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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 51520 Based on record review, resident interview, staff interview, and review of the facility policy, the facility failed to document and follow up on resident concerns brought up in the Resident Council meetings. This affected 10 (Residents #12, #15, #33, #36, #40, #46, #51, #63, #72, #78) of 10 residents who regularly attended the Resident Council meetings. The facility census was 89 residents. Findings include: Review of the monthly Resident Council meeting minutes dated May 2024 to April 2025 revealed the facility did not follow up on concerns raised in Resident Council meetings. The section of the minutes titled Old Business was left blank and did not include follow up on previous concerns brought by residents which include agency staffing, call lights, medications, laundry, and menus. Interview on 05/07/25 at 10:06 AM with Resident #200 confirmed she was the president of the Resident Council, and the facility had not provided follow up to the group on concerns brought up during the meetings. Interview on 05/07/25 at 10:07 A.M. with Resident #51 confirmed the facility had not provided follow up to resident concerns raised in the Resident Council meetings. Interview on 05/07/25 at 10:08 AM with Activities Director (AD) #200 confirmed the facility had no documentation of follow-up to the concerns brought up by the Resident Council members for the monthly meetings dated May 2024 to April 2025. Review of the facility policy titled Resident Council dated 01/12/22 revealed the facility would track and document response and resolution to concerns raised by the Resident Council members.

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51520 Based on medical record review, staff interview, and review of the facility policy, the facility failed to notify resident physicians/medical providers of significant weight loss. This affected one (Resident #45) of eight residents reviewed for weight changes. The facility census was 89 residents. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), panic disorder, and pulmonary hypertension. Review of the physician's orders for Resident #45 revealed an order dated 10/07/24 for daily weights. Review of the Minimum Data Set (MDS) assessment for Resident #45 dated 03/05/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the weight record for Resident #45 revealed the following weights: 187 pounds on 12/04/24, 169 pounds on 12/05/24, 169.5 pounds on 12/06/24. Interview on 05/08/35 at 2:17 PM with Dietician #504 confirmed staff did not notify Nurse Practitioner (NP) #510 of Resident #45's significant weight loss from 12/04/24 to 12/06/24. Interview on 05/08/25 at 2:34 PM with NP #510 confirmed staff had not notified her of the weight change for Resident #45 from 12/04/24 to 12/06/24. NP #510 confirmed this was significant weight loss of 9.3 percent (%) and she should have been notified by staff members. NP #510 confirmed if the facility had notified her, she would have ordered lab work for the resident. Review of facility policy titled Impaired Nutrition/Unplanned Weight Loss dated September 2012 revealed staff members should observe and report significant weight gain or loss to the physician/provider. The policy defined significant weight loss as a 5 % loss and severe weight loss as greater than 5 %.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on medical record review, observation, staff interview, and review of the facility policy the facility failed to ensure resident personal privacy was maintained . This affected three (Residents#10, #21, and #43) of three residents reviewed for personal privacy. The facility census was 89 residents. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including diabetes, schizoaffective disorder, bipolar disorder, and dementia. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 04/01/25 revealed the resident had severely impaired cognition and was dependent on staff for activities of daily living (ADLs.) Review of the nurse progress note for Resident #10 dated 04/03/25 revealed the resident's representative informed Registered Nurse Unit Manger (RNUM) #160 she did not want the resident's picture posted on social media. Interview on 05/06/25 at 3:16 P.M. of Activity Director (AD) #200 confirmed the facility had posted a picture of Resident #10 on social media a couple months ago and the picture remained online for a few weeks. Resident #10's representative reported her concerns to RNUM #160. AD #200 confirmed the facility had not obtained prior consent from the resident and/or the resident's representative before posting the resident's picture on social media. Interview on 05/06/25 at 3:44 P.M. with Medical Records Clerk (MRC) #179 confirmed Resident #10's record did not include consent to post the resident's picture on social media. Interview on 05/06/25 at 4:25 P.M. with RNUM #160 confirmed Resident #10's representative contacted her when she saw a picture of the resident posted on social media by the facility and asked for the picture to be removed. RNUM #160 confirmed Resident #10's representative had not consented for the facility to post the resident's picture on social media. Review of facility policy titled Videotaping, Photographing and Other Imaging of Residents dated April 2017 revealed the staff could not release images of any resident without explicit written consent from the representative prior to obtaining images. Transmitting unauthorized images of any resident through social media was considered a violation of resident rights. 51520 2. Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including heart failure, vascular dementia, and major depressive disorder. Review of the MDS assessment for Resident #21 dated 02/18/25 revealed the resident had severely impaired cognition and was dependent on staff assistance with ADLs. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation of incontinence care for Resident #21 on 05/07/2025 at 1:30.PM. per Certified Nursing Assistant (CNA) #133 and Licensed Practical Nurse (LPN) #146 revealed the curtain to the outside window which opened to the staff parking lot was not closed during provision of care. Interview on 05/07/25 at 1:35 PM with CNA #133 confirmed she had not closed the curtain to the window of the resident's room during incontinence care for Resident #21. Interview on 05/07/25 at 1:36 P.M. with LPN #146 confirmed staff members could potentially see inside Resident #21's window during incontinence care because the curtain was not drawn. LPN #146 further confirmed the curtain to the outside window should be drawn to provide visual privacy for the resident. Review of the facility policy titled Resident Rights undated revealed residents have the right to privacy. 51523 3. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including diabetes mellitus, bipolar disorder, and Alzheimer's Disease. Review of the MDS assessment for Resident #43 dated 3/12/25 revealed the resident had severely impaired cognition and received insulin. Observation on 05/05/25 at 11:27 A.M. revealed Resident #43 was seated in the dining room with multiple residents who were waiting for lunch to be served. Registered Nurse (RN) #152 approached Resident #43 and told her she was going to check her blood sugar. RN #152 did not obtain consent from the resident. RN #152 then cleansed Resident #43's finger and pierced it with a lancet to obtain a blood sample to perform a blood sugar check. Interview on 05/05/25 at 11:35 A.M. with RN #152 confirmed she checked Resident #43's blood sugar in the dining room in the presence of other residents and did not provide visual privacy during treatment for the resident. This deficiency represents noncompliance investigated under Complaint Number OH00162453.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51520 Based on observation and staff interview, the facility failed to ensure adequate lighting in resident rooms. This affected one (Resident #21) of 16 residents reviewed for adequate lighting. The facility also failed to ensure a clean environment. This affected the 48 residents residing on the C Unit who used the shower room (Residents #01, #03, #04, #06, #09, #11, #13, #14, #15, #16, #17, #18, #19, #21, #22, #25, #26, #27, #29, #32, #33, #34, #36, #39, #40, #41, #45, #46, #48, #49, #50, #51, #52, #59, #61, #64, #67, #75, #76, #77, #78, #80, #85, #89, #146, #147, #196, and #196). The facility census was 89 residents. Findings include: 1.Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including heart failure, vascular dementia, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 02/18/25 revealed the resident had severe cognitive impairment and was dependent on staff assistance with activities of daily living (ADLs.) Observation of wound care for Resident #21 on 05/07/25 at 1:32 PM per Licensed Practical Nurse (LPN) #146 revealed the resident's room did not have adequate overhead lighting when the curtain was closed. Light sources in Resident #21's room included a sink light, a bathroom light, and an over the bed light. Interview on 05/07/25 at 1:35 PM with LPN #146 confirmed Resident #21's room did not have adequate light for performing wound care and staff sometimes had to use a flashlight when providing care for Resident #21 due to inadequate overhead lighting when the curtain was closed. 42731 2. Observation on 05/07/25 at 10:11 A.M. of the C Hall shower room with LPN #146 revealed there was an area measuring approximately two inches by three inches of brown skid marks of an unidentified substance on the wall by the toilet. Further observation revealed the walls surrounding the entire shower area contained a layer of a brown unidentifiable material where the wall met the floor, measuring approximately two inches up the wall. Interview on 05/07/25 with LPN #146 confirmed the brown skid marks on the wall by the toilet and the brown substance on the walls surrounding the shower and all of the C Hall residents had access to the shower room. This violation represents noncompliance investigated under Master Complaint Number OH00165072 and Complaint Number OH00164179 and Complaint Number OH00161596 and Complaint Number OH00161253

