STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365375	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	8211 Weller Road Cincinnati, OH 45242

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interviews, and review of facility policy, the facility failed to ensure their policy regarding abuse was implemented when facility staff found a male and female resident in a bed together. This affected one (#4) of the two residents reviewed for abuse. The facility census was 95. Findings include: Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia, malnutrition, anxiety, depression and hypertension. Resident #4 resided on the secured memory care unit. Resident #4 had been deemed incompetent. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 had severely impaired cognition, no range of motion impairment of upper and lower extremities and was frequently incontinent of bowel and bladder. The resident required supervision with eating, bed mobility and transfers, moderate assistance for oral and personal hygiene, toileting and dressing and maximal assistance for bathing. Review of the medical record revealed Resident #41 was admitted on [DATE] with diagnoses of dementia and diabetes mellitus type II. Resident #41 resided on the secured memory care unit. Review of the quarterly MDS assessment dated [DATE] revealed the Resident #41 had moderate cognitive impairment, no range of motion impairment of upper and lower extremities and was always continent of bowel and occasionally incontinent of bladder. The resident required set up assistance with eating, supervision with oral hygiene, personal hygiene, toileting, bathing, and dressing and was independent for transfers. Review of Resident #41's admission MDS dated [DATE], quarterly MDS dated [DATE] and quarterly MDS dated [DATE] revealed the resident exhibited no physical or behavioral symptoms directed towards others. (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: 365375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8211 Weller Road Cincinnati, OH 45242	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the documents provided by the facility revealed facility staff statements were obtained from Registered Nurse (RN) #320, Licensed Practical Nurse (LPN) #415, Medication Technician #575, Certified Nursing Assistant (CNA) #550 and Resident #41 for a reported incident which occurred on 11/19/24. Additionally, the facility provided staff education on 11/20/24 for resident rights, abuse and neglect protocol and that all observed or suspected allegations are to be reported immediately to the Director of Nursing and to the Administrator, in relation to the alleged incident. The facility did not conduct a formal investigation of this incident or issue the formal findings. Review of the written statement submitted on 11/19/24 by Medication Technician #575 revealed Resident #4 was found in Resident #41's bed undressed and Resident #41 was sitting on the side of the bed. Resident #41 seemed confused and stated that Resident #4 had an odor. Review of the written statement submitted on 11/19/24 by LPN #415 revealed she did not witness any of the alleged events between Resident #4 and Resident #41. What she knows is only what was alleged by CNA #550. LPN #415 stated Resident #4 was previously seen in the living room which is next to Resident #41's room. Review of the interview document with RN #320, as provided by the Director of Nursing, revealed LPN #415 approached RN #320 regarding the alleged incident between Resident #4 and Resident #41. LPN #415 stated she overheard CNA #550 talking to other staff about the alleged incident in a casual and flippant manner. LPN #415 told RN #320 she never saw Resident #4 undressed but did see Resident #41 sitting on the edge of his bed. Resident #41 told LPN #415 he heard the girls talking and he was not on top of Resident #4. Resident #4 told LPN #415 that Resident #4 smells, and he wanted her out of his bed. LPN #415 confirmed Resident #41's bed was soaked, and she changed the sheets. Later that evening she stated she overheard CNAs talking about trying to get LPN #415 fired for not reporting this alleged incident. At the end of the shift RN #320 asked LPN #455 to walk LPN #415 to her car because CNA #550 was overheard talking about swinging on LPN #415. Review of the interview document with CNA #550 dated 11/20/24, as provided by the Director of Nursing, revealed CNA #550 walked into Resident #41's room and found him laying on top of Resident #4 with one hand in front of female and one hand in back like they were cuddling. She stated Resident #41 was dressed and Resident #4 didn't have a brief on and her gown was hanging on the bed. When she walked in Resident #41 rose up and sat on the edge of the bed. Review of the interview document with Resident #41 dated 11/20/24, as provided by the Director of Nursing, revealed Resident #41 thought a female resident followed him into his room. He was not sure if she was already in his room when he entered, but thought she may have followed him. He reported she lay down in his bed and then he laid down. Resident #41 stated he wanted to go to sleep, and the female resident smelled like explicit term. He reported he was next to her in the bed and said she acted like she didn't want to go anywhere. He