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	05/15/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure call lights were within reach for one (#43) of four residents reviewed for call light accessibility. The census was 81. Findings include: Review of the medical record for Resident #43 revealed an admission date of 06/14/24. Diagnoses included venous insufficiency, multiple sclerosis, and osteoporosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 was cognitively intact, dependent for toileting, showering/bathing, upper body dressing, lower body dressing, and required substantial/maximal assistance for personal hygiene. Observation on 05/12/25 at 10:26 A.M. revealed the call light laying on the floor beside Resident #43's bed. Interview with Certified Nurse Aide (CNA) #449 on 05/12/25 at 10:47 A.M. verified Resident #43's call light was lying on the floor out of the resident's reach. Observation on 05/12/25 at 10:48 A.M. revealed CNA #492 attached the call light to Resident #43's bed sheet near her right arm. Resident #43 attempted to grab the call light and could not reach it. Interview with CNA #492 on 05/12/25 at 10:58 A.M. verified she placed the call light on the bed sheet in an area that Resident #43 could not reach.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, medical record review, resident interview, and staff interview, the facility failed to maintain a clean environment. This affected two (6 and #49) of four residents reviewed for physical environment. The facility census was 81. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 04/14/25. Diagnoses included acute kidney failure, asthma, hypertensive heart and chronic kidney disease, type II diabetes, and anxiety. Review of the admission Minimum Data Set (MDS) assessment completed on 04/21/25 revealed Resident #6 was cognitively intact. Observation on 05/12/25 at 9:45 A.M. of Resident #6's room revealed a cup with popcorn coming out of it all over the floor. Observation and interview on 05/12/25 at 1:43 P.M. of Resident #6's room revealed the popcorn remained on the floor. Resident #6 stated the popcorn on the floor bothered her and she would like it to be cleaned up. Interview with Licensed Practical Nurse (LPN) Manager #475 on 05/12/25 at 1:52 P.M. verified the popcorn on the floor in Resident #6's room. 2. Review of the medical record for Resident #49 revealed an admission date of 09/04/21. Diagnoses include hypertensive chronic kidney disease, iron deficiency anemia secondary to blood loss, anxiety, major depressive disorder, and weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #49 was cognitively intact. Observation on 05/12/25 at 12:04 P.M. revealed the floor in Resident #49's room was sticky. Observation on 05/12/25 at 1:46 P.M. revealed bloody tissues, a mustard packet, a cotton swab, and pieces of pretzels on the floor. The floor in Resident #49's room remained sticky. Concurrent interview with Resident #49 stated it bothered him that his guests would see the trash on the floor and feel the stickiness. Interview with LPN Manager #475 on 05/12/25 at 1:54 P.M. verified the trash on Resident #49's floor and verified the floor was also sticky.

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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 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** Based on medical record review, staff interview, and policy review, the facility failed to ensure residents who received psychotropic medications were monitored for behaviors, adverse effects, and efficacy. This affected one (#24) of five residents reviewed for psychotropic medications. The facility census was 81. Findings include: Review of the medical record revealed Resident #24 was admitted to the facility on [DATE]. Diagnoses included anxiety, depression, and hypertension. Review of the plan of care dated 03/24/25 revealed Resident #24 received antidepressant medication. Interventions included monitoring and documenting side effects and effectiveness. Review of the plan of care dated 03/24/25 revealed Resident #24 received antianxiety medication. Interventions included monitoring and documenting side effects and effectiveness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. The resident received antianxiety and antidepressant medication. Review of Resident #24's active physician orders for May 2025 identified an order for desvenlafaxine (antidepressant medication) extended-release oral tablet with instructions for one tablet by mouth one time per day for depression; and an order for buspirone (antianxiety medication) oral tablet with instructions for one tablet by mouth three times per day for anxiety. Review of Resident #24's medication administration records (MARs) for March, April, and May 2025 revealed the resident