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, staff interview and review of the facility policy, the facility failed to ensure hypnotic medications were used with adequate indications for administration and with adequate monitoring. This affected one (Resident #75) of five residents reviewed for unnecessary medications. The facility census was 89 residents. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including dysphagia, generalized anxiety disorder, and cerebral infarction. Review of the physician's orders for Resident #75 revealed an order dated 01/08/25 for Ambien five milligrams (mg) one table per mouth at bedtime for sleep assistance. Review of the Minimum Data Set (MDS) assessment for Resident #75 dated 02/04/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs) and received a hypnotic medication during the review period. Review of the care plan for Resident #75 last updated on 02/19/25 revealed the care plan did not address the use of Ambien, a hypnotic medication. Review of the diagnosis list for Resident #75 dated 05/07/25 revealed the resident had no diagnosis of a sleep disorder or related diagnosis. Interview on 05/08/25 at 8:05 A.M. with the Director of Nursing (DON) confirmed Resident #75 had an order for Ambien at bedtime for sleep assistance but the resident's record did not include an appropriate diagnosis or medical indication for hypnotic use. Interview with the DON on 05/08/25 at 8:31 A.M. confirmed the facility had not developed a care plan for Ambien use for Resident #75 to outline how the facility would monitor the resident for use of the hypnotic medication. Review of the facility policy titled Psychotropic Medication Use dated 01/19/24 revealed residents would not receive medications that were not clinically indicated to treat a specific condition. Residents receiving psychiatric medications would be monitored and assessed for adverse consequences. This deficiency represents noncompliance investigated under Complaint Number OH00161596.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review and staff interview, the facility failed to issue appropriate bed hold notices and/or Ombudsman notification when residents were discharged or transferred to the hospital. This affected four (Residents #06, #10, #197, #200) of five residents reviewed for discharge and hospitalization . The facility census was 89 residents. Findings include: 1. Review of the medical record for Resident #200 revealed an admitted [DATE] with a diagnosis of acute on chronic diastolic heart failure. The resident discharged to the hospital on 02/04/25 and did not return to the facility. Review of the Minimum Data Set (MDS) assessment for Resident #200 dated 01/23/25 revealed the resident had intact cognition. Review of the medical record for Resident #200 revealed the record did not include documentation of Ombudsman notification of the resident's transfer to the hospital on 02/04/25. Interview on 05/06/25 at 2:02 P.M. with the Administrator confirmed the facility failed to the notify the Ombudsman of Resident #200's discharge to the hospital on 02/04/25. 2. Review of the medical record for Resident #197 revealed an admitted [DATE] with diagnoses including right hip fracture and osteomyelitis. Resident #197 transferred to the hospital on 02/19/25 and returned to the facility on [DATE]. The resident transferred to the hospital again on 03/20/25 and did not return. Review of the MDS assessment for Resident #197 dated 03/11/25 revealed the resident had severely impaired cognition. Review of the medical record for Resident #197 revealed the record did not include documentation of Ombudsman notification of the resident's transfers to the hospital on 02/19/25 and 03/20/25. Interview on 05/06/25 at 2:02 P.M. with the Administrator confirmed the facility failed to the notify the Ombudsman of Resident #197's transfers to the hospital on 02/19/25 and 03/20/25. 43062 3. Review of the medical record for Resident #06 revealed an admitted [DATE] with diagnoses including hypothyroidism, cardiomegaly, and atrial fibrillation. Resident #06 was discharged to the hospital on 02/15/25 and readmitted to the facility on [DATE]. Review of the MDS assessment for Resident #06 dated 03/21/25, revealed the resident had mild cognitive impairment and required staff assistance with activities of daily living (ADLs) (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/06/25 at 1:46 P.M. with Business Office Manager (BOM) #104 confirmed the facility failed to provide a bed hold notice to Resident #06 for the hospitalization from [DATE] and 02/20/25. Interview on 05/06/25 at 2:02 P.M. with the Administrator confirmed the facility failed to the notify the Ombudsman of Resident #06's transfer to the hospital on 02/20/25. 44083 4. Review of the medical record for Resident #10 revealed and admitted [DATE] with diagnoses including diabetes, schizoaffective disorder and chronic kidney disease. Resident #10 was hospitalized from 11/14/24 to 12/13/24 and returned to the facility. Review of the MDS assessment for Resident #10 dated 04/01/25 revealed the resident had severely impaired cognition and was dependent on staff for ADLs. Interview on 05/06/25 at 2:25 P.M. with Regional Operations Manager (ROM) #501 confirmed the facility failed to provide a bed hold notice to Resident #10's representative for the resident's hospitalization from [DATE] to 12/13/24.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure the accuracy of resident Minimum Data Set (MDS) assessments regarding resident dental status and range of motion and mobility. This affected three (Residents #19, #75 and #80) of 21 residents reviewed for MDS accuracy. The facility census was 89 residents. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including benign prostatic hyperplasia, chronic kidney disease, and unspecified intellectual disabilities. Review of the admission Minimum Data Set (MDS) assessment for Resident #19 dated 03/26/25 revealed the resident was moderately cognitively impaired and was not coded as edentulous (having no natural teeth.) Observation on 05/05/25 at 11:35 A.M. of Resident #19 revealed the resident was edentulous. Interview on 05/05/25 at 11:36 A.M with Resident #19 confirmed he was edentulous and had been so upon admission to the facility. Interview on 05/06/25 at 4:20 P.M with MDS Registered Nurse (MDS RN) #175 confirmed Resident #19 was edentulous upon admission, and the facility had not correctly coded the resident's dental status on the resident's admission MDS dated [DATE]. 2. Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including cerebral infarction, asthma, and anxiety disorder. Review of the occupational therapy evaluation and plan of treatment for Resident #75 dated 12/10/24 revealed the resident had a contracture of the left hand. Review of the quarterly MDS for Resident #75 dated 02/04/25 revealed the resident was cognitively intact and had no functional impairment to the upper extremities. Review of the occupational therapy discharge summary for Resident #75 dated 03/27/25 revealed the resident was discharged from therapy with recommendations to wear a left carrot splint as tolerated and for staff to provide passive range of motion (PROM) to left upper extremity as tolerated. Observation on 05/05/25 at 11:46 A.M of Resident #75 revealed the resident had a contracture of his left hand and was unable to open his left hand. Interview on 05/05/25 at 11:46 A.M. with Resident #75 confirmed he had a contracture of the left hand which required the use of a carrot. Resident #75 reported he was unable to open his left hand. Interview with on 05/06/25 at 4:20 P.M. with MDS RN #175 confirmed Resident #75 had a left-hand contracture which the facility had not accurately coded on the quarterly MDS dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #80 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, peripheral vascular disease, and cerebral infarction. Review of the admission MDS assessment for Resident #80 dated 03/20/25 revealed the resident was cognitively intact and the MDS was not coded for the presence of broken natural teeth. Interview on 05/05/25 at 3:58 P.M with Resident #80 confirmed he had a broken teeth which had broken prior to his admission to the facility. Observation on 05/05/25 at 4:20 P.M. of Resident #80 revealed the resident had a broken tooth on the rear left side of his mouth and had black spots on his back teeth. Interview on 05/06/25 at 4:20 P.M with MDS RN #175 confirmed the resident had a broken tooth on the rear left side of his mouth and had black spots on his back teeth which possibly could have been cavities. MDS RN #175 confirmed the facility had not accurately coded Resident #80's dental status on the admission MDS dated [DATE].