told her she could stay but had to go to the unoccupied bed in the room. He repeated the female resident smelled really bad. When asked if he laid on top of her, Resident #41 stated, God no, you know the life, she was dead weight. I tried to move her, and the girl came in and it was all. I sat there (on the side of the bed). Resident #41 stated she had a gown on and was not sure if she had a brief on or if she took it off, but he denied removing her clothing or brief. He denied touching the resident's private parts and stated he was just trying to get her to move to the other bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meadowbrook Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8211 Weller Road Cincinnati, OH 45242	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/25/24 at 12:28 P.M. with the Director of Nursing verified the alleged incident happened on the evening of 11/19/24 and she was not notified until 11/20/24. She verified she should have been notified on 11/19/24, a Self-Reported Incident (SRI) initiated, a formal investigation completed, and a formal report generated and submitted. The Director of Nursing verified staff statements were obtained from RN #320, LPN #415, Medication Technician #575 and CNA #550, that staff education was provided on 11/20/24 in the areas of resident rights, abuse and neglect protocol and that all observed or suspected allegations are to be reported immediately to the Director of Nursing and to the Administrator and that the Resident #41 was placed on one : one supervision on 11/20/24. Interview on 11/25/24 at 2:40 P.M. with Resident #41, revealed he had known the Resident #4 a long time and stated when he came into his room that evening, she was in the bed closest to the door. Resident #41 resides alone in a semi-private room with two beds. He wanted Resident #4 to move to the bed closest to the window and said he was going to lift her, but she smelled terrible. He said he laid down beside her to go to sleep, but she smelled terrible and that is when staff found her in his bed. He said there was no kissing or touching. He did not remember if the Resident #4 was dressed but he just kept saying she stinks, she stinks. Interview on 11/25/25 at 3:00 P.M. with the Administrator verified the facility policy on Abuse and Neglect was not followed with the incident involving Residents #4 and #41. The Administrator verified he was not notified until 11/20/24 and should have been notified on 11/19/24 of the incident. He also verified the alleged incident should have been reported within 24 hours, a formal investigation completed, and a formal report generated and submitted. Telephone interview on 11/26/24 at 9:17 A.M. with CNA #550 revealed she was not working on the secured memory care unit the evening of 11/19/24 but went there for resident nutrition supplies and that is when she was told by LPN #415 and Medication Technician #575, they were looking for Resident #4. CNA #550 said she assisted the staff by going room-to-room and that is when she found Resident #4 in bed with Resident #41. CNA #550 stated Resident #4 was dressed with a gown on and brief off, in the bed nearest the door and Resident #41 who was fully dressed was in the bed too. CNA #550 stated she did not see Resident #41 touching Resident #4 inappropriately in any way. In her statement dated 11/20/24, CNA #550 initially stated Resident #41 was on top of Resident #4 but when interviewed on 11/26/24 she stated Resident #41 was more lying next to Resident #4 in the bed. She stated Resident #41 just kept saying she stinks, she stinks. CNA #550 confirmed Resident #4's brief and the bed were soaked with urine. She finished by stating she reported what she saw to LPN #415, who with Medication Technician #575 came immediately to Resident #41's room. Telephone interview on 11/26/24 at 10:09 A.M. with LPN #415 verified she did not witness Resident #41 and Resident #4 in the bed together. LPN #415 said she observed Resident #41's bed had what appeared to be coffee stains on the sheets and she changed his bed linen after this incident had occurred. LPN # 415 referred to Resident #41 as a gentleman. When asked who she reported this incident to, LPN #415 stated she reported the allegation to RN #320 within 30 minutes of the incident occurrence. She was not sure when RN #320 reported it to the Director of Nursing. Interview on 11/26/24 at 11:24 A.M. with Medication Technician #575 verified she did not see Resident #41 physically touch Resident #4. By the time she got to the room Resident #41 was sitting on the side of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Self-Reported Incidents (SRIs) on the State of Ohio website revealed the facility did not complete an SRI related to this alleged incident. Review of the facility policy titled, Abuse and Neglect Protocol, revised date of 06/13/21, revealed it is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Administrator or Director of Nursing. If such incidents occur after hours or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such an incident. If an incident of suspected abuse occurs, the facility shall report immediately, but not later than two hours after forming the suspicion, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to designated state agency. An immediate investigation will be made and a copy of the findings of such an investigation will be provided to the state agency within five working days or as designated by state law. This deficiency represents noncompliance investigated under Complaint Number OH00160042.