received buspirone three times per day from 03/06/25 through 04/06/25, 04/08/25 through 04/21/25, 04/23/25 through 04/27/25, and 05/01/25 through 05/11/25. In addition, the resident received desvenlafaxine daily from 03/06/25 through 04/21/25, 04/23/25 through 04/27/25, and 05/02/25 through 05/11/25. Review of the medical record revealed no evidence Resident #24 was monitored for behaviors between 03/06/25 through 04/03/25. In addition, there was no evidence the resident was ever monitored for efficacy and adverse consequences related to antidepressant and antianxiety medication. Interview on 05/15/25 at 11:14 A.M. with the Administrator verified Resident #24 received psychotropic medication and there was no evidence of monitoring for efficacy and adverse consequences. The Administrator also verified there was no evidence of monitoring for behaviors unit 04/03/25. Review of the facility policy titled, Psychotropic Medication Use, revised February 2025, revealed residents who received psychotropic medications would be monitored for adverse consequences. Review of the facility policy titled, Behavioral Assessment, Intervention, and Monitoring, revised February 2025, revealed if psychotropic medications were used to treat behavioral symptoms, the interdisciplinary team would monitor side effects and adverse consequences related to psychotropic medications.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to provide ongoing assistance and coordination, with resident involvement, in developing discharge goals and plans for discharge. This affected one (#62) of one residents reviewed for discharges in a facility census of 81. Findings include: Review of the medical record revealed Resident #62 admitted to the facility on [DATE] with diagnoses including atrial fibrillation, venous insufficiency, segmental and somatic dysfunction of the lower extremity, major depressive disorder, hypertension, dysphagia, and right artificial hip joint. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was assessed with intact cognition, utilized a wheelchair for mobility, was independent with activities of daily living, was occasionally incontinent of bladder and was continent of bowel, and assessed at risk for pressure ulcer development with no skin breakdown. Review of Resident #62's social service admission assessment dated [DATE] revealed a documented discharge goal to return home. Review of Resident #62's interdisciplinary discharge planning update document dated 11/14/23 noted Resident #62 goal to return home. Review of the medical record revealed a nursing plan of care dated 02/02/24 which documented Resident #62 was anticipated to remain as permanent resident. Review of a social service quarterly assessment dated [DATE] noted Resident #62 planned to return to the community and listed an address. Review of Resident #62's physical therapy Discharge summary dated [DATE] noted the resident's discharge destination as long-term care setting due to his highest practical level achieved. Discharge recommendations included an assistive device for safe functional mobility and elevated toilet seat/three in one commode. The prognosis to maintain current level of function was determined as excellent with consistent staff support. There were no further instructions to staff documented and no documentation contained in the medical record included Resident #62 was informed long-term placement was recommended. On 05/13/25 at 10:04 A.M. interview with Resident #62, during observation, noted the resident in bed and alert. Resident #62 stated 06/01/25 was the last day he could return to his apartment and wanted to return home. Resident #62 stated he was never informed he was going to remain in the facility long-term and had limited contact with social services related to discharge planning. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/25 at 2:57 P.M. interview with Licensed Social Worker (LSW) #425 revealed, when assuming role of LSW in April 2024, she was told Resident #62 was staying in the facility under long-term care. Approximately two weeks prior (the end April 2025), LSW #425 was informed by Resident #62 he wanted to transition to the community and the resident had an apartment being held since admission to the facility. LSW #425 proceeded to refer Resident #62 to therapy services and confirmed the medical record lacked documentation indicating Resident #62 was involved or updated regarding potential discharge from the facility. Observation and interview on 05/14/25 at 12:15 P.M. noted Resident #62 independently seated in a wheelchair in his bathroom completing activities of daily living independently. The resident was dressed and groomed, and stated he was preparing for a therapy session and working to get stronger before discharge from facility.

