STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365665	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Wind Health Care Center	300 23rd Street NE Massillon, OH 44646

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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 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** Based on record review and interview, the facility failed to ensure the accuracy of resident assessments. This affected two residents (Resident #9 and Resident #11) reviewed for accuracy of assessments. The facility census was 77. Findings include:1.Review of the medical record for Resident #9 revealed an admission date of 04/24/26. Diagnoses included acute respiratory failure with hypercapnia; acute bronchitis due to other specified organisms; dependence of respirator (ventilator); pseudomonas; muscle weakness, dysphagia; symbolic dysfunctions; weakness; need for assistance with personal care; pneumonia; acute and chronic respiratory failure with hypoxia; chronic obstructive pulmonary disease with exacerbation; benign prostatic hyperplasia with lower urinary tract symptoms; type two diabetes mellitus without complications. Review of medication orders, both current and discontinued, revealed no orders for insulin injections. Review of medication orders revealed on 05/23/26, Resident #9 was ordered Levaquin (antibiotic) 750 milligrams (mg) daily for seven days for bilateral pneumonia. Review of a quarterly Minimum Data Set (MDS) version 3.0 assessment, dated 05/26/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale, which would indicate the resident was cognitively intact. Functionally, the resident used a walker, he required supervision for oral hygiene, moderate assistance for toileting, upper body and lower body dressing and putting on or taking off footwear, and maximal assistance for showering and bathing. Review of Section N of the MDS revealed the resident had been receiving insulin injections for the past seven days with no changes. Section N failed to reveal the resident to be taking a hypoglycemic (which would include insulin). It also revealed he was not taking antibiotics at the time of the assessment. On 06/29/26 at 9:15 A.M., an interview with MDS Nurse #513 confirmed she had incorrectly coded the MDS assessment dated [DATE] for Resident #9. He was on Levaquin at the time and had never been given any insulin injections during his stay at the facility. 2. Review of the medical record for Resident #11 revealed an admission date of 07/11/24 with diagnoses including chronic respiratory failure, quadriplegia and depression. She was admitted to hospice on 08/22/24. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 was on hospice. However, on section J question J1400 staff had answered incorrectly that Resident #11 did not have a life expectancy of less than six months. (continued on next page)

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

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #11 was on hospice. However, on section J question J1400 staff had answered incorrectly that Resident #11 did not have a life expectancy of less than six months. Interview on 06/29/26 at 9:40 A.M. with Licensed Practical Nurse (LPN) #513 verified Resident #11's MDS's on 01/22/26 and 04/20/26 were incorrect under section J as she was on hospice and the prognosis question should have been answered yes that she had a life expectancy less than six months.

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility investigation, staff and family interviews and review of facility policy, the facility failed to ensure advance directives were honored for residents. This affected one (Resident #91) of two residents reviewed for Cardio-pulmonary Resuscitation (CPR). The facility also failed to ensure advanced directives were accurate in the medical records. This affected one (Resident #28) of 29 residents reviewed for advance directives. The facility census was 77.Findings include: 1.Review of the closed medical record for Resident #91 revealed an admission date of [DATE] with diagnoses of acute respiratory failure with hypoxia, and pulmonary embolism and tracheostomy status. Resident #91 did not have a power of attorney or legal guardian. Resident #91's son was listed as the first emergency contact, and daughter-in-law was listed as the second emergency contact. Review of the physician order dated [DATE] for Resident #91 revealed the resident had a Do Not Resuscitate Comfort Care Arrest (DNRCCA which indicates lifesaving treatments would be utilized up to the point of cardiac arrest) order. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #91 was cognitively impaired. Resident #91 was totally dependent on staff for all activities of daily living (ADL). Review of Resident #91's care plan dated [DATE] revealed Resident #91 was a DNRCCA. Interventions included advocating for residents end-of-life wishes and ensure advance directives are implemented accordingly, effectively communicate DNR wishes by placing in the front of the chart. Review of the facility investigation dated [DATE] revealed on [DATE] at 1:54 P.M. a Certified Nursing Assistant (CNA) reported to the nurse that Resident #91 was having trouble breathing. At 1:55 P.M. the nurse notified the Respiratory Therapist (RT) going to Resident #91's room. At 1:57 P.M. the RT entered the room, noticed the resident was not breathing and initiated CPR. At 1:59 P.M. additional staff arrived to assist with the crash cart, CPR continued, and emergency medical services (EMS) were called. At 2:02 P.M. the Director of Nursing (DON) auscultated a strong apical pulse and at 2:03 P.M. EMS arrived to continue CPR and left the facility with the resident at 2:10 P.M. while continuing respiration assistance. Review of the witness statement dated [DATE] and authored by Licensed Practical Nurse (LPN) #615 revealed LPN #615 entered Resident #91's room after hearing someone call for a crash cart and found the RT doing chest compressions with another nurse present. Resident #91's spouse was present and standing