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure a resident Preadmission Screening and Resident Review (PASARR) was completed within 30 days of being admitted to the facility with a hospital exemption. This affected one (Resident #19) of four residents reviewed for PASARR completion. The facility census was 89 residents. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including osteoarthritis, benign prostatic hyperplasia, chronic kidney disease stage three, and unspecified intellectual disabilities. Review of the admission Minimum Data Set (MDS) assessment for Resident #19 dated 03/26/25 revealed the resident was moderately cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the hospital exemption from preadmission screening notification for Resident #19 dated 03/22/25 revealed the resident had a mental disability that was not solely caused by mental illness and was manifested prior to age 22. Resident #19's intellectual disability was listed on the hospital exemption. Further review of the hospital exemption revealed the nursing facility accepted responsibility for electronically initiating a PASARR prior to the 30th day following the resident's the admission from the hospital. Review of the medical record for Resident #19 revealed it did not include a completed PASARR. Review of the hospital record for Resident #19 dated 03/18/25 revealed the resident had a history of intellectual disabilities and presented to the emergency department on 03/18/25 from a group home after having progressively increased lower extremity swelling prior to admission to the facility. Review of the diagnosis list for Resident #19 revealed the resident's diagnosis of unspecified intellectual disabilities was added to the diagnosis list on 03/22/25, the date of the resident's admission to the facility. Interview on 05/07/25 at 2:12 P.M with Licensed Social Worker (LSW) #205 confirmed Resident #19 was admitted to the facility on [DATE] with a diagnosis of an intellectual disability which had manifested prior to the resident's 22nd birthday, and the facility had not completed a PASARR for the resident. Review of the facility policy titled Admissions dated March 2017 revealed the PASARR will be provided to the facility prior to or upon the resident's admission.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on medical record review and staff interview facility failed to revise Preadmission Screening and Resident Review (PASARR) assessments after a change in resident condition. This affected one (Resident #58) of four residents reviewed for PASARR completion. The facility census was 89 residents. Findings include: Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses including cerebrovascular disease, chronic obstructive pulmonary disease, neurocognitive disorder, and diabetes. Review of the physician's orders for Resident #58 revealed an order dated on 09/11/24 for the resident to begin receiving hospice services. Review of the Minimum Data Set (MDS) assessment for Resident #58 dated 02/28/25 revealed the resident had moderately impaired cognition and required staff assistance with activities of daily living (ADLs.) Interview on 05/08/25 at 9:20 A.M. with Social Worker (SW) #205 on 05/08/25 confirmed the facility should have completed an updated PASARR for Resident #58 when the resident was enrolled in hospice on 09/11/24, but the facility had not done so.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to develop comprehensive resident care plans. This affected two (Residents #19 and #75) of 21 residents reviewed for care planning. The facility census was 89. Findings include: 1.Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including dysphagia, generalized anxiety disorder, and cerebral infarction. Review of the physician's orders for Resident #75 revealed an order dated 01/08/25 for Ambien five milligrams (mg) one table per mouth at bedtime for sleep assistance. Review of the Minimum Data Set (MDS) assessment for Resident #75 dated 02/04/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs) and received a hypnotic medication during the review period. Review of the care plan for Resident #75 last updated on 02/19/25 revealed the care plan did not address the use of Ambien, a hypnotic medication. Review of the diagnosis list for Resident #75 dated 05/07/25 revealed the resident had no diagnosis of a sleep disorder or related diagnosis. Interview on 05/08/25 at 8:31 A.M with the Director of Nursing (DON) confirmed the facility had not initiated a care plan for Resident #75's use of Ambien, a hypnotic medication. 2. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including benign prostatic hyperplasia, chronic kidney disease, and unspecified intellectual disabilities. Review of the admission MDS assessment for Resident #19 dated 03/26/25 revealed the resident was moderately cognitively impaired and was not coded as edentulous (having no natural teeth.) Review of the dental care plan for Resident #19 dated 04/03/25 revealed Resident #19 had the potential for oral or dental health issues related to the disease process and an ADL self-care deficit. Interventions included the following: coordinate and arrange for dental care and transportation as needed, provide mouth care, occupational therapy screen for adaptive equipment as needed, diet as ordered and monitor, document and report as needed signs and symptoms of dental problems. The care plan did not address Resident #19's status as edentulous status. Observation on 05/05/25 at 11:35 A.M. of Resident #19 revealed the resident was edentulous. Interview on 05/05/25 at 11:36 A.M with Resident #19 confirmed he was edentulous and had been so upon admission to the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/06/25 at 4:20 P.M with MDS Registered Nurse (MDS RN) #175 confirmed Resident #19 was edentulous upon admission, and the facility had not correctly coded the resident's dental status on the resident's admission MDS dated [DATE]. MDS RN #175 also verified Resident #19's dental care plan did not address that Resident #19 was edentulous. Review of the facility policy titled Comprehensive Person-Centered Care Plans dated 10/10/22 revealed the facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, staff interview, and review of the facility policy, the facility failed to conduct quarterly care conferences. This affected three (Residents #10, #24, and #81) of four residents reviewed for care planning. The facility census was 89 residents. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including dementia, schizophrenia, bipolar disorder, and diabetes mellitus type two. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 04/01/25 revealed the resident had severe cognitive impairment and required staff assistance with activities of daily living (ADLs.) Review of the care conference records for Resident #10 revealed the revealed the facility did not conduct a quarterly care conference for Resident #10 for the first, second, and third quarters of 2024. The only documented quarterly care conference for Resident #10 was on 10/03/24. Interview on 05/08/25 at 11:52 A.M. with the Social Services Director (SSD) #205 confirmed care conferences were to be conducted on a quarterly basis, and Resident #10 did not have a care conference in the first, second and third quarters of 2024. 2. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses of Parkinson's disease and dementia. Review of the MDS assessment for Resident #24 dated 03/07/25 revealed the resident had intact cognition and required staff assistance with ADLs. Review of the care conference records for Resident #24 revealed the facility did not conduct a quarterly care conference for Resident #24 during 2024. Interview on 05/08/25 at 11:53 A.M. with SSD #205 confirmed the facility had not conducted a care conference for Resident #24 during 2024. 3. Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension, and atrial fibrillation. Review of the MDS assessment for Resident #81 dated 04/17/25 revealed the resident had intact cognition and required staff assistance with ADLs. Review of the care conference records for Resident #81 revealed the facility did not conduct a quarterly care conference for Resident #81 in the first quarter of 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 11:52 A.M. with the SSD #295 confirmed the facility did not conduct a care conference for Resident #81 in the first quarter of 2024. Review of the facility policy titled Care Planning-Interdisciplinary Team dated 10/10/22, revealed the facility would include the resident and/or the resident's representative in the care planning process. Care plan meetings should be scheduled at the best time of the day for resident and family when possible.