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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 - 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** Based on observation, medical record review, review of wound center documentation, staff interview, and review of a facility clinical protocol, the facility failed to provide timely assessment, monitoring, and interventions to prevent the development of a pressure ulcer. Actual harm occurred when Resident #56, who was assessed at moderate risk for pressure ulcer development, had care plan interventions for skin checks each shift with no documented evidence of the skin checks completed. Subsequently, the resident was discovered with a unstageable pressure ulcer (obscured full-thickness skin and tissue loss) to the left lateral heel and no ongoing assessments were completed to determine causative factors of the wound development or need to change pressure reduction interventions. Resident #56's wound required surgical debridement and ongoing treatment applications as a result. This affected one (#56) of two residents reviewed for pressure ulcers. The census was 81. Findings include: Review of the medical record revealed Resident #56 admitted to the facility on [DATE] with the diagnoses including, a stage four sacral pressure ulcer (full-thickness skin and tissue loss), atrial fibrillation, congestive heart failure, type II diabetes mellitus, tracheostomy, history of hemorrhage from a tracheostomy stoma, gastrostomy, colostomy, cerebral infarction, chronic respiratory failure, anemia, anxiety disorder, major depressive disorder, and a chronic non-pressure right lower leg ulcer. Review of the Minimum Data Set (MDS) assessments dated 01/22/25 and 04/03/25 revealed Resident #56 had intact cognition, was able to make needs known, was not assessed with any refusal of care, and had no range of motion impairments to bilateral upper and lower extremities. Resident #56 was dependent on staff for the completion of activities of daily living, utilized a motorized wheelchair independently, was incontinent of bladder, received nutrition via feeding tube, was assessed at risk for pressure ulcer development with one stage four pressure ulcer present on admission and three venous and arterial ulcers, and received antianxiety, antidepressant, anticoagulant, diuretic, and opioid medications. Review of a nursing plan of care dated 03/13/24 revealed the care plan was initiated due to Resident #56's potential for alteration in skin integrity related to immobility, diabetes mellitus type II, congestive heart failure, depression, and contractures. Interventions included to administer treatments as ordered and monitor effectiveness, apply moisturizing lotion as needed to dry skin, offload heels as tolerated, turn and reposition as needed, and use pillows/pads to support/position as appropriate. Additional interventions were implemented on 08/28/24 to include pressure redistribution mattress to the bed, heel lift suspension boots to be worn to bilateral feet at all times as tolerated and to be removed for bathing/hygiene and every shift skin checks. Review of a nursing plan of care dated 04/04/24 revealed the care plan was developed to address Resident #56's alteration in skin integrity related to a stage four pressure ulcer to the coccyx. Interventions included the application of a low air loss pressure redistribution mattress to bed and refer to a wound treatment specialist as needed. Review of Resident #56's physician order dated 11/23/24 revealed an order was initiated to off load heels while in bed as tolerated every shift for skin breakdown prevention. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing plan of care dated 01/02/25 revealed the care plan was implemented to address Resident #56's venous stasis ulcer to the left foot and left first toe and indicated the resident was at risk for further breakdown and/or slow, delayed healing related to cardiovascular disease, decreased mobility, impaired circulation, and incontinence of bowel and bladder. Interventions included treatment as ordered and wound consultation as indicated. Review of assessments for predicting pressure sore risk dated 01/22/25 and 04/02/25 revealed Resident #56 was at moderate risk for pressure sore development. Review of Resident #56's treatment order dated 01/16/25 revealed treatment to the resident's vascular wounds to the left foot, great toe (hallux) to include for staff to cleanse with normal saline, pat dry, paint the wound bed with betadine and leave open to air daily and as needed. An order was implemented on 01/23/25 for the vascular wound to the top (dorsum) of the left foot and included to cleanse with normal saline, pat dry, and apply skin prep daily and as needed. An order was implemented on 01/30/25 for treatment of the vascular wound to the right lower extremity, anterior and posterior, to cleanse with normal saline, pat dry, apply adaptic, wrap the leg with an unna boot (compression dressing), abdominal dressing (ABD), wrap with Kerlix and change three times weekly and as needed. Additionally, on 01/30/25 the resident's coccyx wound was ordered a treatment to cleanse with normal saline, pat dry, apply hydrogel and packing strip to the wound bed, and cover with foam dressing three times weekly and as needed. Review of a nursing plan of care dated 02/10/25 revealed the care plan was initiated to address Resident #56's risk for pressure ulcers and other skin problems such as skin tears, bruising, bleeding, abrasions, rashes, and excoriation related to debility, immobility, and peripheral vascular disease. Interventions included to monitor skin daily with routine care. Further review of Resident #56's medical record revealed no documentation indicating the resident's skin was being assessed every shift