in the corner. A staff member had the spouse exit the room to be with other family members in the hallway. LPN #615 assisted putting a backboard under the resident and deflating the air mattress and then went to get the code status from the chart. The resident's family (which family member not identified) was asked if they wanted the resident placed on life support if needed and they said yes and to do whatever was needed to save her. EMS arrived and took over. Review of the witness statement dated [DATE] and authored by CNA #587 revealed around 1:54 P.M. the family of Resident #91 got her and said Resident #91 was having a hard time breathing. When CNA #587 walked in, the resident was breathing heavy. The nurse was notified at 1:55 P.M. of the (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breathing difficulty and the nurse notified respiratory therapy (RT). CNA #587 was answering call lights when she heard the RT yelling for help. She and the nurse grabbed oxygen tanks and the crash cart. RT was doing chest compressions when the nurse relieved the RT then CNA #587 relieved the RT for three sets then Resident #91 had a faint pulse. 911 was called and the family was present. CNA #587 then left to answer call lights. An interview on [DATE] at 2:20 P.M. with Regional Registered Nurse (RRN) #609 confirmed Cardiopulmonary Resuscitation (CPR) was initiated on Resident #91 on [DATE] when it should not have been due to the resident having an order and advance directive for DNRCCA dated [DATE]. RRN #609 stated he did an investigation regarding the whole incident and determined when Resident #91 went unresponsive the husband of Resident #91 (who had dementia and was not the first or second emergency contact) wanted CPR to be done so the RT initiated CPR. An interview on [DATE] at 2:38 P.M. with DON #508 revealed they heard someone yelling for help around 1:55 P.M. on [DATE] and went running. The DON stated that she called a code and staff got the crash cart. DON #508 stated a respiratory therapist was doing CPR and the unit managers were helping on Resident #91. DON #508 stated family was removed from the room and the husband stated to do everything to save her. DON #508 stated staff was able to get a pulse prior to EMS arriving and Resident #91 was then taken to the hospital at 2:10 PM. An interview on [DATE] at 10:35 A.M. with admission Director (AD) #561 revealed Resident #91 was physically unable to sign paperwork and could not speak due to being on a ventilator but understood questions. AD#561 stated Resident #91 did not have a living will or power of attorney paperwork, but with a DNRCCA order the facility was to honor that status. An interview on [DATE] at 11:48 A.M. with Resident #91's family member revealed the family decided to make Resident #91 a DNRCCA after a hospitalization in January at the Cleveland Clinic, so Resident #91's code status was a DNRCCA upon admission to the facility. Resident #91's family member stated when her husband (Resident #91's first emergency contact) and her walked around the corner toward Resident #91's room they both heard someone screaming for help and to get a crash cart. Resident #91' family member stated when she and her husband walked into the room at the facility, they saw staff doing CPR on Resident #91. Resident #91's family member stated they did not tell them to stop because they were in complete shock by what they were seeing. Resident #91's family member stated Resident #91's husband had dementia and was not the emergency contact so he would not be the person to ask about code status. The family member verified they would not have wanted CPR to be started on Resident #91. An interview on [DATE] at 2:30 P.M. with Respiratory Therapist (RT) #614 confirmed on [DATE] LPN #512 asked her to go check on Resident #91 because family stated she was having breathing problems. RT #614 stated LPN #512 never assessed Resident #91 and never went into the room. RT #614 stated she went into the room right away by herself and the husband and son of Resident #91 were in there. RT #614 stated Resident #91 was not breathing, not wheezing, and her chest was not moving. RT #614 stated that she yelled for help and no one was coming so she had to send the family out to get staff for assistance. RT #614 stated she immediately started doing chest compressions when she noticed Resident #91 was not breathing. RT #614 stated DON #508 came in and just stood there and did nothing. RT #614 stated she yelled for her boss RT #616. RT #616 came in and they were able to ambu bag (a bag that provides air) Resident #91 after she held her finger over the trach. RT #614 stated they called 911 and CNA #587 came in and took over compressions. RT #614 stated when paramedics arrived Resident #91 had a heart rate. RT #614 stated the RTs used to be allowed to (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carry a sheet with the code status of each resident on it but that was stopped due to administration saying it was a privacy violation. RT #614 stated she had to look in the charts to get the code status and during the incident with Resident #91, RT #614 stated she did not have time to look in the chart. RT #614 stated the family didn't say anything during the incident and were in shock. An interview on [DATE] at 2:46 P.M. with DON #508 revealed they believe they told someone to go verify Resident #91's code status while they continued the code and got Resident #91's pulse back. DON #508 stated she didn't know if the confirmation of the code status was before or after Resident #91 regained a pulse. DON #508 stated LPN #512 never went into the room, and stated LPN #512 she was a newer nurse in the field. An interview on [DATE] at 3:30 P.M. with RT #616 revealed when he arrived at Resident #91's room the family was not in the room. RT #616 stated RT#614 was in the room and two other staff members along with a crash cart. RT #616 stated he started to assist RT #614 in bagging Resident #91, and stated Resident #91 had a pulse and he believed it was DON #508 who confirmed