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F 0684 Level of Harm - Minimal harm or potential for 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** 44083 Based on medical record review and staff interview, the facility failed to reassess resident nutritional status following hospitalization . This affected one (Resident #81) of two residents reviewed for readmission. The facility census was 89 residents. Findings include: Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including end stage renal disease, congestive heart failure, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #81 dated 03/26/25 revealed the resident had intact cognition and required minimal staff assistance for activities of daily living (ADLs.) Review of the May 2025 monthly physician's orders for Resident #81 revealed orders for the resident to have low concentrated sugar renal diet with a fluid restriction of 2000 milliliters (ml) per day. Review of hospital records for Resident #81 dated 03/31/25 to 04/11/25 revealed the resident was hospitalized for volume overload and had 44 pounds of fluid removed during the stay hospitalization . Resident #81's hospital admission weight was 256 pounds, and the discharge weight was 212 pounds. Review of the medical record for Resident #81 revealed the facility had not completed an assessment of the resident's nutritional status upon the return from the hospital per Registered Dietitian (RD) #504 and Dietitian Technician (DT) #505. Interview on 05/07/25 at 10:56 A.M. with DT #505 stated the she had not updated the resident's nutrition assessment upon Resident #81's readmission to the facility. DT #505 further confirmed she was unaware Resident #81 had been hospitalized and for a fluid volume overload of 44 pounds. Interview on 05/08/25 at 2:17 P.M. with RD #504 confirmed she had not completed a nutritional assessment for Resident #81 and had been unaware the resident had been hospitalized for fluid volume overload. RD #504 confirmed Resident #81's hospitalization was of nutritional significance and should have had a nutritional assessment upon return from the hospital.

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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** 51520 Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to timely and adequately assess resident skin. This affected one (Resident #21) of three residents reviewed for pressure ulcers. The facility also failed to follow the physician's orders regarding wound care for pressure ulcers and also failed to document the completion of wound care in the resident's medical record. This affected one (Resident #19) of three residents reviewed for pressure ulcers. The facility census was 89 residents. Findings include: 1.Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including heart failure and vascular dementia. Review of the pressure ulcer risk assessment for Resident #21 dated 11/20/24, revealed the resident was at very high risk for developing pressures ulcers. Review of the physician's orders for Resident #21 revealed an order dated 12/06/24 to cleanse the resident's bilateral hips with normal saline, pat dry, and apply skin prep every shift and as needed as a preventative measure and an order dated 01/08/24 for the resident to have weekly skin checks to be documented in the electronic medical record (EMR.) Review of the care plan for Resident #21 dated on 01/21/25 revealed the resident was at risk for the development of pressure ulcers. Interventions included the following: administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new area of skin breakdown. Review of the Treatment Administration Records (TARs) for Resident #21 dated December 2024, January 2025, and February 205 revealed the preventative treatment to the resident's bilateral hips was signed off as completed. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 02/18/25 revealed the resident was severely cognitively impaired and required substantial staff assistance with activities of daily living (ADLs.) Review of the skin check for Resident #21 dated 02/19/25 revealed there were no new areas of skin impairment noted. Review of a nurse progress note for Resident #21 dated 02/20/25 per Licensed Practical Nurse (LPN) #146 revealed the resident's family noticed an open area to the resident's right hip. Staff notified Wound Nurse Practitioner (WNP) #502 who gave an order to cleanse the area and apply Medihoney and a border foam dressing two times a day. The note did not include measurements or a description of the open area to the resident's right hip. (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 the skin check for Resident #21 dated 2/21/25 revealed there was an open area to the resident's right hip. The skin check did not include measurements, staging or a description of the wound. Review of the visit note for Resident #21 dated 02/26/25 per WNP #502 revealed the resident had a facility-acquired unstageable pressure ulcer to the right hip which measured 1.3 centimeters (cm) in length by 4.0 cm. in depth by 0.3 cm in depth with a heavy amount of serous drainage from the wound and 100 percent (%) slough tissue present to the wound bed. WNP #502 gave an order to cleanse the wound daily with wound cleanser, apply medical grade honey to the wound and secure with a border foam dressing. Interview on 05/06/25 at 11:35 A.M. with LPN #146 confirmed Resident #21's family notified the nurse that Resident #21 had an open area to the right hip on 02/20/25. LPN #146 further confirmed he notified WNP #502 of the open area and he obtained orders for wound care, but the facility did not measure or document the appearance of the wound to the resident's right hip. Observation on 05/07/25 at 1:30 P.M. of wound care for Resident #21 per LPN #146 revealed the resident had a nickel- sized open area to the right hip. The wound bed was pink with no drainage. LPN #146 cleansed the wound with normal saline, applied Medihoney, and covered the wound with a border foam dressing. Interview on 05/07/25 at 1:45 P.M. with WNP #502 confirmed on 02/26/25 she examined Resident #21 and documented the resident had an unstageable facility-acquired pressure ulcer the resident's right hip. Review of the facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated March 2014 revealed assessment of a pressure ulcer should include the nurse describing and documenting a full assessment of a pressure ulcer, including location, stage, length, width, and presence of exudate or necrotic tissue. 39967 2. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including osteoarthritis, benign prostatic hyperplasia glaucoma, chronic kidney disease, and intellectual disabilities. Review of the MDS assessment for Resident #19 dated 03/26/25 revealed the resident was moderately cognitively impaired, required supervision with ADLS, and was admitted with two stage III pressure ulcers and one unstageable pressure ulcer. Review of the care plan for Resident #19 dated 04/01/25 revealed the resident was at risk for the development of pressure ulcers related to the disease process, decreased mobility and moisture exposure. Interventions included staff to administer treatments as ordered and monitor for the effectiveness and to follow facility protocols for the prevention of and treatment of skin breakdown. (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 the wound assessment for Resident #19 dated 04/02/25 per WNP #502 revealed upon admission the resident had the following three pressure ulcers: a stage three pressure ulcer to the left buttock which measured 3.5 centimeters (cm) in length, by 1.5 cm in width by 0.3 cm in depth, a stage three pressure ulcer to the right buttock which measured 0.5 cm in length by 0.5 cm in width by 0.3 cm in depth, an unstageable pressure ulcer to the left ischium which measured 7.5 cm in length by 3.5 cm in width by 2.3 cm in depth. WNP #502 gave an order to cleanse the wounds to the left and right buttocks with normal saline, apply medical grade honey, and cover with a border foam dressing and to cleanse the wound to the left ischium with normal saline (do not use wound cleanser), gently pack the wound with half-strength Dakin's solution moistened fluffed gauze and apply a border foam dressing every shift and as needed. Review of the wound assessment for Resident #19 dated 04/09/25 per WNP #502 revealed the pressure ulcer to the resident's left buttock was