as described in the nursing plans of care dated 03/13/24 and 02/10/25. Review of a skin and wound evaluation dated 02/12/25 noted, on the same date, Resident #56 was discovered with an intact pink or red blister to the left lateral heel that was in-house acquired measuring 0.7 centimeters (cm) long by (x) 1.0 cm wide. Additional care interventions included heel suspension/protection device, incontinence management, and a mattress with a pump. Further review revealed the notes documented a new wound to the left lateral heel had the appearance of a loose blister. Resident #56 had heel boots on and the nurse practitioner was notified. There was no documentation contained in the medical record which revealed the potential origin of the wound or additional mechanical interventions to promote healing. Review of Resident #56's physician treatment orders dated 02/12/25 revealed a treatment for wound care to the left lateral heel blister area. The order was to cleanse with normal saline, pat dry, apply foam dressing, and change every other day and as needed. Review of skin and wound evaluation dated 02/13/25 revealed Resident #56's left lateral heel wound measured 1.5 cm long x 1.3 cm wide x undetermined depth with a light amount of serosanguineous exudate (a fluid that contains both serum (clear, watery liquid) and blood cells). The wound seen by the wound nurse practitioner. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #56's wound treatment orders revealed the orders were modified on 02/13/25 to include wound care to the left lateral heel blister area to include cleanse with normal saline, pat dry, apply skin prep, and cover with a foam dressing to be change three times a week and and as needed on day shift every Tuesday, Thursday, and Saturday. Review of wound specialist documentation dated 02/20/25 assessed Resident #56's left medial heel wound as a stage three acute pressure ulceration (full-thickness skin loss) that measured 1.4 cm long x 1.0 cm wide x 0.1 cm deep. The acute ulceration was debrided by sharp methods and devitalized tissue was removed to the level of healthy bleeding tissue which included biofilm and slough. The debridement area extended down to the level of soft tissue. All surrounding periwound hyperkeratotic skin was also removed. The post-debridement measurements of the left heel wound was 1.4 cm long x 1.0 cm wide x 0.2 cm deep. Review of out-patient wound center discharge instructions dated 05/06/25 assessed Resident #56's wound to the left heel as a stage three pressure wound. The wound measured 2.2 cm long x 2.0 cm wide x 0.1 cm deep with serosanguinous drainage. Review of a skin and wound evaluation dated 05/08/25 revealed Resident #56's left lateral heel blister was in-house acquired and developed on 02/12/25. The measurements were 1.1 cm long x 2.0 cm wide, no depth and a moderate amount of serosanguineous drainage present. Interventions included a heel suspension/protection device, incontinence management, and a mattress with a pump. Further review revealed the wound was improving with recommendation to keep heels elevated. Review of Resident #56's physician order on 05/08/25 noted the wound dressing to the left lateral heel was changed to include for staff to cleanse with antibacterial soap and water, rinse well, apply silver alginate to the wound, and cover with silicone border foam dressing. The treatment was to be changed daily and as ordered. Observation on 05/13/25 at 12:53 P.M. with Unit Manager Licensed Practical Nurse (LPN) #474 noted Resident #56 was in bed with an air mattress and bilateral heel protector boots in place. LPN #474 applied a prescribed treatment to Resident #56 stage four coccyx wound and proceeded to remove the left heel protector boot. Resident #56's left lower extremity was noted with a flexible-type tape wrapped around the ankle and upper foot. LPN #474 removed the tape and a padded dressing was observed to the heel. LPN #474 removed the dressing which resulted in a small to moderate amount of serosanguineous drainage. LPN #474 proceeded to cleanse the wound with a four inch long by four inch wide gauze and antibacterial soap and water, which resulted in a moderate amount of bleeding. LPN #474 then placed silver alginate to the wound and covered with a silicone border foam dressing. Interview on 05/14/25 at 1:55 P.M., with Unit Manager LPN #474, during review of the medical record, stated Resident #56 had heel protector boots in place at time of the left lateral heel pressure ulcer discovery and no further evaluation had occurred to determine the origin of the wound. Unit Manager LPN #474 verified there were no additional mechanical interventions implemented to prevent further deterioration or promote healing of the left lateral heel pressure ulcer. Unit Manager LPN #474 also confirmed there was no documented evidence to indicate Resident #56's heel protectors were removed each shift to assess skin integrity. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 05/15/25 at 10:20 A.M. interview with the Director of Nursing (DON), during review of Resident #56's medical record, confirmed no documentation contained in the medical record indicated Resident #56's skin under the offloading boots was assessed each shift as indicated in the nursing plan of care to monitor for pressure ulcer development. In addition, Resident #56 was assessed at moderate risk and not high risk for pressure ulcer development in spite of being admitted with a stage four pressure ulcer to the coccyx and vascular skin breakdown to the lower extremities. Review of facility pressure ulcers/skin breakdown clinical protocol, revised April 2018, revealed monitoring will include physician guidance of the care plan, especially when wounds are not healing or new wounds develop despite existing interventions.