it. RT #616 stated they kept ventilating Resident #91 with 100 percent oxygen until the paramedics arrived. RT #616 confirmed he did not find the code status, and he did not talk to the family. An interview on [DATE] at 7:42 A.M. with LPN #615 revealed she was fired for unsatisfactory work performance related to the code of Resident #91. LPN #615 stated she was present for Resident #91's code and when she arrived to the room, CPR was already being performed. LPN #615 stated it was chaotic and the crash cart was there with RT #614 doing compressions, so LPN #615 assumed someone had already checked the code status of Resident #91. LPN #615 stated she removed the family out of the room and that they did not say anything. LPN #615 stated she was in the room and doing compressions and had CNA #587 take over. LPN #615 stated she then went out and confirmed the code status was DNRCCA and she went to speak to the family. LPN #615 stated the family didn't understand what was happening and because CPR had already been initiated, they decided to have the facility continue and send her out. An interview on [DATE] at 10:20 A.M. with LPN #520 verified that resident code status was kept in the front of the residents' hard chart. 2. Review of the medical record for Resident #28 revealed an admission date of [DATE] with diagnoses including hemiplegia, diabetes mellitus, respiratory failure, anxiety and depression. Review of the physician order dated [DATE] for Resident #28 revealed he was a do not resuscitate comfort care arrest (DNRCCA). Review of Resident #28's care plan dated [DATE] revealed he was a DNRCCA. Interventions included to effectively communicate DNR wishes by placing in the front the chart and/or when resident must be transferred outside the facility. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #28 had intact cognition. An interview on [DATE] at 2:09 P.M. with RN #504 verified Resident #28's code status in the electronic chart was for DNRCCA. He was unable to provide signed documentation that resident had chosen DNRCCA in his hard chart. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A interview on [DATE] at 1:20 P.M. with RRN #609 verified Resident #28 did not have a signed code status paper in his medical record to verify he was a DNRCCA. RRN #609 stated he had spoken to the resident on [DATE] and he wanted to be a full code. Review of the facility policy titled, Advance Directives, dated [DATE], revealed if the resident had executed one or more advance directives or executes one upon admission, copies of these documents were obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. The resident's wishes were to be communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care plan meetings. Advance directives are to be followed. A Do Not Resuscitate indicates that, in case of respiratory or cardiac failure, no CPR or other life sustaining treatments are to be used. If a resident does not have an advance directive, then the resident representative is given the option to accept or decline assistance. This deficiency represents non-compliance investigated under Complaint Number 3008139.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interview, and review of facility policy, the facility failed to ensure Resident #44 received treatment and care in accordance with professional standards of practice for treatment of urinary tract infection.Actual harm occurred to Resident #44 on 06/07/26, when the facility failed to notify the nurse practitioner (NP) of abnormal urine analysis and culture results, which were positive for Klebsiella pneumoniae ESBL (extended spectrum beta-lactamase) bacteria greater than 100,000 colony-forming units per milliliter, causing a delay in treatment for a urinary tract infection (UTI). The results were not reported to the NP until 06/16/26 at approximately 9:51 P.M. At approximately 11:00 P.M. on 06/16/26, Resident #44 was found by Licensed Practical Nurse (LPN) #515 during medication pass to slowly respond to questions but not open her eyes and had an abnormal pulse of 44 beats per minute. At 12:35 A.M. on 06/17/26 Resident #44 was transported by emergency medical services (EMS) to the local hospital and admitted for low heart rate (bradycardia) and unresponsiveness. Resident #44 was diagnosed with acute kidney injury on chronic stage three kidney disease and urinary tract infection. Urine analysis and culture results in the hospital resulted positive for Escherichia coli (E-coli) and Klebsiella pneumoniae. Resident #44 required a nine-day hospital stay which included an infectious disease consult, and insertion of a peripherally inserted central catheter (PICC) to administer intravenous antibiotics. Resident #44 returned to the facility on [DATE]. This affected one (Resident #44) of two residents (Resident #44 and Resident #96) reviewed for hospitalization. The facility census was 77. Findings include:Review of the medical record for Resident #44 revealed an admission date of 02/07/25 with diagnoses including need for assistance with personal care, muscle weakness, stage three pressure ulcer of sacral region, moderate protein-calorie malnutrition, noninfective gastroenteritis and colitis, other iron deficiency anemia, heart disease and other dysphagia.Review of the care plan for Resident #44, date initiated 02/07/25 and revised 06/10/25, revealed bladder incontinence related to generalized weakness requiring assistance with activities of daily living (ADL) care and toileting. Interventions included clean peri-area with each incontinence episode, have call light within easy reach, maintain resident dignity with care, and monitor and document signs and symptoms of urinary tract infections: pain, burning, blood-tinged urine, cloudiness, no urine output, increased pulse, increased temperature, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns.Review of a quarterly Minimum Data Set (MDS) 3.0 assessment, dated 05/21/26, revealed Resident #44 was cognitively intact, required a wheelchair for mobility, was dependent for toileting