STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365535	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Meadows Post Acute	10540 Fremont Pike Rd Perrysburg, OH 43551

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and resident and staff interview, the facility failed to ensure residents with identified hearing concerns were seen timely by the audiologist. This affected one resident (#82) of three residents reviewed for ancillary services. The facility census was 101. Findings Include:Review of Resident #82's medical record revealed an admission date of 10/24/24. Diagnoses included endometrium cancer, chronic obstructive pulmonary disease, lymphedema, anxiety disorder, osteoarthritis, depression, and unspecified hearing loss.Review of Resident #82's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #82 was cognitively intact. Resident #82 had moderate difficulty hearing. Resident #82 was on hospice at the time of the review. Review of Resident #82's care plan revised 12/22/25 revealed supports and intervention for risk for pain, self-care deficit, risk for falls, terminal illness and receiving hospice services, risk for changes in mood, refusal of care behaviors, and hearing deficit. Interventions for hearing deficit included getting Resident #82's attention before beginning to speak, have speakers face in the light, face Resident #82 and do not cover mouth when speaking or conversing, if necessary lower speaking tone, move resident to low noise place or remove as much background noise as possible. Review of Resident #82's Ancillary Services Consent form dated 02/03/25 revealed Resident #82 requested an audiological consultation by an audiologist for the purpose of obtaining additional information necessary for the evaluation of the need for, or appropriate type of, medical or surgical treatment of a new hearing deficit or related medical problem. It was noted Resident #82's recent decreased patient responsiveness. Review of the Hospice Agreement Sample from Resident #82's initial hospice provider, as her signed agreement was not available, revealed it was the facility's primary responsibility to provide facility services. It was the facility's responsibility to provide facility services which met the personal care needs and nursing needs which would have been provided by the primary caregiver at home and the facility shall perform facility services at the same level of care provided to each hospice resident before hospice care was elected. The facility was to ensure all facility services were provided and competently and efficiently. Facility services were to meet the standards of care for provided services and shall be in compliance with all applicable law, rules, regulations. Observation on 02/11/26 at 12:18 P.M. Resident #82 was seated in bed with the head of her bed raised. Resident #82 was not able to hear an introduction when spoken to her while standing at the foot of her bed. Resident #82 scrunched her face appearing frustrated and stated she could not hear. She asked who are you. Resident #82 was able to hear if the surveyor stood very close to and the volume was increased.Interview on 02/11/26 at 12:19 P.M. with Resident #82 verified she was not able to hear, did not have hearing aids, and needed staff to come very close to her and shout so she could hear them. Resident #82 stated she would like hearing aids, but she had not seen anyone about her ears since she had been at the facility. Resident #82 stated she knew she needed to have her ears checked before she could get help (continued on next page)

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for her hearing. Interview on 02/12/26 at 7:10 A.M. with the Administrator and the Director of Nursing (DON) verified Resident #82 had not seen the audiologist since she had been at the facility. It was reported Resident #82 was not on the list to be seen when she first was admitted and they switched providers. It was stated Social Services would have additional information.Interview on 02/12/26 at 10:00 A.M. with Licensed Social Worker (LSW) #150 verified Resident #82 had not been seen by the audiologist during her time in the facility. The LSW #150 reported Resident #82 was admitted in October of 2024 and would not sign the consent for ancillary services until February of 2025. At that time the audiologist was scheduled for March 2025 and Resident #82 was not on the list and was not seen. There was then an issue with the provider not having an audiologist in their area. They recently acquired a new provider and they were ironing out the details regarding who would be seen and when. Review of Resident #82's scheduled appointments revealed Resident #82 was scheduled to be seen by the audiologist on 02/18/26 and was scheduled for an ear health appointment with the Nurse Practitioner on 02/23/26.Follow up interview on 02/17/26 at 2:56 P.M. with LSW #150 revealed any long-term resident was offered ancillary services and a consent form requesting/accepting services. This deficiency represents non-compliance investigated under Complaint Number 2724907.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, and policy review, the facility failed to ensure post fall follow up assessments were completed and care planned fall interventions were implemented. This affected one resident (#52) out of three residents reviewed for falls. The facility census was 101. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE]. Diagnoses included neuroleptic induced Parkinsonism, hemiplegia and hemiparesis following cerebral infarction affecting the right dominate side, bipolar disorder, anxiety disorder, repeated falls, adrenocortical insufficiency, chronic kidney disease stage 3B. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 14. Further review of the MDS revealed Resident #52 was independent with eating, needed set up or clean up assistance with oral hygiene, substantial/maximal assistance with toileting, bathing, partial assistance with upper body dressing, dependent on staff for lower body dressing, footwear application, and substantial assistance with personal hygiene.Review of the care plan dated 07/30/25 revealed Resident #52 was at risk for falls with or without injury related to altered mental status, antidepressant medication, antipsychotic medication, history of falls, unsteady gait, poor safety awareness, noncompliance. Interventions included anticipating and meeting needs, assisting with all transfers, locomotion, and mobility, bag secured to bedside commode to hold wipes within reach, bed placed against wall, and room arranged for ease of transfers to commode, bedside commode, bright colored tape to call light, catheter leg bag as resident allows during day, and non-skid strips between the bed and the commode.Review of the nurse progress notes dated 11/23/25 revealed Resident #52 was found on the floor. Staff assisted resident onto the chair to assess from the fall. Resident #52 was educated on the use of the call light and not ambulating without assistance. Vital signs were stable and the resident denied pain. Resident #52 stated the need to walk and did not want to use the commode. Staff notified the Nurse Practitioner (NP) on call and neurological checks per protocol were started.Review of the neurological checks on 11/23/25 revealed a nurse was to begin checking neurological checks every 15 minutes times one hour, every 30 minutes times two hours, every hour times two hours, and every shift times 72 hours. On 11/23/25 neurological checks were not completed as indicated every 15 minutes. Neurological checks were completed at 1:30 P.M., 1:45 P.M., and 2:10 P.M. Further review of the neurological checks revealed neurological checks were not completed every half hour and were completed on 11/23/25 at 3:00 P.M., 5:00 P.M, 9:00 P.M., and 11:00 P.M.Interview with the Director of Nursing (DON) on 02/09/26 at 2:43 P.M. verified staff had not followed the neurological check protocol on 11/23/25 when Resident #52 was to have checking neurological checks every 15 minutes times one hour, every 30 minutes times two hours, every hour times two hours, and every shift times 72 hours. On 11/23/25 neurological checks were not completed as indicated every 15 minutes. Neurological checks were completed at 1:30 P.M., 1:45 P.M., and 2:10 P.M. The DON further verified the neurological checks were not completed every half hour and were completed on 11/23/25 at 3:00 P.M., 5:00 P.M, 9:00 P.M., and 11:00 P.M.Observation on 02/10/26 at 2:05 P.M. of Resident #52's bedroom revealed there were no skid strips next to Resident #52's bed leading to the bedside commode next to the bed.Interview on 02/10/26 at 2:05 P.M. with Resident #52 revealed the skid strips helped with not slipping while transferring from the bed to the bedside commode and that there were never any skid strips in place after her bedside mat was removed on 01/30/25.Interview with the Director of Rehabilitation (DR) #240 on 02/17/26 at 2:30 P.M. revealed Resident #52 had a bedside mat to prevent injury due to frequent falls; however, the mat became problematic due (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the bedside table not being sturdy on the bed mat causing potential falls. DR #240 stated that skid strips should be in front of the bedside commode and directly next to the bed.A follow-up interview with the DON on 02/17/26 at 3:00 P.M. verified there were no skid strips in front of Resident #52's bed or bedside commode.Review of the facility policy titled Neurological Assessment dated 10/2023, revealed routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury. Neurological checks were to be conducted as frequently as ordered.This deficiency represents non-compliance investigated under Complaint Number 2722676

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure physicians orders were followed for oxygen therapy and the use of a Continuous Positive Airway Pressure (CPAP). This affected one (#94) of three residents reviewed for assistive breathing devices. The census was 101.Findings Included:Review of the medical record for Resident #94 revealed an admission date of 02/17/22. Diagnoses included acute respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), acute on chronic diastolic congestive heart failure, chronic kidney disease stage three, and dysphagia.Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/03/25, revealed the resident had intact cognition. The resident was dependent on staff for Activities of Daily Living (ADL) and eating. Resident #94 required the use of a motorized wheelchair for mobility and was dependent on staff for transferring using a mechanical lift. Resident #94 was frequently incontinent of bowel and bladder.Review of the plan of care dated 12/01/25 revealed Resident #94 required the use of continuous oxygen related to acute respiratory failure, COPD, pneumonia, and shortness of breath while lying flat. Interventions included administering oxygen at two liters per minute (L/M), educating the resident on the importance of keeping oxygen on and at the prescribed setting, maintaining the head of bed elevated, and reporting signs of hypoxia.Review of the after-visit summary from Resident #94's pulmonology appointment on 11/18/25 revealed Resident #94 had Obstructive Sleep Apnea (OSA) and was to resume the CPAP 15 centimeters of water column (cm of H2O) when the CPAP was available. Further review of the after-visit summary revealed Resident #94 had been getting more short of breath at night at the facility while he was not on oxygen and does not want to depend on oxygen. Resident #94's CPAP malfunctioned and the facility ordered a new machine months ago. Resident #94 was not using his CPAP at 15 cm of H2O. Resident #94 has insomnia and sleeps with the Head of Bed (HOB) elevated. Resident #94 stated he did not use the CPAP machine because the mask was broken but he now has a new mask.Review of the physician's orders dated 11/28/25 revealed oxygen two L/M via nasal cannula, for shortness of breath related to pneumonia.Review of the physician's orders dated from November 2025 through February 2026 revealed no orders for the CPAP 15 cm of H2O.Review of the Nurse Practitioner (NP) progress notes on 12/19/25 revealed Resident #94 was seen at the request of the nursing