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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 observation, medical record review, staff interview, and policy review, the facility failed to provide adequate staff assistance and implement fall interventions during care to prevent falls. This affected one (#19) of two residents reviewed for falls. The facility census was 81. Findings include: 1. Review of the medical record for Resident #19 revealed an admission date of 02/26/24 with diagnoses of congestive heart failure, anxiety, and dementia, repeated falls. Resident #19 was under hospice care. Review of the modified quarterly Minimum Data Set (MDS) assessment, dated 10/31/24, revealed Resident #19 was dependent for toileting and required substantial/maximal assistance for bed mobility. Further review revealed Resident #19 did not have any falls since the previous assessment. Review of the current care plan, initiated 02/26/24, revealed Resident #19 was at risk for falls due to impaired balance, impaired mobility, and incontinence. Further review of the care plan revealed Resident #19 had an activities of daily life (ADL) self-care deficit related to impaired balance and limited mobility. An intervention was added on 04/01/24 and revealed Resident #19 required extensive assistance of two staff members for bed mobility, including rolling from left to right. Review of the quarterly fall review document, dated 10/31/24, revealed Resident #19 was at high risk for falls. Review of the nursing progress note dated 01/30/25 revealed Resident #19 had a witnessed fall while receiving care. Resident #19 received a skin tear to his left elbow that was cleaned with normal saline and dressed with bordered gauze. No additional injuries were noted during the nursing assessment after the fall. Review of the interdisciplinary progress note dated 01/31/25 revealed Resident #19 reported rolling off the bed during incontinence care. An intervention for two staff assistance for bed mobility was implemented. Review of the facility's fall investigation revealed a statement by Certified Nurse Assistant (CNA) #530 indicating Resident #19 turned to the left and CNA #530 provided care and got linens in place. Resident #19 then rolled to the right and kept rolling onto the floor. Interview on 05/12/25 at 3:47 P.M. with Resident #19 revealed he fell approximately four months ago when he rolled off the bed while staff was changing him. Resident #19 stated he sustained a skin tear but did not have any broken bones and was not taken to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/13/25 at approximately 3:15 P.M. with CNA #530 revealed she was providing incontinence care for Resident #19 at the time of his fall on 01/30/25. CNA #530 stated she had often previously provided incontinence care to Resident #19 and the resident was able to roll himself over in bed independently. CNA #530 stated she was walking around the foot of the bed while Resident #19 rolled himself over and rolled off the bed on 01/30/25. Interview on 05/14/25 at 9:32 A.M. with the Director of Nursing (DON), during concurrent review of Resident #19's medical record, confirmed Resident #19's MDS assessment dated [DATE] revealed the resident required substantial/maximal assistance for bed mobility. The DON stated substantial/maximal assistance meant staff would provide hands-on assistance as needed, and ensure the resident rolled toward the staff while he/she stood at the edge of the side of the bed. Review of the policy, Activities of Daily Living (ADL), Supporting, revised April 2025, defined substantial/maximal assistance - if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 2. Review of the comprehensive annual MDS assessment, dated 01/31/25, revealed Resident #19 had impaired cognition and was dependent for toileting, and required substantial/maximal assistance for bed mobility. Further review revealed Resident #19 had one fall with a non-major injury since the previous assessment. Review of the fall risk observation (assessment) document, completed 01/30/25, revealed Resident #19 was at high risk for falls. Review of the current care plan, initiated 02/26/24, revealed Resident #19 was at risk for falls due to impaired balance, impaired mobility, and incontinence. An intervention added on 01/31/25 revealed Resident #19 required two staff assistance for bed mobility. Further review of the care plan revealed Resident #19 had an ADL self-care deficit related to impaired balance and limited mobility. Review of an intervention added 01/31/25 revealed resident #19 required extensive assistance of two people for bed mobility, including rolling to left and right. An intervention added 05/12/25 revealed Resident #19 required assistance of two people for toileting. Observation on 05/12/25 at 3:51 P.M. revealed Resident #19's call light was on. Concurrent interview with Resident #19 revealed he needed to be changed. Observation on 05/12/25 at 3:56 P.M. revealed CNA #495 entered Resident #19's room alone and closed the door. Observation on 05/12/25 at approximately 4:02 P.M. revealed CNA #495 exited Resident #19's room with a bag of soiled items. Interview on 05/12/25 at 4:04 P.M. with CNA #495 confirmed she provided incontinence care to Resident #19 by herself. CNA #495 stated Resident #19 could roll himself over in bed and CNA #495 was not aware Resident #19 required two staff to be present during incontinence care. Interview on 05/12/25 at 4:11 P.M. with Licensed Practical Nurse Unit Manager (LPN UM) #475, during concurrent review of Resident #19's care plan, confirmed two staff members should assist Resident #19 while he received incontinence care. (continued on next page)

