluid the nurses gave Resident #47 during her medication passes and between meals. LPN #157 indicated nurses did not have another way to track fluid allowances for residents who have fluid restrictions. LPN #157 revealed that she should start tracking how much fluid she gives Resident #47 during the day. Interview with the Director of Nursing on 03/24/25 at 10:14 A.M. revealed that the nursing team should keep track of their own calculations of the fluid consumed on a daily basis by a resident on a fluid restriction. 49039 5. Review of the medical record for Resident #19 revealed an admitted [DATE], diagnoses included type II diabetes mellitus, morbid obesity, mild cognitive impairment, and major depressive disorder. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders dated 11/21/24 revealed weights should be obtained twice per week, during the day shift on Mondays and Thursdays. The provider should be notified if there is a weight gain of 2.5 pounds or more between weigh-ins or a weight gain of 5 pounds or more in a week. Review of the Minimum Data Set (MDS) 3.0 assessment completed on 11/27/24 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the care plan 02/13/25 revealed Resident #19 has demonstrated non-compliance of recommended treatment at times related to weight monitoring as ordered, interventions include document education attempts and notify the physician of non-compliance. Review of the Treatment Administration Record (TAR) for November 2024 revealed Resident #19 refused to have her weight obtained on 11/21/24. Review of progress notes dated 11/21/24 revealed no record the physician was notified, the resident was educated on weight refusals, or additional attempts at obtaining a weight were made. Review of the TAR for December 2024 revealed Resident #19 refused to have her weight obtained on 12/12/24, 12/16/24, 12/23/24, and 12/26/24. Review of progress notes dated 12/12/24, 12/16/24, 12/23/24, and 12/26/24 revealed no record the physician was notified, the resident was educated on weight refusals, or additional attempts at obtaining a weight were made. Review of the TAR for January 2025 revealed Resident #19 refused to have her weight obtained on 01/06/25, 01/13/25, and 01/30/25. Review of progress notes dated 01/06/25 revealed the resident was educated on weight refusals; however, additional attempts were not documented, nor was the physician notified of the refusal. Progress notes dated 01/13/25 and 01/30/25 revealed no record the physician was notified, the resident was educated on weight refusals, or additional attempts at obtaining a weight were made. Review of the TAR for February 2025 revealed Resident #19 refused to have her weight obtained on 02/06/25, 02/13/25, and 02/24/25. Review of progress notes dated 02/06/25 and 02/13/25 revealed the resident was educated on weight refusals; however, additional attempts were not documented, nor was the physician notified of the refusal. Review of progress notes dated 02/24/25 revealed no record the physician was notified, the resident was educated on weight refusals, or additional attempts at obtaining a weight were made. Review of the TAR for March 2025 revealed Resident #19 refused to have her weight obtained on 03/03/25. Review of progress notes dated 03/03/25 revealed the resident refused to be weighed and stated she would do it tomorrow. Review of the resident's record revealed a follow-up weight was obtained on 03/06/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/24/25 at 1:52 P.M. with Licensed Practical Nurse #107 confirmed Resident #19 occasionally refuses to have her weight obtained. Nursing staff are expected to attempt to obtain her weight three times before documenting refusals in the TAR. Upon the final refusal, the staff will educate the resident and notify the physician of the refusals. Interview on 03/24/25 at 1:57 P.M. with the Director of Nursing (DON) and Regional Nurse #300 confirmed Resident #19 has a history of non-compliance with obtaining weights. Nursing staff should document the refusals and notify the physician. Staff should ensure all attempts are documented in the resident's medical record. Interview on 03/24/25 at 2:15 P.M. with Dietician #192 confirmed she is at the facility daily, where she monitors and reviews patients' weights. Dietician #192 confirmed Resident #19 had physician orders for weight checks twice a week due to a history of weight fluctuations. It is her responsibility to notify the physician if the resident's weight falls outside specific parameters, such as a 2.5-pound or greater gain between weigh-ins or a 5-pound gain within a week. She also reports significant weight changes to the physician, including notable weight loss, weight gain related to specific diagnoses, or any concerning fluctuations. However, when these parameters are exceeded, requiring notification to the physician, she does not document any attempts to contact the physician. Occasionally, she alerts the physician when patients refuse to have their weight taken but is unsure whether the nursing staff communicates these instances to the physician. This deficiency represents non-compliance investigated under Complaint Number OH00163772.