hygiene, required substantial/maximal assistance for showering and all dressing, and was frequently incontinent of both bowel and bladder. The resident was medically complex and had no significant weight loss. Review of progress notes dated 05/27/26 authored by Nurse Practitioner (NP) #617 revealed Resident #44 was being seen for management of chronic diseases and symptomatic hypotension over the weekend which was suspected to be related to post EGD (esophagogastroduodenoscopy) procedure on 05/22/26. Current midodrine (anit-hypotension medication) was increased and use of compression hose when out of bed. The resident was noted to have a history of urinary tract infection with acute cystitis and positive urine culture which had been treated with antibiotics in 03/2026. The resident was noted to be resting comfortably in bed and was alert and oriented to person, place and time on exam but noted to not seem herself and was tearful. No complaints or problems with urination or pain with urination were noted. A psychiatric consult was ordered to address depression symptoms.Review of a progress note written by NP #612 on 06/01/26 revealed Resident #44 was seen for altered mental status which included being tearful at times with some confusion over the past week. Resident #44 was awake, alert, and in no distress. The plan was for a complete blood count (CBC), basic metabolic panel (BMP), and a urinalysis with culture and sensitivity to be obtained on 06/02/26.Review of a progress note written by Registered Nurse (RN) #504 on 06/02/26 at 9:07 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	P.M., revealed laboratory results were reviewed and (unnamed) NP aware.Review of a progress note written by NP #613 on 06/02/26 revealed Resident #44 was seen for follow up of altered mental status and to re-evaluate for hypotension. The resident was alert, oriented and able to participate by answering questions appropriately during the examination. Lab results dated 05/28/26 were reviewed as WBC (white blood cells) 5.4 (normal), glucose 69 (normal), sodium 144 (normal), potassium 4.6(normal), chloride 109 (normal), BUN (blood urea nitrogen) 32 (high), creatinine 1.3 (high), calcium 9.1 (normal), protein 5.1 (low), albumin less than 3.0 (low), hemoglobin 10.6 (low), and hematocrit 32.2 (low). A TSH (thyroid stimulation hormone) dated 05/22/26 was 6.091 (high). It was noted the elevated TSH could be contributing to symptoms, so Synthroid medication was added and to check a complete blood count (CBC) and basic metabolic panel (BMP) on Thursday (in one week). The note also indicated the urinalysis with culture and sensitivity was ordered but had not yet been obtained. Review of a progress note written by Licensed Practical Nurse (LPN) #650 on 06/03/26 at 6:11 A.M. revealed the order for urinalysis with culture and sensitivity had been obtained.Review of a progress note written by NP #613 on 06/05/26 revealed Resident #44 was seen for follow up of altered mental status. Resident #44 was awake, alert and oriented to person, place and time, in no distress, sitting up in her wheelchair, and able to answer questions appropriately. Resident #44 was noted to be having no pain with urination and no blood in the urine. 06/01/26 labs results were reviewed and recorded as WBC (white blood cells) 5.8 (normal), glucose 69 (normal), sodium 143 (normal), potassium 4.3 (normal), chloride 106 (normal), BUN (blood urea nitrogen) 37 (high), creatinine 1.2 (normal), calcium 9.0 (normal), hemoglobin 11.0 (low), and hematocrit 33.5 (low). The note indicated the urinalysis with culture and sensitivity was pending positive.Review of the document titled Lab Reports Result, dated 06/07/26, for Resident #44 revealed the urine specimen was collected on 06/03/26 and reported to the facility on [DATE] at 2:38 P.M. but did not indicate to whom the report was given for the results. The results indicated the resident's urine culture was positive for Klebsiella pneumoniae ESBL (extended spectrum beta-lactamase). ESBL was highly resistant to many common antibiotics including penicillin and cephalosporins. Review of progress notes dated 06/07/26 through 06/15/26 revealed no evidence the facility reported the 06/07/26 urine culture and sensitivity results for Resident #44 to the NP or physician. Progress notes indicated on 06/14/26 that Resident #44 was at baseline for vitals and level of alertness.Review of a progress note for Resident #44 dated 06/16/26 at 11:09 P.M., written by RN #504, indicated urine culture results from 06/07/26 were reviewed and [unnamed] NP aware. New orders were received for Nitrofurantoin Macrocrystal (antibiotic used to treat UTI) oral capsule 100 milligram (mg) one capsule by mouth every shift for abnormal urine results for five days.Review of a progress note for Resident #44 dated 06/17/26 at 12:46 A.M., written by Licensed Practical Nurse (LPN) #515 revealed at 11:00 P.M. on 06/16/26 during medication pass, the resident was slow to respond to commands. She would not open her eyes, had no response to sternal rub, but was answering questions. Her heart rate was 44 and her blood pressure was 108/63. The resident was sent to the emergency room at 12:35 A.M. on 06/17/26. Two EMS providers were called due to the first being unable to provide transport, and the second one was able to provide transport within 45 minutes. Review of the hospital record for Resident #44 revealed she was sent to the hospital by the nursing home due to altered mental status, as she was not aroused when attempting to wake her. EMS was able to arouse her with voice and sternal rub. In the emergency room she was awake, alert and able to answer questions appropriately and not complaining of any pain or discomfort. Resident #44 was admitted to the hospital on [DATE] with bradycardia. On 06/20/26 a urinalysis with culture was obtained resulting in a diagnosis of urinary tract infection positive for ESBL E-coli and Klebsiella pneumoniae bacteria in the urine. Ceftriaxone (antibiotic) one-gram intravenous (IV) daily was ordered and on 06/22/26 the