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	365535	A. Building B. Wing	05/15/2025

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Falls - Clinical Protocol, revised March 2018, revealed the facility will identify pertinent interventions to try to prevent subsequent falls.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the dialysis contract, the facility failed to ensure effective communication took place between the facility and the dialysis center. This affected one (#34) of one residents reviewed for dialysis. The facility census was 81. Findings include: Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included end-stage renal disease, heart failure, type II diabetes mellitus, hypertension, and dependence on renal dialysis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact. The resident was assessed to receive dialysis. Review of Resident #34's active physician orders for May 2025 identified an order for dialysis on Mondays, Wednesdays, and Fridays. Review of Resident #34's dialysis communication forms for 03/01/25 through 05/08/25 revealed each form had three sections. The first section was to be completed by nursing staff prior to dialysis treatments, the second section was to be completed by the dialysis center during treatments, and the third section was to be completed by nursing staff upon the resident's return from dialysis. Further review revealed dialysis communication forms dated 03/03/25, 03/05/25, 03/07/25, 03/10/25, 03/19/25, 04/11/25, 04/23/25, and 05/07/25 had the first and third sections completed by the facility, but did not have the second section completed by the dialysis center. Review of the electronic and paper medical records for Resident #34 revealed there was no evidence the dialysis center was contacted on the aforementioned dates in attempt to have the form completed or to inquire about the status of the resident while at dialysis. Interview on 05/14/25 at 1:03 P.M. with the Director of Nursing (DON) verified the dialysis center had not completed their portion Resident #34's communication forms and there was no evidence facility staff attempted to communicate with the dialysis center on each occurrence. Review of the dialysis contract, dated 05/01/25, revealed the facility would ensure there was documented evidence of collaboration of care and communication between the nursing facility and end-stage renal disease dialysis unit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure medications were provided as ordered by the physician and within prescribed time frames. This resulted in 12 of 28 medications being administered in error with an error rate of 42.86 percent (%). This affected three (#53, #16, and #74) of four residents observed for medication administration in a facility census of 81. Findings include: 1. Observation on 05/13/25 at 10:21 A.M. noted Registered Nurse (RN) #482 preparing medications for Resident #53. The medications included the medication to treat symptoms of Parkinson's disease Carbidopa-Levodopa 25-100 milligrams (mg), the anticonvulsant medication divalproex delayed release 125 mg, the heart failure medication Sacubitril-Valsartan 24-26 mg, the antihypertensive medication Hydralazine 25 mg, and the pain medication Tylenol eight (8)-hour extended release 650 mg two tablets. Continued observation at 10:31 A.M., revealed RN #482 administered the medications to Resident #53 one-by-one using a spoon. Review of the medical record noted Resident #53's physician orders and prescribed time frames listed on the medication administration record (MAR) noted the following; the order dated 03/04/25 for Carbidopa-Levodopa 25-100 mg three times a day for Parkinson's disease, scheduled at 9:00 A.M., 1:00 P.M., and 9:00 P.M.; the order dated 03/04/25 for divalproex delayed release 125 mg two times a day for depression, scheduled at 9:00 A.M. and 9:00 P.M., the order dated 03/04/25 for Sacubitril-Valsartan 24-26 mg two times daily for hypertension, scheduled at 9:00 A.M. and 9:00 P.M.; the order dated 03/04/25 for Hydralazine 25 mg give three times daily for high blood pressure, scheduled at 9:00 A.M., 1:00 P.M., and 9:00 P.M., and the order dated 03/04/25 for Tylenol 8-hour extended release 650 