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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, family interview, and staff interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) care received adequate assistance with personal hygiene. This affected one (#59) of four residents reviewed for ADL care. The facility census was 80. Findings include: Review of the medical record revealed Resident #59 was admitted on [DATE]. Diagnoses included paraplegia, injury to sacral spinal cord, other front temporal neurocognitive disorder, dementia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #59 was rarely understood and dependent on staff for assistance with personal hygiene. Review of the care plan dated 10/04/22 revealed Resident #59 had paraplegia and required one person assistance with ADL care. Observation on 01/27/25 at 10:38 A.M. revealed Resident #59 had unshaven facial hair on face and neck. Interview on 01/27/25 at 10:40 A.M. with Resident #59's Resident Representative revealed the resident was a businessman and was always well kept including shaving on a daily basis. It was reported the facility had been asked to ensure he was shaved daily. Resident #59's resident representative reported he had approximately four to five days of facial hair growth. Interview on 01/27/25 at 11:10 A.M. with Certified Nurse Assistant (CNA) #431 verified Resident #59 had unshaven facial hair with growth of approximately a few days. This deficiency represents non-compliance investigated under Master Complaint Number OH000161547, Complaint Number OH00161076, and Complaint Number OH00161078.

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

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

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/10/25, WCCNP #200's evaluation noted Resident #71 stated he had a fall on 01/04/25 that resulted in re-injury of head for which he went to the ER. Per documentation: Resident #71 found to have big head injury with active bleeding. Resident's bleeding was controlled with hemostatic bandage and was appropriately wrapped. Resident #71 presented with bulky dressing and ACE wrap sitting on top of his head. He stated the dressing had not been changed since it was applied on 01/04/25 in the ER. Review of the (hospital) discharge instructions showed recommendations to schedule follow-up appointment with WCCNP #200 in clinic within two days. Review of charting shows no calls were placed to the clinic notifying the wound clinic of new wound or requesting earlier visit. On arrival, dressing was found to be severely adhered to the scalp. Copious amounts of saline irrigation were utilized to soften dressing for removal. Unfortunately, this was unsuccessful, and debridement was required to remove embedded dressings. On removal, Resident #71 was found to have a large amount of foul-smelling drainage between layers of dressings and wound with exposed bone noted to scalp wound. The treatment was changed to apply cuticerin to bone. Cover with saline moistened gauze and ABD pad. Secure stockinet/hat. Change daily. Wound descriptions noted a head wound etiology as traumatic, wound cleansed with saline. Measurements with wound length 10. 2 cm x width 6.2 cm and depth 0.4 cm. Wound assessment identified exposed structure bone; granulation tissue; pale granulation tissue; pink/red slough, and moderate serosanguineous (blood tinged) drainage. Observation on 01/28/25 at 2:07 P.M. revealed Assistant Director of Nursing (ADON) #322 administered Resident #71's head wound dressing including removing the existing undated dressing. ADON #322 proceeded to cleanse the open areas to his head and cleanse his wound parameter with chlorahexine. Comb his hair, apply cuticerin dressing over bone and normal saline wet gauze to remaining open areas. Followed by covering the entire head wound with an ABD and stockinet. On 01/30/25 at 8:42 A.M., an interview with the Director of Nursing (DON), ADON #322, Regional Registered Nurse (RRN) #500, and Administrator during review of Resident #71's medical record confirmed the wound clinic and/or WCCNP #200 were not informed of Resident #71's fall with injury to his head until previously scheduled appointment on 01/10/25. Staff also confirmed the treatment for the head wound was not administered between 01/04/25 and 01/10/25, and were unaware what treatment had been applied when the resident was evaluated at the hospital emergency roiagnom on [DATE] which was left in place until the wound clinic appointment on 01/10/25. On 01/30/25 at 10:20 A.M., review of the medical record with ADON #322 and RRN #500 confirmed there was no documentation of a nursing plan of care addressing the head wound until 01/29/25. Telephone interview on 01/30/25 at 3:18 P.M. with WCCNP #200 confirmed Resident #71 was under her care regarding the wound to the head and additional wounds prior to admission to the facility. WCCNP #200 confirmed she was not contacted by the facility when Resident #71 sustained an injury to the head wound which caused an additional skin impairment to the head wound WCCNP #200 was treating. WCCNP #200 indicated they were not made aware of the injury until Resident #71 was evaluated at the wound clinic on 01/10/25. Resident #71 was observed with an ACE bandage wrapped around his head and a dressing which was not prescribed was applied to the top of his head. WCCNP #200 verified all documentation of Resident #71's wound evaluations were accurate including wound descriptions. Prior to the injury on 01/04/25, the head wound did not have an area of exposed bone. WCCNP #200 confirmed Resident #71 did not develop infection and currently wounds were improving. (continued on next page)

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

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

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