antibiotic was changed to ertapenem 500mg IV daily after infectious disease consult indicated due to the urine culture, which was done in the hospital being positive for, the ertapenem was the more appropriate antibiotic. A peripherally inserted central catheter (PICC) was inserted on 06/23/26 to support more long-term (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	antibiotic use. The resident remained hospitalized until 06/26/26. Final diagnoses included acute kidney injury on chronic kidney disease.An interview on 06/23/26 at 2:11 P.M. with RN #504 revealed when labs are ordered at the facility and results finalized at the lab, the lab results were faxed to the nurse's station and also automatically sent to the electronic medical record from the lab. The nurse who would get the labs from the fax machine should call the provider and notify the provider if there were abnormal results. When asked why the urine with culture lab results dated 06/07/26 for Resident #44 did not get reported to an NP or physician until 06/16/26, RN #504 stated he did not know how it got missed because someone should have been looking for it within three days of collection. RN #504 stated he found the lab result sitting on the top of a desk in the middle of a pile of stuff on 06/16/26 and reported the result to the provider immediately as well as the Director of Nursing (DON). RN #504 stated he believed the late reporting of the results caused a delay in treating Resident #44 with the appropriate medications for the UTI.An interview on 06/23/26 at 3:50 P.M. with Regional RN (RRN) #609 confirmed there was a delay in care when urine analysis and culture laboratory results for Resident #44 were not reported for nine days after they had been received by the facility.An interview was attempted by phone on 06/29/26 at 3:30 P.M. with Licensed Practical Nurse (LPN) #515 and no return contact was received. An interview on 06/29/26 at 3:43 P.M. with NP #213 revealed Resident #44 had a delay in getting her urine tested from when it was originally ordered on 06/01/26 but did not know why. NP #213 confirmed Resident #44 was admitted to the hospital with bradycardia and unresponsiveness. NP #213 stated she could not say for certain if the urinary tract infection caused the bradycardia and unresponsive episode or not. NP #213 confirmed there had been a delay in reporting the lab results showing a UTI from 06/07/26 to 06/16/26. An interview on 06/30/26 at 1:00 P.M. with Resident #44 revealed she was alert and oriented to person, place, and time and answered questions appropriately. Resident #44 stated she did not recall the events which led to her hospitalization; however, she knew she had been sick. Resident #44 stated she was feeling better and had no more confusion.Review of a facility policy titled Lab and Diagnostic Test Results Clinical Protocol, revised September 2012, revealed a physician would identify and order diagnostic and lab testing based on needs. A nurse would review all results. The nurse should discuss, when reporting the results, why the test was obtained. The nurse would identify the urgency of communicating the results to the provider, the seriousness of the abnormality, and the individual's current condition. Situations which required prompt physician notification included a result which should be conveyed to a provider regardless of other circumstances (the abnormal result was problematic) or the resident's clinical status was unclear or worsening.This deficiency represents non-compliance investigated under Complaint Number 2715972.

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	365665	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Wind Health Care Center	300 23rd Street NE Massillon, OH 44646

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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. Based on record review and staff interviews, the facility failed to ensure vision services were provided to Resident #90. The affected one (Resident #90) of one resident reviewed for vision services. The facility census was 77.Findings include: Review of the medical record for Resident #90 revealed admission date of 03/02/26 for diagnoses of end-stage renal disease, renal dialysis, heart failure, dysphagia, and a dialysis fistula. Review of the facility admission packet for Resident #90 revealed a consent signed by Resident #90's daughter and dated 03/02/26 to receive services from 360 Care (ancillary service partner) for audiology, vision, and podiatry services.Review of the initial comprehensive MDS 3.0 assessment completed on 03/09/26 for Resident #90 revealed she required hearing aid and use of glasses with no significant impairments and able to make self-understood and understood others. Resident #90 required substantial to maximum assistance with oral hygiene, toileting, dressing, and transfers and partial to moderate assistance with showering/bathing.Review of physician orders dated April 2026 revealed an order for an antibiotic eye drop, Ciprofloxacin HCL ophthalmic solution 0.3% 1 drop in both eyes every morning and bedtime for seven days. An additional two weeks of treatment was prescribed on 04/21/26 to continue Ciprofloxacin HCL ophthalmic solution 0.3% 1 drop in both eyes twice a day until 05/05/26.Review of the nursing progress note dated 04/26/26 at 11:09 A.M. revealed Resident #90 refused the antibiotic eye drops due to affecting vision. On 04/23/26 at 7:53 P.M. a progress note revealed Resident #90 refused eye drops again and due to making eyes blurry and the physician was notified.Review of a Nurse Practitioner (NP) note dated 04/24/26 by NP #612 revealed she evaluated Resident #90 and discontinued the Cipro eye drops due to resident refusing them.Review of a NP note dated 04/28/26 by NP #612 revealed she evaluated Resident #90 for conjunctivitis and had discussion with Resident #90 family regarding treatment options and prescribed a lubricating eye drop to be started.Review of an email provided by Social Service Director (SSD) #563 revealed SSD #563 authored the