staff reporting Resident #94 had been wearing oxygen at four L/M. Resident #94 had a history of COPD, OSA, and does not wear a CPAP at night. Oxygen was reading at 98 percent (%) on 2 L/M, with oxygen off reading 93% to 94%. The NP educated the resident on the use of the CPAP with naps and at night. Resident #94 was to wear his CPAP at nighttime and with naps, staff was to monitor oxygen levels and administer oxygen at two liters as needed to keep oxygen above 90%.Review of the physicians' orders for December 2025 revealed an order for continuous oxygen at two L/M via nasal cannula. Further review of the physicians' orders revealed no order for as needed oxygen at two liters to maintain oxygen above 90%.Review of the Nurse Practitioner (NP) progress notes on 01/06/26 revealed Resident #94 was seen due to not feeling well and shortness of breath. The diagnoses and plan revealed Resident #94 was educated on wearing the CPAP at night and with naps. Staff was to monitor oxygen levels, and supplement with oxygen at two liters as needed to keep oxygen above 90%. Resident #94 had a sleep study appointment on 01/07/26. Resident #94 had oxygen on with new orders for a Complete Blood Count (CBC), Basic Metabolic Panel (BMP) once, start prednisone (a steroid medication) 10 milligrams (mg) one tablet daily for four days.Review of the NP #338 progress note on 01/29/26 revealed Resident #94 was seen due to cough and congestion. NP #338 stated Resident #94 was wearing his oxygen to help with shortness of breath. Under the section titled Physical Exam revealed for respiratory no increased work of breathing at rest on (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen.Review of the physician orders dated for January 2026 and February 2026 revealed no orders for as needed oxygen at two liters to maintain oxygen above 90%.Interview with the Director of Nursing (DON) on 02/10/26 at 11:30 A.M. verified the NP #338 had an order for Resident #94 to receive as needed oxygen at two liters to maintain an oxygen level above 90%, and there was no order on 12/19/25 written. The DON further stated she was unsure where the order for continuous oxygen at two liters on 11/28/25 came from. The DON stated Resident #94 had a CPAP machine but the face mask was broken and was being replaced. The DON stated Resident #94 frequently refused, however there was no documentation supporting refusals.Interview on 02/10/26 at 1:03 P.M. with NP #338 revealed Resident #94 should not been on continuous oxygen. NP #338 stated Resident #94 at times requested oxygen for comfort, but it was not recommended and NP #338 had educated Resident #94 on this. NP #338 stated staff at the facility at times would approach her and ask if Resident #94 could have oxygen and she would give a verbal order for Resident #94 to have an as needed order for oxygen at two L/M via nasal cannula for shortness of breath or oxygen levels falling below 90%. NP #338 further verified on 12/19/25 the oxygen orders should have been as needed to maintain an oxygen level above 90% and not continuous. NP #338 further said Resident #94 should have had an order for the CPAP, though he was not always compliant, it should be offered at bedtime and naps. NP #338 was unsure where the continuous order for oxygen came from on 11/28/25, but stated it was most likely from a previous hospitalization in November.Review of the facility policy titled Oxygen Administration dated 10/2010, revealed verify that there is a physician order for oxygen administration. Turn on oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of two to three liters per minute.Review of the facility policy titled CPAP/BiPAP Support dated 03/2015, revealed staff was to review medical record and determine his/her baseline oxygen saturation, and respiratory status. Resident should be NPO for at least two hours before using full-face mask. CPAP is used when residents have not responded to other types of oxygen delivery systems.This deficiency represents non-compliance investigated under Complaint Number 2734513.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure medication was available as prescribed. This affected one (#94) of two residents reviewed for medication administration. The facility census was 101.Findings Included:Review of the medical record for Resident #94 revealed an admission date of 02/17/22. Diagnoses included acute respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), acute on chronic diastolic congestive heart failure, chronic kidney disease stage three, and dysphagia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent on staff for Activities of Daily Living (ADLs) and eating. Resident #94 required the use of a motorized wheelchair for mobility and was dependent on staff for transferring using a mechanical lift. Resident #94 was frequently incontinent of bowel and bladder.Review of the plan of care dated 12/01/25 revealed Resident #94 required the use of continuous oxygen related to acute respiratory failure, COPD, pneumonia, and shortness of breath while lying flat. Interventions included administering oxygen at two Liters/Minute (L/M), educating the resident on the importance of keeping oxygen on and at the prescribed setting, maintaining the head of bed elevated, and reporting signs of hypoxia.Review of the physician's orders for February 2026 revealed Resident #94 had an order on 02/05/26 for Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 micrograms (mcg) per actuation (act), one puff inhale orally one time a day for COPD.Observation on 02/17/26 at 9:41 A.M. of medication administration revealed the facility did not have Resident #94's Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 mcg/act inhaler.Interview with Licensed Practical Nurse (LPN) #302 verified the facility did not have Resident #94's Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 mcg/act inhaler.Review of the facility policy titled Administering Medications dated 04/2019, revealed medications are administered in accordance with prescriber orders, including any required time frame.This deficiency represents non-compliance investigated under Complaint Number 2724907.