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interviews, review of facility's Self-Reported Incidents (SRIs), and facility policy review, the facility failed to timely report an an alleged incident of abuse. This affected one (#4) of the two residents reviewed for abuse. The facility census was 95. Findings include: Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia, malnutrition, anxiety, depression and hypertension. Resident #4 resided on the secured memory care unit. Resident #4 had been deemed incompetent. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 had severely impaired cognition, no range of motion impairment of upper and lower extremities and was frequently incontinent of bowel and bladder. The resident required supervision with eating, bed mobility and transfers, moderate assistance for oral and personal hygiene, toileting and dressing and maximal assistance for bathing. Review of the medical record revealed Resident #41 was admitted on [DATE] with diagnoses of dementia and diabetes mellitus type II. Resident #41 resided on the secured memory care unit. Review of the quarterly MDS assessment dated [DATE] revealed the Resident #41 had moderate cognitive impairment, no range of motion impairment of upper and lower extremities and was always continent of bowel and occasionally incontinent of bladder. The resident required set up assistance with eating, supervision with oral hygiene, personal hygiene, toileting, bathing, and dressing and was independent for transfers. Review of Resident #41's admission MDS dated [DATE], quarterly MDS dated [DATE] and quarterly MDS dated [DATE] revealed the resident exhibited no physical or behavioral symptoms directed towards others. Review of the documents provided by the facility revealed facility staff statements were obtained from Registered Nurse (RN) #320, Licensed Practical Nurse (LPN) #415, Medication Technician #575, Certified Nursing Assistant (CNA) #550 and Resident #41 for a reported incident which occurred on 11/19/24. Additionally, the facility provided staff education on 11/20/24 for resident rights, abuse and neglect protocol and that all observed or suspected allegations are to be reported immediately to the Director of Nursing and to the Administrator, in relation to the alleged incident. The facility did not conduct a formal investigation of this incident or issue the formal findings. Review of the written statement submitted on 11/19/24 by Medication Technician #575 revealed Resident #4 was found in Resident #41's bed undressed and Resident #41 was sitting on the side of the bed. Resident #41 seemed confused and stated that Resident #4 had an odor. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the written statement submitted on 11/19/24 by LPN #415 revealed she did not witness any of the alleged events between Resident #4 and Resident #41. What she knows is only what was alleged by CNA #550. LPN #415 stated Resident #4 was previously seen in the living room which is next to Resident #41's room. Review of the interview document with RN #320, as provided by the Director of Nursing, revealed LPN #415 approached RN #320 regarding the alleged incident between Resident #4 and Resident #41. LPN #415 stated she overheard CNA #550 talking to other staff about the alleged incident in a casual and flippant manner. LPN #415 told RN #320 she never saw Resident #4 undressed but did see Resident #41 sitting on the edge of his bed. Resident #41 told LPN #415 he heard the girls talking and he was not on top of Resident #4. Resident #4 told LPN #415 that Resident #4 smells, and he wanted her out of his bed. LPN #415 confirmed Resident #41's bed was soaked, and she changed the sheets. Later that evening she stated she overheard CNAs talking about trying to get LPN #415 fired for not reporting this alleged incident. At the end of the shift RN #320 asked LPN #455 to walk LPN #415 to her car because CNA #550 was overheard talking about swinging on LPN #415. Review of the interview document with CNA #550 dated 11/20/24, as provided by the Director of Nursing, revealed CNA #550 walked into Resident #41's room and found him laying on top of Resident #4 with one hand in front of female and one hand in back like they were cuddling. She stated Resident #41 was dressed and Resident #4 didn't have a brief on and her gown was hanging on the bed. When she walked in Resident #41 rose up and sat on the edge of the bed. Review of the interview document with Resident #41 dated 11/20/24, as provided by the Director of Nursing, revealed Resident #41 thought a female resident followed him into his room. He was not sure if she was already in his room when he entered, but thought she may have followed him. He reported she lay down in his bed and then he laid down. Resident #41 stated he wanted to go to sleep, and the female resident smelled like explicit term. He reported he was next to her in the bed and said she acted like she didn't want to go anywhere. He told her she could stay but had to go to the unoccupied bed in the room. He repeated