email to 360 Care coordinator dated 04/28/26 and timed 4:14 P.M. requesting resident #90 be added for a visit on 04/29/26 and listed as priority to evaluated. There was no evidence of confirmation that the 360 Care coordinator confirmed or responded to the email prior to 04/29/26.Review of the medical record revealed a Resident Cancelled/Not Seen Visit Report from 360 care services dated 04/29/26 and timed 5:53 P.M. noting Resident #90 refused services on 04/29/26.Further review of email communication from SSD #563 to the 360 Care coordinator revealed an email sent by SSD#563 on 04/30/26 at 10:26 A.M. requesting an emergent appointment for Resident #90 due to not being seen yesterday 04/29/26 and her daughter was present and stated Resident #90 was not seen even though there was a note from 360 Care stating Resident #90 declined appointment. On 05/01/26 another email was sent from SSD #563 to follow up with the prior email and if any appointment could be made for Resident #90. There were no further emails provided regarding 360 Care and any appointments. An interview on 06/25/26 at 8:55 A.M. SSD #563 revealed she sent the referral for vision services for Resident #90 to 360 Care and she was supposed to be seen by vision provider on 04/29/26 and was on the list. SSD #563 further reported that she recalled on 04/29/26 in the afternoon maybe around 2:00 or 3:00 P.M. the daughter was at the facility with Resident #90 and was aware of her appointment with the vision team. Both the daughter and resident were waiting for her to be seen and went down to the treatment room, and the vision team was packing up for the day and reported they would not see Resident #90. The daughter became upset and had to leave the facility. SSD #563 reported that the administrator got involved and she would be able to elaborate more on the event. SSD#563 stated after that happened there was a process change to make all ancillary service providers report to the SSD on arrival and prior to leaving to make sure all residents are seen who needed services that day. SSD #563 recalled that the administrator was very upset about the events and called management at 360 Care over the situation.An interview on 06/25/26 at 12:05 P.M. via telephone with the facility Administrator revealed Resident #90 was assigned to the Administrator directly for caring angel (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program (program in which each administrative team member was assigned a resident to oversee and check in with regarding their care and experience). The Administrator reported that everyone was made aware of Resident #90 having an appointment for vision care on 04/29/26 including herself and Resident #90's daughter. The administrator continued to reveal that she wasn't made aware until late in the afternoon on 04/29/26 that Resident #90 was not seen by the vision team and that apparently the daughter went down to see them directly to see why her mom wasn't seen and they were closing up for day and said she wasn't seen. The Administrator stated that Resident #90's daughter was so upset she couldn't even discuss the issue with her that day and had to leave. The Administrator called and spoke with management at 360 Care that day and was told that they offered to see Resident #90, but she refused. The administrator reported that she talked with daughter and offered to attempt to get Resident #90 seen the next day, but the daughter had already called her regular vision provider and made a community appointment to be seen. The facility did not have a policy related to ancillary services or referrals. This deficiency represents non-compliance investigated under Complaint Number 3019055.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy the facility failed to inform the nurse practitioner of a dietary recommendation to address hydration needs for Resident #96. This affected one resident (Resident #96) of four residents reviewed for change of condition. The facility census was 77.Findings include:Review of the closed medical record for Resident #96 revealed an admission date of 10/01/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic systolic congestive heart failure, need for assistance with personal care, muscle weakness, hypothyroidism, mild gastritis and gastrointestinal bleed. Resident #96 was discharged to the hospital on [DATE] and did not return to the facility.Review of the care plan for Resident #96, initiated 10/05/24 and revised on 05/21/26, revealed she was at risk for altered nutrition and fluid imbalance related to hypothyroid, gastrointestinal bleed, stroke, mild gastritis, congestive heart failure, behaviors, episodes of meal intake less than 50 percent, history of significant weight loss and fluid shifts. Interventions, initiated 10/05/24, included to monitor weight every month and report and concerns to the physician, family and resident, update food preferences and provide foods resident likes, supplements as ordered, water pitcher within reach of resident, responsible party/physician will be notified of weight loss/weight concerns, diet as ordered, monitor nutritional labs routinely, encourage fluid intake at meals and record, and monitor for signs and symptoms of dehydration. The care plan also indicated Resident #96 was frequently incontinent of urine.Review of progress notes for Resident #96 revealed on 05/19/26 the resident was seen by Nurse Practitioner (NP) #613. Resident #96 was seen for fatigue and was very tired during the exam. A chest X-ray, complete blood count (CBC), a basic metabolic panel (BMP) and a thyroid stimulating hormone (TSH) level were to be drawn on 05/20/26. The NP noted there was no suprapubic tenderness and would hold off on any IV (intravenous) fluids.Review of a progress note for Resident #96 dated 05/20/26 at 11:59 P.M. written by NP #612 revealed results of the chest X-ray on 05/19/26 indicated left basilar infiltrates and Doxycycline (antibiotic) treatment regimen dated 05/20/26 to 05/27/26 ordered for pneumonia.Review of a dietary note dated 05/21/26 at 