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, interview, review of drug administration labeling, and facility policy review, the facility failed to ensure residents receive anti-psychotics as clinically indicated. This affected one (Resident #7) out of five residents reviewed for unnecessary medications. The facility census was 95. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses of metabolic encephalopathy, muscle weakness, dysphagia, urinary tract infection, dementia without behavioral/psychotic/mood disturbance, and anxiety. Review of the antipsychotic risk versus benefit assessment dated [DATE] revealed Resident #7 was prescribed Seroquel (Quetiapine Fumarate) (antipsychotic) 400 milligrams twice a day for agitation and increased anxiety. Behaviors include increased anxiety, which at times, interferes with care. Person-centered approaches included redirection, repositioning, one-on-one supervision, and environmental alterations. The conclusion included a gradual dose reduction was not recommended. However, a requirement for this rationale included documentation of previous reductions attempted and a clinical rationale explaining why further reductions would likely impair function or increase stressful behaviors. Those attempts were not found within the medical record. Review of the care plan dated 02/18/25 revealed Resident #7 was at risk for adverse effects related to psychoactive medication use. Interventions include assessing behaviors for which medications are prescribed, evaluating for adverse effects, exploring non-drug approaches, using the minimum effective dose if continued drug use is necessary, and reducing medication doses when appropriate. Medications are to be monitored for effectiveness. Review of the Minimum Data Set (MDS) 3.0 assessment, completed 02/24/25, revealed a brief interview for mental status score of 11, indicating moderate cognitive impairment. The resident had no hallucinations, delusions, or any physical or verbal behavioral issues. The diagnoses section revealed no diagnosis of bipolar disorder, psychotic disorder, or schizophrenia. The medication section indicated the resident is prescribed an antipsychotic on a routine basis, with no gradual dose reduction attempted or noted as clinically contraindicated by a physician. Review of physician orders from 02/17/25 to 03/13/25 revealed the resident was prescribed Quetiapine Fumarate 400 milligrams, one tablet twice a day for anxiety. A change in the physician orders was noted starting 03/14/25, with Quetiapine Fumarate prescribed for depression at the same dosage. Review of behavior symptoms from 02/23/25 through 03/24/25 revealed no behavioral concerns or symptoms observed daily, except on 03/11/25 at 6:59 P.M., when repeat movement was noted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 03/24/25 at 12:37 P.M. with the Director of Nursing (DON) confirmed the house nurse practitioner reviewed Resident #7's medication upon admission, and the rationale for prescribing Seroquel was the resident's diagnoses of depression and anxiety. She confirmed these diagnoses are not approved indications for Seroquel use. Additionally, she confirmed residents with dementia are at higher risk of potentially fatal side effects from Seroquel. Interview on 03/24/25 at 1:10 P.M. with house Nurse Practitioner (NP) #301 confirmed she took over Resident #7's care at the end of February 2025. She confirmed the resident was currently receiving Seroquel for anxiety. The medication was initially prescribed by the primary care physician in 2021, and the NP was unsure if the medication had been reduced or discontinued within the past four years. She confirmed the resident was not seeing a neurologist or psychiatrist to provide a rationale for continuing the medication. She stated if the resident was not exhibiting any behaviors, a reduction or discontinuation in dosage would be appropriate. She acknowledged residents with dementia have an increased risk of adverse side effects from Seroquel. The medication had not been discontinued because it was still considered effective for managing the resident's behaviors. Interview on 03/24/25 at 3:30 P.M. with house NP #302 confirmed she was the physician who admitted Resident #7 to the facility and reviewed the resident's medication record. She confirmed the resident