the female resident smelled really bad. When asked if he laid on top of her, Resident #41 stated, God no, you know the life, she was dead weight. I tried to move her, and the girl came in and it was all. I sat there (on the side of the bed). Resident #41 stated she had a gown on and was not sure if she had a brief on or if she took it off, but he denied removing her clothing or brief. He denied touching the resident's private parts and stated he was just trying to get her to move to the other bed. Interview on 11/25/24 at 12:28 P.M. with the Director of Nursing verified the alleged incident happened on the evening of 11/19/24 and she was not notified until 11/20/24. She verified she should have been notified on 11/19/24, a Self-Reported Incident (SRI) initiated, a formal investigation completed, and a formal report generated and submitted. The Director of Nursing verified staff statements were obtained from RN #320, LPN #415, Medication Technician #575 and CNA #550, that staff education was provided on 11/20/24 in the areas of resident rights, abuse and neglect protocol and that all observed or suspected allegations are to be reported immediately to the Director of Nursing and to the Administrator and that the Resident #41 was placed on one : one supervision on 11/20/24. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/25/24 at 2:40 P.M. with Resident #41, revealed he had known the Resident #4 a long time and stated when he came into his room that evening, she was in the bed closest to the door. Resident #41 resides alone in a semi-private room with two beds. He wanted Resident #4 to move to the bed closest to the window and said he was going to lift her, but she smelled terrible. He said he laid down beside her to go to sleep, but she smelled terrible and that is when staff found her in his bed. He said there was no kissing or touching. He did not remember if the Resident #4 was dressed but he just kept saying she stinks, she stinks. Interview on 11/25/25 at 3:00 P.M. with the Administrator verified the facility policy on Abuse and Neglect was not followed with the incident involving Residents #4 and #41. The Administrator verified he was not notified until 11/20/24 and should have been notified on 11/19/24 of the incident. He also verified the alleged incident should have been reported within 24 hours, a formal investigation completed, and a formal report generated and submitted. Telephone interview on 11/26/24 at 9:17 A.M. with CNA #550 revealed she was not working on the secured memory care unit the evening of 11/19/24 but went there for resident nutrition supplies and that is when she was told by LPN #415 and Medication Technician #575, they were looking for Resident #4. CNA #550 said she assisted the staff by going room-to-room and that is when she found Resident #4 in bed with Resident #41. CNA #550 stated Resident #4 was dressed with a gown on and brief off, in the bed nearest the door and Resident #41 who was fully dressed was in the bed too. CNA #550 stated she did not see Resident #41 touching Resident #4 inappropriately in any way. In her statement dated 11/20/24, CNA #550 initially stated Resident #41 was on top of Resident #4 but when interviewed on 11/26/24 she stated Resident #41 was more lying next to Resident #4 in the bed. She stated Resident #41 just kept saying she stinks, she stinks. CNA #550 confirmed Resident #4's brief and the bed were soaked with urine. She finished by stating she reported what she saw to LPN #415, who with Medication Technician #575 came immediately to Resident #41's room. Telephone interview on 11/26/24 at 10:09 A.M. with LPN #415 verified she did not witness Resident #41 and Resident #4 in the bed together. LPN #415 said she observed Resident #41's bed had what appeared to be coffee stains on the sheets and she changed his bed linen after this incident had occurred. LPN # 415 referred to Resident #41 as a gentleman. When asked who she reported this incident to, LPN #415 stated she reported the allegation to RN #320 within 30 minutes of the incident occurrence. She was not sure when RN #320 reported it to the Director of Nursing. Interview on 11/26/24 at 11:24 A.M. with Medication Technician #575 verified she did not see Resident #41 physically touch Resident #4. By the time she got to the room Resident #41 was sitting on the side of the bed. Review of Self-Reported Incidents (SRIs) on the State of Ohio website revealed the facility did not complete an SRI related to this alleged incident. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse and Neglect Protocol, revised date of 06/13/21, revealed it is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Administrator or Director of Nursing. If such incidents occur after hours or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such an incident. If an incident of suspected abuse occurs, the facility shall report immediately, but not later than two hours after forming the suspicion, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to designated state agency. An immediate investigation will be made and a copy of the findings of such an investigation will be provided to the state agency within five working days or as designated by state law. This deficiency represents noncompliance investigated under Complaint Number OH00160042.