improving and the treatment changed to cleanse with soap and water, pat dry, apply triad paste and leave open to air every shift and as needed. The pressure ulcer to the right buttock was resolved. The pressure ulcer to the left ischium was improving and the treatment order was unchanged. Review of the wound assessment for Resident #19 per WNP #502 dated 04/23/25 revealed the pressure ulcer to the left buttock was resolved. The pressure ulcer to the left ischium was improving and the treatment was changed to cleanse the left ischium with wound cleanser, gently pack the wound with quarter-strength Dakin's solution moistened fluffed gauze and apply a border foam dressing every shift and as needed. Review of the TAR for Resident #19 dated April 2025 revealed the treatment order given by WNP #502 dated 04/02/25 to 04/09/25 to cleanse the wounds to the left and right buttocks with normal saline, apply medical grade honey and a border dressing daily were not noted in the TAR and there was no record of the treatments being completed. Further review of the TAR revealed the treatment order to cleanse the left buttock with soap and water, pat dry, apply triad paste and leave open to air every shift from 04/09/25 to 04/23/25 was not listed on the TAR and there was no record that the treatment was completed. The treatments to the left ischium were not documented as completed on 04/04/25, 04/16/25 and 04/29/25 on the night shift. The treatment order to the left ischium indicated the wound was to cleansed with wound cleanser but WNP #502's order from 04/02/25 to 04/09/25 indicated the left ischium wound should be cleansed with normal saline. Interview on 05/07/25 at 10:49 A.M. with the Director of Nursing DON confirmed the treatment orders for the pressure ulcers to Resident #19's right and left buttocks were not included in the April TAR for 04/02/25 to 04/09/25 and the facility had no evidence the treatments had been completed. The DON further confirmed the treatment order for the pressure ulcer to Resident #19's left buttock was not included in the April TAR for 04/09/25 to 04/23/25 and the facility had no evidence the treatments had been completed. The DON confirmed the treatment orders for the pressure ulcer to Resident #19's left ischium were not signed off as completed on the night shift on 04/04/25, 04/16/25 and 04/29/25 and the facility had no evidence the treatments had been completed on those dates. The DON confirmed wound cleanser was used on Resident #19's left ischium from 04/02/25 to 04/09/25 and WNP #502's wound care order indicated staff should cleanse the left ischium with normal saline and should not use wound cleanser on the left ischium until the order was changed on 04/09/25. Review of the facility policy titled Wound Care dated October 2010 revealed wound treatments should be completed per physician's orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH00161253 and Complaint Number OH00164317.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review and staff interview, the facility failed to obtain resident weights as ordered by the physician. This affected one (Resident #06) of eight residents reviewed for weight changes. The facility census was 89 residents. Findings include: Review of the medical record for Resident #06 revealed an admitted [DATE] with diagnoses including hypothyroidism, cardiomegaly, and atrial fibrillation. Review of the Minimum Data Set (MDS) assessment for Resident #06 dated 03/21/25 revealed the resident had mildly impaired cognition and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #06 revealed an order dated 04/01/25 to obtain a weight upon admission, to obtain weights for the following two days, to obtain a weight every week for four weeks, and then to obtain a weight monthly thereafter. Review of the Medication Administration Record (MAR) for Resident #06 dated April 2025 revealed the following weights were obtained: 04/01/25-106 pounds, 04/02/25-106 lbs, 04/03/25-no weight was obtained, 04/04/25-106 pounds, 04/07/25-105.8 pounds. There were no weights recorded from 04/08/25 to 04/30/25. Interview on 05/07/25 10:23 A.M. with Dietary Technician (DT) #676 confirmed the facility failed to obtain weights as ordered by a physician for Resident #06. Review of the facility policy titled Impaired Nutrition/Unplanned Weight Loss Clinical Protocol dated September 2012 revealed the physician with input from the staff would determine the most appropriate intervals for resident weight assessments.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure staff administered resident tube feedings in a sanitary manner. This affected one (Resident #75) of one residents reviewed for tube feeding. The facility census was 89 residents. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with dysphagia following cerebral infarction, generalized anxiety disorder, and gastrostomy status. Review of the Minimum Data Set (MDS) assessment for Resident #75 dated 02/04/25 revealed the resident was cognitively intact and had a gastrostomy tube. Review of the physician's orders for Resident #75 revealed an order dated 10/24/24 for an enteral feeding two times a day of Jevity 1.5 to be administered via pump at 70 cubic centimeters (cc) per hour 8:00 P.M. to 6:00 A.M. Review of the care plan for Resident #75 dated 11/11/24 revealed the resident required tube feedings related to dysphagia. Interventions included the following: elevate the head of the bed 45 degrees during and thirty minutes after the tube feeding, check for tube placement, gastric contents and residual volume per facility protocol, provide care to the gastrostomy tube (g-tube) site as ordered and monitor for signs and symptoms of infection, Registered Dietitian (RD) to evaluate quarterly and as needed, speech therapy evaluation and treatment as ordered and discuss with the resident, family and caregivers concerns about the tube feeding. Observation on 05/06/25 at 4:20 P.M. revealed Resident #75 was lying in bed and the tube feeding pump next to the bed was not running. A container of Jevity 1.5 dated 05/05/25 was hanging on the pump and was connected to g-tube tubing which had a piece of paper towel stuck in the end of the tubing to keep the Jevity 1.5 from spilling out. Interview on 05/06/25 at 4:21 P.M with Registered Nurse (RN) #175 confirmed there was a partially used bag of Jevity 1.5 and g-tube tubing hanging on the tube feeding pump with a piece of paper towel stuck in the end of the tubing to keep the Jevity 1.5 from spilling out. Interview on 05/06/25 at 4:22 P.M. with Licensed Practical Nurse (LPN) #905 confirmed Resident #75's tube feed had been disconnected by night shift prior to the beginning of her shift, and the partially used bag of Jevity 1.5 should have been discarded after the feeding was disconnected on 05/06/25 at 6:00 A.M. Review of the facility policy titled Enteral Tube Feeding by Continuous Pump dated March 2015 revealed the facility should refrigerate formulas that have been reconstituted in advance and discard within 24 hours.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, review of a medication error report, staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #200) of one resident reviewed for medication errors. The facility census was 89 residents. Findings include: Review of the medical record for Resident #200 revealed an admitted [DATE] with diagnoses including chronic diastolic heart failure, anxiety disorder, acute respiratory failure with hypoxia, hypertension, chronic obstructive pulmonary disease, and chronic kidney disease The resident discharged to the hospital on 02/04/25. Review of the Minimum Data Set MDS assessment for Resident #200 dated 01/23/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the medical record revealed the resident had no known medication allergies. Review of a progress note for Resident #200 dated 02/04/25 timed at 12:39 A.M. per Registered Nurse (RN) #503 revealed the nurse prepared medication intended for another resident, but she inadvertently administered the other resident's medications to Resident #200. RN #503 assessed the resident and notified the resident's physician and emergency contact of the medication error. The physician gave orders to monitor the resident for 72 hours. Review of the hospital transfer form for Resident #200 dated 02/04/25 revealed the resident was sent to the hospital per the family's request due to a medication error. The resident was a DNR-CC (do not resuscitate-comfort care) code status Review of a progress note for Resident #200 dated 02/04/25 timed at 2:37 A.M. revealed Resident #200's family arrived at the facility after being notified of the medication error and requested the resident go to the hospital. Staff sent the resident to hospital via emergency medical services (EMS.) Review of the hospital note for Resident #200 dated 02/04/25 revealed the resident presented from her nursing facility with altered mental status following improper medication administration. The hospital performed lab work and an electrocardiogram (EKG) with no significant abnormalities. The hospital administered one liter of intravenous fluids to Resident #200 and monitored the resident for over eight until the resident returned to her baseline. Resident #200 was diagnosed with accidental drug overdose and altered mental status, and once stabilized the resident's family chose to place the resident in a different nursing facility. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the medication error report summary for Resident #200 revealed on 02/03/25 at approximately 11:37 P.M. staff administered the following medications to the resident in error: Aricept 5 milligrams (mg), gabapentin 600 mg, rosuvastatin 40 mg, duloxetine 30 mg, Keppra 500 mg, oxycodone 10 mg, ropinirole 0. 25 mg, sennosides-docusate 8.6-50 mg (two tablets), and clonazepam 0.5 mg. As a result of the medication error, RN #503 was terminated, and all resident electronic health record pictures were audited and verified they matched the facility room name plates. All nursing staff were reeducated on the medication administration policy and procedure. Review of a written statement per RN #503 dated 02/05/25 timed at 4:05 P.M. revealed the nurse prepared the medications for Resident #148 and administered them to Resident #200, thinking she was Resident #148. RN #503 stated, approximately 20 minutes later, she realized what she had done and notified management and assessed Resident #200. RN #503 stated that when administering medications to Resident #200, she did not ask her name or attempt to identify her in any way. Review of the facility policy titled Administering Medications April 2019 revealed the individual administering medications was to verify the resident's identity before giving the resident their medications. Medications ordered for one resident must not be administered to another resident. This deficiency represents noncompliance investigated under Complaint Number OH00163155 and Complaint Number OH00161596.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview, and consulting pharmacist interview, the facility failed to ensure insulin pens were properly labeled and stored. This affected three (Residents #65, #39 and #34) of 21 facility- identified residents who received insulin. The facility census was 89 residents. Findings include: 1. Review of the medical record for Resident #65 revealed an admitted [DATE] with a diagnosis of diabetes mellitus (DM.) Review of the Minimum Data Set (MDS) assessment for Resident #65 dated 03/25/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #65 revealed an order dated 02/18/25 for the resident to receive insulin lispro per sliding scale. Observation on 05/06/25 at 10:46 A.M. of the A-nursing unit front medication cart revealed the cart contained two insulin lispro pens for Resident #65 that were not dated. Interview on 05/06/25 at 10:46 A.M. with Licensed Practical Nurse (LPN) #260 confirmed the two insulin lispro pens for Resident #65 were not dated, and insulin is to be dated when removed from refrigeration storage and/or placed in the medication cart. 2. Review of the medical record for Resident #39 revealed an admitted [DATE] with a diagnosis of DM. Review of the MDS assessment for Resident #39 dated 03/12/25 revealed the resident had intact cognition and required set-up assistance and supervision with ADLs. Review of the physician's orders for Resident #39 revealed an order dated 03/03/25 for insulin glargine twice daily. Observation on 05/06/25 at 11:05 A.M. of the C-nursing unit front medication cart revealed the cart contained an insulin glargine pen for Resident #39 that was not dated. Interview on 05/06/25 at 11:05 A.M. with LPN #172 confirmed the insulin glargine pen for Resident #39 was not dated and insulin is to be dated when removed from refrigeration storage and/or placed in the medication art. 3. Review of the medical record for Resident #34 revealed an admitted [DATE] with a diagnosis of DM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment for Resident #34 dated 04/08/25 revealed the resident had intact cognition and required set-up assistance with ADLs. Review of physician's orders for Resident #34 revealed an order dated 02/27/25 for insulin glargine twice daily. Observation on 05/06/25 at 11:05 A.M. of the C-nursing unit front medication cart revealed the cart contained an insulin glargine pen for Resident #34 that was not dated. Interview on 05/06/25 at 11:05 A.M. with LPN #172 confirmed the insulin glargine pen for Resident #34 was not dated, and insulin is to be dated when removed from refrigeration storage and/or placed in the medication art. Interview on 05/06/25 at 1:10 P.M. with the Director of Nursing (DON) confirmed insulin is to be dated when removed from refrigerator storage and/or placed in the medication cart. The DON confirmed the facility did not have a policy specific to the storage and dating of Insulin. Interview on 05/06/25 at 3:02 P.M. with the Consulting Pharmacist (CP) #250 confirmed insulin is to be refrigerated until needed for administration. The vial or injector pen was to be dated when removed from refrigerated storage or used for the first time.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44083 Based on review of medical records, observation, staff interview and review of the facility policy, the facility failed to serve food portions as planned by the Registered Dietitian (RD). This affected six (Residents #9, #13, #21, #30, #38, #65) of six residents with orders for a pureed diet. The facility census was 89 residents. Findings include: Review of the medical records for Residents #9, #13, #21, #30, #38 and #65 revealed the residents had physician's orders to receive a pureed diet. Observation of lunch being served on 05/07/25 at 11:27 A.M. revealed [NAME] #188 served pureed portions of barbeque ham sandwiches and pureed potatoes for Residents #9, #13, #21, #30, #38, and #65. [NAME] #18 used a four-ounce scoop to plate the pureed barbeque ham sandwiches and a three-ounce scoop for the potatoes. Further observation revealed there was a poster in the kitchen which explained coded measurement indicators on utensils for reference when portioning food. Review of the dietary spreadsheet for lunch on 05/07/25 revealed the barbeque ham sandwich portion should be five and one-half ounces and the potato portion should be four ounces. Dietary manager confirmed that inappropriate scoop sizes were being used for the pureed barbeque ham and pureed potatoes servings. Interview on 05/07/25 at 11:45 A.M with the Dietary Manager (DM) confirmed [NAME] #18 had used the wrong scoop sizes to plate the pureed barbeque ham sandwiches and potatoes for Residents #9, #13, #21, #30, #38, and #65. The DM confirmed [NAME] #18 had not followed the spreadsheet which had been planned and approved by the RD. Review of facility policy titled Kitchen Weights and Measures dated April 2007 revealed staff were to be trained in appropriate measurement and type of serving utensil to use for each food. This deficiency represents noncompliance investigated under Complaint Number OH00161596 and Complaint Number OH00164317.