was discharged from the hospital with an order for Seroquel, who voiced it is typically prescribed for behavioral issues or disturbances in the hospital setting. Upon admission to the facility, appropriate diagnoses for antipsychotic use include schizophrenia or major depressive disorder with delusions, agitation, or aggression. She emphasized the nursing staff should monitor behaviors, and if no behaviors are observed, consideration for a gradual dose reduction or discontinuation of the medication would be appropriate. Review of federal drug administration labeling for Seroquel dated 11/2009 revealed WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA and antipsychotic drugs are associated with an increased risk of death. Indication for Seroquel usage include schizophrenia, bipolar mania, bipolar depression and bipolar I disorder maintenance therapy. Review unnecessary drugs policy dated 06/27/15 revealed unnecessary drugs are drugs when used in excessive dose; for excessive duration; without adequate monitoring; without adequate indications for it use; or in the presence of adverse consequences which indicate the dose would be reduced or discontinued. If the drug is used outside of indicated guidelines, justification may include a medical/psychiatric evaluation to confirm the necessity; documentation in the clinical record that the resident is being monitored for adverse complications; documentation confirming previous attempts at dose reduction have been unsuccessful; documentation of improvements due to medication usage; and documentation of ineffective non-pharmacological interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366446	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Grove Transitional Care	5919 Blue Star Drive Grove City, OH 43123

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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 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. 50008 Based on observations and staff interviews, the facility failed to store and serve food in a safe and sanitary manner. This had the potential to affect all 95 residents in the facility who were identified as receiving meals from the kitchen. Findings include: 1. Observations in the kitchen on 03/17/25 from 8:22 A.M. to 8:28 A.M. revealed a box containing 12 containers of a nutritional supplement was holding the door to the dry storage room ajar and resting on the floor, a large meat roast was resting on the floor of the walk in refrigerator, tulip serving bowls were not inverted on the storage rack, a bottle of opened barbecue sauce in the walk in refrigerator was undated, two opened bags containing frozen food items were unlabeled and undated in the walk in freezer, a black fuzzy substance was on the walk in refrigerator fan, and a black fuzzy substance was on the overhead vent located directly over the serving tray line. Interview with Dietitian #192 on 03/17/25 at 8:28 A.M. confirmed a box containing 12 containers of a nutritional supplement was holding the door to the dry storage room ajar and resting on the floor, a large meat roast was resting on the floor of the walk in refrigerator, tulip serving bowls were not inverted on the storage rack, a bottle of opened barbecue sauce in the walk in refrigerator was undated, two opened bags containing frozen food items were unlabeled and undated in the walk in freezer, a black fuzzy substance was on the walk in refrigerator fan, and a black fuzzy substance was on the overhead vent located directly over the serving tray line. Interview further confirmed these were not sanitary food storage practices. Observation on 03/19/25 at 10:44 A.M. revealed there was a broken plastic light cover over the food service tray line that had a piece of plastic missing from a corner, a loose screw that was not securing a corner of the light and was hanging down, and that it was also covered in a brown residue on the exterior of the light cover. Interview with Dietary Supervisor #165 on 03/19/25 at 10:44 A.M. confirmed that the light cover over the tray line was broken and had food residue on it. Interview with Maintenance Supervisor #138 on 03/19/25 at 10:57 A.M. confirmed he knew the light cover over the serving tray line was broken and dirty. He confirmed he was going to replace it as soon as possible. 2. Observation of the dining room on 03/18/25 at 11:56 A.M. revealed that Certified Nursing Aide (CNA) #219 was buttering a dinner roll by holding it in her bare hand. Interview with CNA #219 on 03/18/25 at 11:56 A.M. confirmed that she was buttering the dinner roll in her bare hand and that it was unsanitary to hold the food in her bare hand. Observation of the dining room on 03/18/25 from 12:08 P.M. to 12:13 P.M. revealed that CNA #185 was holding a dinner roll in her bare hand and feeding it to Resident #71. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with CNA #185 on 03/18/25 at 12:13 P.M. confirmed that she was holding the dinner roll in her bare hand and that she should not use her bare hand to hold food that was being served to a resident. Interview with Dietitian #192 on 03/20/25 at 4:37 P.M. revealed that the facility does not have a policy for the safe and sanitary storage and/or serving of food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observations, interviews, record reviews, and facility policy review, the facility failed to complete hand hygiene during medication administration for one resident (Resident #50) of five residents observed for medication administration. The facility failed to disinfect a glucometer used to monitor finger stick blood sugars for one observed resident (Resident #27) and had the potential to affect six (Resident #1, Resident #18, Resident #41, Resident #57, Resident #145, and Resident #147) residents on the identified hallway who utilized the same glucometer. Additionally, the facility failed to use gloves during tracheostomy for one resident (Resident #46) and had the potential to affect all 15 residents identified by the facility as requiring Enhanced Barrier Precautions (Residents #1, #11, #33, #34, #44, #46, #51, #80, #84, #85, #86, #146, #198, #199, #200). The facility census was 95. Findings include: 1. Review of the medical record for resident #50 revealed an admitted [DATE] with diagnoses of anemia, vitamin D deficiency, mild cognitive impairment, hyperlipidemia and bipolar disorder. Review of Minimum Data Set (MDS) 3.0 assessment completed 01/24/25 revealed Resident #50 has a brief interview for mental status of five, indicating a serious cognitive impairment. Review of medication administration record for 03/19/25 for medication time from 7:00 A.M. to 11:00 A.M. revealed Resident #50 was ordered to receive one Sertraline (antidepressant) 50 milligrams (mg) tablet, one Ascorbic Acid (supplement) 500 mg tablet, one Aspirin (analgesic) 325 mg tablet, a Cyanocobalamin (vitamin) 1000 microgram (mcg) half tablet, one Docusate Sodium (stool softener) 100 mg tablet, two Magnesium (supplement) 400 mg tablets and one Vitamin D 25 mcg tablet. Observation on 03/19/25 at 8:24 A.M., Registered Nurse (RN) #175 was observed preparing the morning medications for Resident #50. She performed hand hygiene and donned clean gloves. RN #175 then removed Resident #50's pre-portioned medication pouch from the cart, emptied the contents onto the top of the cart, and discarded the plastic pouch in the garbage. Afterward, she retrieved a medication cup from the cart and began preparing the medications, which included both community bottles and prepackaged medications. Medications prepared included Vitamin D 1000 units, Magnesium Oxide 400 mg, Docusate Sodium 100 mg, Aspirin tablet 325 mg, and Ascorbic Acid 500 mg. These were handled without direct contact. RN #175 noticed that one medication, Sertraline 50 mg, was missing. She searched the medication cart and found the medication in the plastic pouch disposed of in the trash can. She retrieved it from the trash can, placed it aside for disposal, and removed her gloves. RN #175 then searched for a replacement dosage in the next day's pouch, popped the replacement into the medication cup without performing hand hygiene or putting on new gloves. The final medication to be administered was Cyanocobalamin 1000 micrograms, which needed to be split. RN #175 put on new gloves, removed the bottle from the top drawer, and placed a pill in the bottle lid. She then used her index finger to guide the pill from the lid to the pill splitter and split the tablet. The split tablet was placed into the medication cup with the other medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before leaving the cart, RN #175 removed her gloves and performed hand hygiene. Interview conducted on 03/19/25 at 11:09 A.M. with RN #175 confirmed hand hygiene was not conducted after searching the trash for the lost medication, nor after removing her gloves when retrieving the new dosage and preparing the medications. Additionally, she did not perform hand hygiene before applying new gloves prior to splitting the medication. Interview conducted on 03/19/25 at 12:53 P.M. with the Director of Nursing (DON) confirmed hand hygiene should be conducted prior to donning clean gloves during medication preparation and after contact with contaminated surfaces. Review of infection prevention and control program dated 11/28/17 revealed all staff shall perform hand hygiene after handling contaminated objects and after personal protective equipment removal. 