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 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** 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. (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: 366446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Meadow Grove Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meadow Grove Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 5. Review of the medical record for Resident #19 revealed an admission date of 07/27/20, diagnoses included type II diabetes mellitus, morbid obesity, mild cognitive impairment, and major depressive disorder. 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. (continued on next page)

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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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (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 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. 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. 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. (continued on next page)

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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	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.