12:58 P.M., written by Dietitian Technician (DT) #537 revealed 05/20/26 labs included BUN (blood urea nitrogen) of 32 milligrams per deciliter (mg/dL) (normal range 7 to 26 mg/dL), creatinine 1.4 mg/dl (normal range 0.41 to 0.95 mg/dL), and GFR (glomerular filtration rate) 44 milliliters per minute (ml/min with normal being greater than 60 ml/min). Recommend NP to review for IV fluids. Nursing aware and will contact NP.Review of a progress note dated 05/21/26 at 2:45 P.M. written by RN #509 revealed lab results were reported to the provider (none specified) and new orders were received at 1:03 P.M. to repeat CBC and BMP on 05/22/26. There was no evidence that the recommendations from DT #537 were relayed to the provider.Review of a progress note dated 05/22/26 at 10:39 A.M. authored by NP #613 revealed follow-up for pneumonia, labs reviewed and new orders for additional antibiotics. There was no indication in the note that the NP had been advised of the dietary recommendation to review for IV fluids. Review of progress notes and physician orders dated 05/22/26 revealed Resident #96 was ordered Ceftriaxone Sodium (antibiotic) inject two grams intramuscularly one time only for pneumonia for one day. Further review of progress notes and physician orders through 05/23/26 revealed no evidence of follow-up on DT #537's recommendation for IV fluids.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #96 was cognitively intact, used a wheelchair for mobility, was dependent with toileting hygiene, showering and dressing. Resident #44 required supervision for oral hygiene, and maximal assistance with personal hygiene. An interview on 06/29/26 at 1:06 P.M. with Licensed Practical Nurse (LPN) #615 revealed she took care of Resident #96 on 05/21/26 and updated the NP on labs results and took orders. LPN #615 stated she did not recall which NP she spoke with and knew she did not speak to DT #537 or a dietitian about IV fluids. LPN #615 stated she was told in nursing report that Resident #96 was improving. LPN #615 stated (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #96 was not feeling the greatest and was alert and oriented but very tired.An interview on 06/29/26 at 3:43 P.M. with NP #612 revealed Resident #96 had been sent to the hospital for pneumonia. NP #612 stated nurses and the dietary manager would notify her of any dietary recommendations. NP #612 stated she was not aware of anyone addressing any recommendation for IV fluids and whether or not she would order any depended on the resident's overall medical condition. An interview on 06/30/26 at 11:50 A.M. with NP #613 revealed she noticed Resident #96 had been more restless and fatigued as of 05/19/26 as she was normally very with it. NP #613 verified she was not made aware of the recommendation by DT #537 nor a dietitian for IV fluids or she would have considered it but probably would have given subcutaneous fluids instead. An interview on 06/30/26 at 4:30 P.M. with DT #537 revealed she thought Resident #96 had medical problems which were affecting her oral intake. DT #537 stated she gave her recommendations verbally to a nurse on 05/21/26 for an NP to review for possible IV fluids. DT #537 stated normally she would write the recommendation, and she did not recall which nurse she gave the verbal recommendation to for the NP to review for IV fluids.Review of a facility policy titled Acute Condition Changes Clinical Protocol, revised March 2018, direct care staff would be trained in recognizing subtle but significant changes in the resident (for example decrease in food intake, increased agitation, changes in skin condition or color) and how to communicate these changes to the nurse. Before contacting a physician about someone with an acute change in condition, the staff would collect pertinent details to report to the physician, including the resident's current symptoms and status. The provider would be contacted based on the urgency of the situation. This deficiency represents non-compliance investigated under Complaint Number 2715972 and 2571934.

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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 observation, interview and record review, the facility failed to ensure respiratory equipment was maintained in a sanitary manner. This affected three (Residents #35, #67 and #70) of four residents reviewed for respiratory care. The facility census was 77. Findings include:1. Review of the medical record for Resident #35 revealed an admission date of 09/14/23 with diagnoses including chronic respiratory failure, tracheostomy status, and dependence on respiratory ventilator status. Review of the physician's orders revealed Resident #35 was to have his oxygen tubing and set-up changed every Thursday and as needed dated 11/03/25. Review of the Treatment Administration Record (TAR) for June 2026 revealed Resident #35's oxygen tubing was to be changed on 06/18/26 and staff had not completed this as ordered. Observation and interview on 06/22/26 at 10:18 A.M. of Resident #35 with Respiratory Therapist (RT) #535 revealed his oxygen tubing was dated 06/12/26. RT #535 verified his oxygen tubing should have been changed on 06/18/26. She verified the respiratory department was in charge of changing the oxygen tubing if a resident was on mechanical ventilation. 2. Review of the medical record for Resident #67 revealed an admission date of 12/01/23 with diagnoses including chronic respiratory failure, tracheostomy status, and dependence on respiratory ventilator status. Review of the physician's orders revealed Resident #67 was to have his oxygen tubing and set-up changed every Thursday and as needed dated 09/25/25. Review of the Treatment Administration Record (TAR) for June 2026 revealed Resident #67's oxygen tubing was to be changed on 06/18/26 and staff had not completed this as ordered. Observation and interview on 06/22/26 at 10:19 A.M. of Resident #67 with RT #535 revealed his oxygen tubing was dated 06/12/26. RT #535 verified his oxygen tubing should have been changed on 06/18/26. She verified the respiratory department was in charge of changing the oxygen tubing if a resident was on mechanical ventilation. 