mg give two tablets three times a day for arthritic pain. 2. Continued observation on 05/13/25 at 10:36 A.M. noted RN #482 preparing Resident #16 medications. The medications included the antihypertensive medication diltiazem 60 mg, the stool softener Docusil 100 mg, the anticoagulant apixaban five (5) mg, the cognitive-enhancing medication memantine 5 mg, the antipsychotic medication risperidone 0.5 mg, and the vasodilator medication Sildenafil 20 mg. RN #482 crushed the medication and placed them in chocolate pudding. Observation at 10:47 A.M. revealed RN #482 administered the medications to Resident #16. Review of the medical record noted Resident #16's physician orders and prescribed time frames listed on the MAR noted the following; the order dated 03/14/25 for diltiazem 60 mg three times daily for blood pressure, scheduled at 9:00 A.M., 1:00 P.M., and 9:00 P.M.; the order dated 03/14/25 for Docusil 100 mg two times daily for constipation, scheduled at 9:00 A.M. and 5:00 P.M.; the order dated 03/14/25 for apixaban 5 mg two times daily for anticoagulant, scheduled at 9:00 A.M. and 5:00 P.M.; the order dated 03/14/25 for memantine 5 mg two times daily for memory, scheduled at 9:00 A.M. and 5:00 P.M.; the order dated 03/14/25 for risperidone 0.5 mg two times daily for mood, scheduled at 9:00 A.M. and 5:00 P.M., and the order dated 03/14/25 for Sildenafil 20 mg two times daily for blood pressure, scheduled at 9:00 A.M. and 5:00 P.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/25 at 10:48 A.M. interview with RN #482 verified Resident #53 and Resident #16's medications not given within prescribed timeframes. 3. Observation and interview on 05/14/25 at 7:59 A.M. revealed Licensed Practical Nurse (LPN) #455 was preparing Resident #74's medications for administration. While placing medications into a medication cup, LPN #455 stated the resident's Sacubitril-Valsartan 97-103 mg oral tablet was not available and would be omitted during the administration. Continued observation at 8:08 A.M., revealed LPN #455 proceeded to provide Resident #74 with medications with the exception of the Sacubitril-Valsartan 97-103 mg oral tablet. Review of the medical record identified Resident #74 had a physician order for the administration of Sacubitril-Valsartan 97-103 mg two times daily for hypertension and was scheduled for 9:00 A.M. and 5:00 P.M. On 05/14/25 at 8:10 A.M., interview with LPN #455 verified Sacubitril-Valsartan 97-103 mg was not available for Resident #74 on 05/14/25 and needed reordered. Review of facility administering medications policy, revised April 2019, revealed medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure medications were administered as ordered, and within ordered time frames, to prevent significant medication errors. This affected three (#53, #16, #74) of four residents observed for the administration of medications in a facility census of 81. Findings include: 1. Observation on 05/13/25 at 10:21 A.M. noted Registered Nurse (RN) #482 preparing medications for Resident #53. The medications included the medication to treat symptoms of Parkinson's disease Carbidopa-Levodopa 25-100 milligrams (mg), the anticonvulsant medication divalproex delayed release 125 mg, the heart failure medication Sacubitril-Valsartan 24-26 mg, and the antihypertensive medication Hydralazine 25 mg. Continued observation at 10:31 A.M., revealed RN #482 administered the medications to Resident #53 one-by-one using a spoon. Review of the medical record noted Resident #53's physician orders and prescribed time frames listed on the medication administration record (MAR) noted the following; the order dated 03/04/25 for Carbidopa-Levodopa 25-100 mg three times a day for Parkinson's disease, scheduled at 9:00 A.M., 1:00 P.M., and 9:00 P.M.; the order dated 03/04/25 for divalproex delayed release 125 mg two times a day for depression, scheduled at 9:00 A.M. and 9:00 P.M., the order dated 03/04/25 for Sacubitril-Valsartan 24-26 mg two times daily for hypertension, scheduled at 9:00 A.M. and 9:00 P.M.; and the order dated 03/04/25 for Hydralazine 25 mg give three times daily for high blood pressure, scheduled at 9:00 A.M., 1:00 P.M., and 9:00 P.M. 2. Continued observation on 05/13/25 at 10:36 A.M. noted RN #482 preparing Resident #16 medications. The medications included the antihypertensive medication diltiazem 60 mg, the anticoagulant apixaban five (5) mg, and the antipsychotic medication risperidone 0.5 mg, and the vasodilator medication Sildenafil 20 mg. RN #482 crushed the medication and placed them in chocolate pudding. Observation at 10:47 A.M. revealed RN #482 administered the medications to Resident #16. Review of the medical record noted Resident #16's physician orders and prescribed time frames listed on the MAR noted the following; the order dated 03/14/25 for diltiazem 60 mg three times daily for blood pressure, scheduled at 9:00 A.M., 1:00 P.M., and 9:00 P.M.; the order dated 03/14/25 for