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide specified foods for residents with physician's orders to be on a renal diet. This affected one (Resident #81) of two residents reviewed for specialized diets. The facility total census was 89 residents. Findings include: Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including end stage renal disease with dialysis, congestive heart failure, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #81 dated 03/26/25 revealed the resident had intact cognition and required minimal staff assistance with activities of daily living (ADLs.) Review of physician's orders for Resident #81 revealed the resident was ordered a renal diet with low concentrated sugar and had a fluid restriction of 2000 milliliters (ml) per day. Review of the breakfast meal ticket for Resident #81 dated 05/07/25 revealed the resident was to receive six ounces of apple or cranberry juice and four ounces of milk for the entire day. Observation on 05/07/25 at 7:44 A.M. revealed Certified Nursing Assistant (CNA) #133 served Resident #81 a breakfast tray which included six ounces of orange juice and eight ounces of milk. Interview on 05/07/25 8:16 A.M. with Resident #81 confirmed he did not ask for the orange juice, but the CNA just gave it to him each morning on his meal tray, and he usually drank all of it. Resident #81 confirmed he always got eight ounces of milk, and he drank it each morning. Resident #81 confirmed he didn't know what foods he was permitted on the specialized renal low sugar diet. Interview on 05/07/25 at 8:35 A.M. with the Dietary Manger, (DM) confirmed Resident #81 should not have been served eight ounces of milk and six ounces of orange juice on his breakfast tray. The DM stated the CNA incorrectly served the juice and the kitchen staff incorrectly served the milk to Resident #81. Observation on 05/08/25 at 8:43 A.M. of breakfast for Resident #81 revealed the resident had consumed an eight ounces container of milk but the resident's meal ticket on the tray revealed the resident was to have a limit of four ounces of milk. Resident #81 received and consumed a portion of sugar syrup which was served on the breakfast tray. The meal ticket indicated the resident was to be served a low concentrated sugar diet. Interview on 05/08/25 at 8:44 A.M. with Resident #81 confirmed he had been served eight ounces of milk and regular sugar syrup at breakfast, and he had consumed all of it. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 a 08:45 A.M. with Registered Nurse Unit Manager, (RNUM) #158 confirmed Resident #81 should not have received eight ounces of milk, and the resident should have received sugar-free syrup instead of regular syrup. Review of the facility policy titled Therapeutic Diets dated October 2017 revealed therapeutic diets were prescribed by the physician to support the resident's treatment plan. This deficiency represents noncompliance investigated under Complaint Number OH00165072 and Complaint Number OH00164317 and Complaint Number OH00161596.

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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. 44083 Based on observation, staff interview, and review of the facility policy, the facility to properly store, label and date food, failed to monitor refrigerator temperatures, failed to dry dishes in sanitary manner, failed to ensure staff prepared food in a clean and sanitary manner, and failed to ensure staff wore beard restraints during food preparation. This had the potential to affect all of the residents residing in the facility. The facility census was 89 residents. Findings include: 1. Observation 05/05/25 at 8:50 A.M. of the free-standing refrigerator revealed the following contents: an open undated jar of grape jelly, unlabeled and undated pitchers of orange drink, lemonade and red punch. Interview on 05/05/25 at 8:50 A.M. with the Dietary Manager (DM) confirmed the jar of jelly and the pitchers of drinks were unlabeled and undated. 2. Observation on 05/05/25 at 8:54 A.M of the walk-in refrigerator revealed temperature logs posted on the front of the refrigerator had not been completed. The refrigerator contained the following: an open and undated carton of a thickened beverage, open and dated containers of barbeque sauce, mayonnaise, sweet and sour sauce, Italian dressing, mustard, and pickle relish. Interview on 05/05/25 at 8:54 A.M. with the DM confirmed the temperature log on the outside of the walk-in refrigerator was not complete and there were open and undated food items in the refrigerator. Dietary manager #180 confirmed all containers to be opened and undated. 3. Observation of the dry storage area on 05/05/25 at 9:07 A.M. revealed the following: an open and undated box of cornstarch, an open, undated, and unlabeled box of cereal, 12 unlabeled and undated individual bowls of cereal. Interview on 05/05/25 at 9:07 A.M. with the DM confirmed there open, unlabeled and undated items in the dry storage area. Review of the facility policy titled Food Receiving and Storage dated October 2017 revealed all food stored in the refrigerator or the freezer would be covered, labeled and dated. The functioning of refrigeration and food temperatures would be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state specified requirements. 4. Observation on 05/05/25 at 9:10 A.M. revealed the insulated lids being used to cover breakfast plates were stored in a manner that allowed for pooling of water after being washed. Interview on 05/05/25 at 9:10 A.M. with the DM confirmed the lids had excess water pooling inside and should have been stored upside down so the water would have run off and allowed the plates to dry properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Observation on 05/07/25 at 11:27 A.M. revealed [NAME] #189 was wearing gloves as he began plating foods. [NAME] #189 used a set of tongs to remove buns from the pan, but he opened and closed buns using his gloved hand. [NAME] #189 touched utensils, the counter, plates, and rubbed his head while plating the food and wore the same pair of gloves the entire time. Interview on 05/07/25 at 11:37 A.M. with the DM confirmed [NAME] #189 did not change gloves and wash his hands while plating food as per the facility policy. 6. Observation on 05/07/25 at 12:03 P.M. revealed [NAME] #189 was observed put oven mitts over his gloves to remove a pan of from the oven. After placing pan in the steam table, [NAME] #189 removed the oven mitts and then continued to plate food with gloved hands and touching sandwich buns with his gloved hands. Interview on 05/07/25 at 12:08 P.M. with the DM confirmed [NAME] #189 placed oven mitts over his gloves to take a plan from the oven and place it in the steam table and then removed the oven mitt and continued to wear the same gloves to plate food with gloved hands and touching sandwich buns with gloved hands. The DM confirmed [NAME] #189 was not changing gloves and washing hands during food preparation as required. Review of facility policy titled Food Preparation and Service dated October 2017 revealed staff would adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. 7. Observation on 05/07/25 at 12:10 P.M. revealed [NAME] #184, [NAME] #189 and Dietary Aide (AD) #185 all had facial hair and were not wearing beard restraints while preparing lunch. Interview on 05/07/25 at 12:15 P.M. with the DM confirmed [NAME] #184, [NAME] #189, and AD #185 were not wearing beard restraints while preparing food and they should have been wearing beard restraints. Review of facility policy titled Food Preparation and Service dated October 2017 revealed food and nutrition staff shall wear hair restraints and beard restraints while preparing food to prevent hair from coming in contact with the food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview, and review of the facility policy the facility failed to ensure staff followed guidelines for enhanced barrier precautions (EBP) and proper infection control practices during care. This affected one (Resident #79) of one resident observed for tracheostomy care. The facility identified one resident who currently had a tracheostomy. The facility also failed to use proper hand hygiene when assisting residents. This affected one (Resident #18) of five residents reviewed for infection control. The facility census was 89 residents. Findings include: 1.Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, hypertension, atrial fibrillation, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment for Resident #79 dated 03/11/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of physician's orders for Resident #79 revealed an order dated 03/05/25 for the resident to have her tracheostomy cleaned at least every shift and as needed and an order dated 04/15/25 for the resident to have EBP in place. Observation on 05/07/25 at 9:50 A.M. of the EBP signage on Resident #79's door revealed everyone must clean their hands, including before entering and when leaving the room. Observation of tracheostomy care for Resident #79 per Licensed Practical Nurse (LPN) #143 revealed the nurse did not perform hand hygiene with alcohol-based hand sanitizer or soap and water prior to entering the resident's room and donning a gown. After donning the gown LPN #143 performed hand hygiene with soap and water for eight seconds. LPN #143 utilized the resident's overbed table as workspace but did not disinfect the tabletop prior to use. LPN #143 then opened the sterile tracheostomy kit and emptied the contents on the resident's overbed tabletop. LPN #143 then placed his non-sterile gloved thumb inside of the sterile tracheostomy kit to move it. The Surveyor then asked LPN #143 not to proceed with tracheostomy care due to infection control concerns. Interview on 04/16/25 at 10:08 A.M. with LPN #143 confirmed he did not perform hand hygiene upon entering Resident #79's room prior to donning the gown. LPN #143 confirmed he washed his hands for approximately eight seconds. LPN #143 confirmed he did not disinfect the resident's overbed tabletop prior to dumping the sterile contents of the tracheostomy kit on the dirty surface of the overbed tabletop. LPN #143 confirmed he should not have placed his non-sterile gloved thumb inside of the tracheostomy kit to move it. Interview on 05/07/25 at 11:21 A.M. with the Director of Nursing confirmed LPN #143 did not adhere to EBP guidelines for handwashing before entering Resident #79's room, did not perform hand hygiene for the recommended period of time, and did not maintain aseptic technique while attempting to perform tracheostomy care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 04/24/24 revealed EBPs were utilized to prevent the spread of multi drug-resistant organisms (MDROs) to residents. EBPs employed targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. Examples of high-contact resident care activities which required the use of gown and gloves for EBPs included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care with any skin opening requiring a dressing. Review of the facility policy titled Handwashing/Hand Hygiene undated revealed the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene was indicated before performing an aseptic task. When washing hands staff should wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. The use of gloves did not replace hand washing/hand hygiene. Review of the facility policy titled Standard Precautions undated revealed standard precautions were used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presumed that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes might contain transmissible infectious agents. Review of the facility policy titled Tracheostomy Care dated 04/30/24 revealed the purpose of the policy was to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. Aseptic technique should be used during cleaning and sterilization of reusable tracheostomy tubes, and during tracheostomy tube changes, either reusable or disposable. Gloved hands should be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves should be used during aseptic procedures. Staff should perform hand hygiene and apply clean gloves, remove old dressings, pull soiled glove over dressing and discard into appropriate receptacle; and perform hand hygiene, open tracheostomy cleaning kit and set up supplies on sterile field and put on sterile gloves. 39967 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including rhabdomyolysis,COPD, and chronic respiratory failure. Review of the MDS assessment for Resident #18 dated 03/06/25 revealed the resident had severe cognitive impairment and required staff assistance with ADLs. Observation on 05/06/25 at 10:59 A.M. revealed Certified Nursing Assistant (CNA) #882 was wearing gloves and entered Resident #18's room Observation on 05/06/25 at 11:00 A.M revealed CNA #882 exited Resident #18's room still wearing gloves and assisted the resident to the dining room. Interview on 05/06/25 at 11:02 AM with CNA #882 confirmed she entered Resident #18's room and she was wearing gloves. CNA #882 confirmed she assisted Resident #18 to the dining room and she was still wearing the same gloves that she was wearing upon entry to the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Master Complaint Number OH00165072 and Complaint Number OH00162543.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure a residents and/or resident representative received education regarding the benefits and potential side effects of the influenza immunization. This affected one (Resident #10) of five residents reviewed for immunizations. The facility census was 89. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, schizoaffective disorder, and chronic kidney disease. Review of the physician order's orders for Resident #10 revealed an order dated 10/24/24 for the resident to receive the influenza vaccine. Review of the Medication Administration Record (MAR) for Resident #10 dated October 2024 revealed on 10/24/24 the resident was documented as having refused the influenza vaccine. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 04/01/25 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the medical record for Resident #10 from 01/01/24 to 05/08/25 revealed the record did not include an influenza vaccine consent or declination form. Review of the immunization record for Resident #10 on 05/07/25 revealed the resident refused the influenza vaccine on an unknown date. Interview on 05/08/25 at 2:01 P.M. with the Director of Nursing (DON) confirmed Resident #10 refused the influenza vaccine on 10/24/24 but the facility did not have an influenza vaccine consent or declination form for the resident. Review of the facility policy titled Influenza Vaccine dated 10/05/22 revealed the facility should provide pertinent information about the significant risks and benefits of vaccines to residents or the resident's legal representatives.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were offered the Coronavirus (COVID-19) vaccine. This affected one (Resident #10) of five residents reviewed for immunizations. The facility census was 89. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, schizoaffective disorder, and chronic kidney disease. Review of the immunization record for Resident #10 revealed the resident received a COVID-19 booster vaccine on 06/09/22 prior to admission to the facility. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 04/01/25 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the medical record for Resident #10 from 01/01/24 to 05/08/25 revealed the resident did not have a COVID-19 vaccine consent or declination form in his chart. Interview on 05/08/25 at 2:01 P.M with the Director of Nursing (DON) confirmed Resident #10 did not have did not have a COVID-19 vaccine consent or declination form in his chart and the facility had no documentation the resident was offered, declined or provided a COVID-19 vaccination since admission to the facility on [DATE]. Review of the facility policy titled COVID-19 Vaccination of Residents dated 04/29/24 revealed each resident was to be offered the COVID-19 vaccine unless the immunization was medically contraindicated or the resident was fully vaccinated. Booster doses should be provided in accordance with Centers for Disease Control and Prevention (CDC) guidance.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Keep all essential equipment working safely. 39967 Based on observation and staff interview, the facility failed to the washers were maintained in a clean manner and free of leaks. This had the potential to affect all of the residents residing at the facility. The facility census was 89 residents. Findings include: Observation on 05/08/25 at 9:21 A.M. of the facility's laundry room revealed there were four washers that had brown, blue and white build-up on the top and along the sides of the washers. Further observation of the laundry room revealed water was coming out of the water reserve tank behind the washers which had run onto the floor in front of the washers. Interview on 05/08/25 at 9:21 A.M. with Housekeeping Supervisor (HS) #900 confirmed there a brown, blue and white build- up on the top and along the sides of the washers. HS #900 confirmed water was coming out of the water reserve tank behind the washers and the water had run on the floor in front of the washers. HS #900 stated that the water on the floor was from the water reserve tank overflowing, and the water reserve tank had been overflowing for over a week onto the laundry room floor.