2. Observation on 03/19/25 at 12:10 P.M. of glucometer blood sugar testing revealed Licensed Practical Nurse #107 preformed Resident #27 blood sugar with a result requiring no Insulin coverage, upon completion of the finger blood stick LPN #107 placed the glucometer on the nursing cart. Unlocked the nurses cart, opened the bottom left drawer and removed disinfecting wipes and placed the on the top of the cart. She closed the drawer, grabbed a plastic cup, opened the wipes container and removed one wipe she proceeded to wipe down the glucometer for approximately 10 seconds, the LPN then placed the glucometer in the cup, discarded of the wipe and removed an additional wipe from the container and wiped down the meter for an additional 10 seconds, she then again placed the meter in the plastic cup and discarded of the wipe. The meter had a wet surface time of approximately 30 seconds, during which time LPN #107 signed off Resident #27 administration record. LPN #107 then started working on an additional residents medication while letting the dry glucometer sit in the plastic cup. Continuous observation noted once completed preparing medications for the other resident, LPN #107 placed the glucometer back into the nurses cart without wiping the surface again or maintaining a consistent surface wet time as directed on the bottle. Interview on 03/19/25 at 12:20 P.M. with LPN #107 revealed the LPN was unaware of a required time the surface needed to be wet for disinfection, typical disinfection after glucometer usage included wiping the meter twice and letting it sit in the cup for a few minutes. LPN #107 does not have a specific wet time she follows. Interview on 03/19/25 at 12:31 P.M. with the DON confirmed the facility staff should follow manufactures instructions located on the side of the bottle which notes a required wet time of 3 minutes for standard disinfection against all organisms. Review of infection prevention and control program dated 11/28/17 revealed all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Review of disinfection wipes instructions revealed to clean and disinfect against all organisms and deodorize hard, nonporous surfaces use enough wipes for treated surface to remain visibly wet for three minutes, let air dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50008 3. Review of Resident #46's electronic medical record revealed that he was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, personal history of malignant neoplasm of larynx, and acquired absence of larynx. Review of Resident #46's Minimum Data Set assessment dated [DATE] revealed that he had a Brief Interview for Mental Status score of 15, indicative of intact cognition. Review revealed that Resident #46 received no oxygen therapy; however, he received tracheostomy care and suctioning. Review of Resident #46's electronic medical record revealed he had physician orders effective 05/16/22 to cleanse his outer stoma with normal saline on every shift and leave open to to air. Resident #46 had physician orders effective on 12/12/22 to suction his stoma as needed. He also had physician orders effective on 07/08/24 for Enhanced Barrier Precautions (EBP). The order further indicated that Personal Protective Equipment (PPE) was required for high-contact activities for Resident #46. Observation of stoma care on 03/19/25 from 8:44 A.M. to 8:55 A.M. revealed that Registered Nurse (RN) #175 performed the open to air stoma care on Resident #46 without wearing a mask or a gown. Observation revealed that RN #175 was cleaning the open stoma and had her uncovered face within two feet of Resident #46's open stoma without a mask. She conversed with Resident #46 throughout the open stoma care process. Resident #46 was observed coughing on two occasions during stoma care, and RN #175 was observed removing mucus from the stoma. Interview with RN #175 on 03/19/25 at 8:55 A.M. revealed that the proper procedure for Enhanced Barrier Precautions and stoma care for Resident #46 would be to wear a gown and a mask. RN #175 confirmed that she did not wear a mask or a gown while performing a high-contact activity on Resident #46. Review of a facility policy titled Infection Prevention and Control Program, which was dated 08/18/10 and revised 11/28/17, revealed that the RNs and Licensed Practical Nurses supervise direct care staff in daily activities to assure that appropriate precautions and techniques are observed, assess the resident's isolation needs and initiate proper precautions. All staff shall perform hand hygiene after handling contaminated objects and after PPE removal. A gown is worn for direct resident contact if the resident has uncontained secretions or excretions. Appropriate mouth, nose and eye protection is worn for procedures that are likely to generate splashes or sprays of body fluids.