apixaban 5 mg two times daily for anticoagulant, scheduled at 9:00 A.M. and 5:00 P.M.; the order dated 03/14/25 for risperidone 0.5 mg two times daily for mood, scheduled at 9:00 A.M. and 5:00 P.M.; and the order dated 03/14/25 for Sildenafil 20 mg two times daily for blood pressure, scheduled at 9:00 A.M. and 5:00 P.M. On 05/13/25 at 10:48 A.M. interview with RN #482 verified Resident #53 and Resident #16's medications not given within prescribed timeframes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Observation and interview on 05/14/25 at 7:59 A.M. revealed Licensed Practical Nurse (LPN) #455 was preparing Resident #74's medications for administration. While placing medications into a medication cup, LPN #455 stated the resident's Sacubitril-Valsartan 97-103 mg oral tablet was not available and would be omitted during the administration. Continued observation at 8:08 A.M., revealed LPN #455 proceeded to provide Resident #74 with medications with the exception of the Sacubitril-Valsartan 97-103 mg oral tablet. Review of the medical record identified Resident #74 had a physician order for the administration of Sacubitril-Valsartan 97-103 mg two times daily for hypertension and was scheduled for 9:00 A.M. and 5:00 P. M. On 05/14/25 at 8:10 A.M., interview with LPN #455 verified Sacubitril-Valsartan 97-103 mg was not available for Resident #74 on 05/14/25 and needed reordered. Review of facility administering medications policy, revised April 2019, revealed medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the diet manual guidance, the facility failed to ensure pureed food items had an appropriate texture. This had the potential to affect two (#51 and #231) of two residents on a pureed diet. The facility census was 81. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 11/24/21 with diagnoses of dysphagia and anorexia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had severely impaired cognition and was able to feed himself with setup or clean-up assistance and received a mechanically altered diet. Review of the physician order dated 02/20/25 revealed Resident #51 received a regular diet with pureed consistency and thin liquids. 2. Review of the medical record for Resident #231 revealed an admission date of 05/12/25 with diagnosis of Alzheimer's disease. Review of the nursing admission evaluation, dated 05/12/25, revealed Resident #231 was in a coma/persistent vegetative state. Review of the care plan, initiated 05/12/25, revealed Resident #231 was dependent on staff for eating. Review of the physician order dated 05/12/25 revealed Resident #231 received a regular diet with pureed texture and nectar thickened liquids. Observation on 05/14/25 at 10:47 A.M. revealed Dietary Aide (DA) #387 making pureed pears for the noon meal. DA #387 used a food processor to puree the pears. Concurrent interview with DA #387 revealed he added an unmeasured amount of apple juice to the pears while processing them. Continued observation revealed DA #387 spooning the pureed pears into bowls. The pears appeared thin and watery. DA #387 stated the pears were not ask thick as he wanted. Further observation revealed DA #387 placing covers over the bowls, dating the covers, and placing the bowls of pears onto the serving tray to be taken to the serving line. Interview on 05/14/25 at 10:52 A.M. with Dietary Director (DD) #409, and concurrent observation of the pureed pears, revealed the texture of the liquid was too thin and chunks of pears were present in the puree. DD #409 confirmed the texture of the pears was inappropriate for residents on a pureed diet. Review of the facility's current Diet Manual revealed pureed foods should be smooth, cohesive, and homogenous. All pureed foods should be smooth and free of lumps.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to ensure resident meal trays were served in a sanitary manner. This affected one (#62) of seven residents observed during dining services. The facility census was 81. Findings include: Review of the medical record for Resident #62 revealed an admission date of 11/06/23 with diagnoses of anxiety, repeated falls, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/14/25, revealed Resident #62 had intact cognition and was able to eat independently. Observation on 05/12/25 at 11:43 A.M. revealed Certified Nurse Aide (CNA) #550 was passing the noon meals trays. CNA #550 entered Resident #62's room and placed a meal tray on the resident's overbed table. Also present on the overbed table was a urinal with urine in it. Interview on 05/12/25 at 11:44 A.M. with CNA #550 confirmed Resident #62's urinal, containing urine, was on the overbed table and CNA #550 placed a meal tray on the same table. CNA #550 stated she did not realize the urinal was on the table. Subsequent observation on 05/12/25 at approximately 11:45 A.M. revealed CNA #550 re-entered Resident #62's room to remove the urinal from his overbed table and emptied the urinal in the toilet.