3. Review of the medical record for Resident #70 revealed an admission date of 08/29/25 with diagnoses including chronic respiratory failure, tracheostomy status, and dependence on respiratory ventilator status. Review of the physician's orders revealed Resident #70 was to have his oxygen tubing and set-up changed every Thursday and as needed dated 01/08/26. Review of the Treatment Administration Record (TAR) for June 2026 revealed Resident #67's oxygen tubing was documented as changed on 06/04/26. Observation and interview on 06/22/26 at 10:20 A.M. of Resident #70 with RT #535 revealed his oxygen tubing was dated 05/14/26. RT #535 verified his oxygen tubing should have been changed on 06/04/26 and on 06/19/26 when he returned from the hospital after a hospital admission. She verified the respiratory department was in charge of changing the oxygen tubing if a resident was on mechanical ventilation. The facility was unable to provide a policy and procedure of respiratory staff changing the oxygen tubing for residents on mechanical ventilation. This deficiency represents non-compliance investigated under Complaint Number 2571934

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility assessment, the facility did not ensure licensed nursing staff completed competencies on hire and demonstrated competencies and skill sets necessary to provide care and services based on residents assessed needs. This affected two (Resident #44 and #96) of two residents reviewed for competent nursing services. The facility census was 77.Findings include:1.Review of the medical record for Resident #44 revealed an admission date of 02/07/25. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, noninfective gastroenteritis and colitis, muscle weakness, pressure ulcer of sacral region, stage three, peptic ulcer, moderate protein-calorie malnutrition, bradycardia, hypotension, and intestinal bypass and anastomosis status. Review of the medical record for Resident #44 revealed on 06/03/26, Resident #44 had a urinalysis completed with culture and sensitivity that was positive for urinary infection. The result of the culture was reported to the facility on [DATE] however the results were not reported by the nursing staff to the nurse practitioner (NP) until 06/16/26. The resident was admitted to the hospital on [DATE], where she was treated for bradycardia, unresponsiveness and given Intravenous (IV) antibiotics for a urinary tract infection caused by ESBL (extended spectrum beta-lactamase) Klebsiella pneumoniae , which was highly resistant to many common antibiotics including penicillin and cephalosporins, and Escherichia coli, more commonly known as E. coli. An interview on 06/23/26 at 2:11 P.M. with Registered Nurse (RN) #504 confirmed the urine with culture lab results dated 06/07/26 for Resident #44 did not get reported to an NP or physician until 06/16/26. RN #504 stated he did not know how it got missed because someone should have been looking for it within three days of collection. RN #504 stated he found the lab result sitting on the top of a desk in the middle of a pile of stuff on 06/16/26 and reported the result to the provider immediately as well as the Director of Nursing. RN #504 stated the nurse was responsible to report the results to the practitioner. 2. Review of the closed medical record for Resident #96 revealed an admission date of 10/01/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic systolic congestive heart failure, need for assistance with personal care, muscle weakness, hypothyroidism, mild gastritis and gastrointestinal bleed. Resident #96 was discharged to the hospital on [DATE] and did not return to the facility.Review of physician orders dated 05/21/26 for Resident #96 revealed blood glucose level to be obtained twice daily.Review of the Medication Administration Record (MAR) dated May 2026 revealed blood glucose levels were only obtained once instead of twice on 05/22/26 at 9:19 A.M.Review of a dietary note dated 05/21/26 at 12:58 P.M., written by Dietitian Technician (DT) #537 revealed 05/20/26 labs included BUN (blood urea nitrogen) of 32 milligrams per deciliter (mg/dL) (normal range 7 to 26 mg/dL), creatinine 1.4 mg/dl (normal range 0.41 to 0.95 mg/dL), and GFR (glomerular filtration rate) 44 milliliters per minute (ml/min with normal being greater than 60 ml/min). Recommend review for IV fluids and change in condition. Nursing aware and will contact NP.Further review of progress notes through 05/23/26 revealed no evidence of follow-up on DT #537's recommendation for IV fluids.An interview on 06/29/26 at 1:06 P.M. with Licensed Practical Nurse (LPN) #615 revealed she took care of Resident #96 on 05/21/26 and updated the NP on labs results and took orders. LPN #615 stated she did not recall which NP she spoke with and knew she did not speak to DT #537 or a dietitian about IV fluids.An interview on 06/29/26 at 3:43 P.M. with NP #612 confirmed she was not aware of anyone addressing any recommendation for IV fluids.An interview on 06/30/26 at 11:50 A.M. with NP #613 revealed she noticed Resident #96 had been more restless and fatigued as of 05/19/26 as she was normally very with it. NP #613 verified she was not made aware of the recommendation by DT #537 nor a dietitian for IV fluids or she would have considered it but probably would have given subcutaneous fluids instead.Review of the employee files for Registered Nurse (RN) #507 (hire date of (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/10/25) and LPN #518 (hire date of 03/12/26) revealed licensed nursing staff did not have nursing competencies completed on hire to ensure they were knowledgeable and skilled. An interview on 06/30/26 at 10:29 A.M. with Regional Registered Nurse (RRN) #609 verified RN #507 and LPN #518 had not had nursing competencies completed on hire. RRN #609 stated the facility had not been ensuring the licensed nursing staff all had nursing competencies on hire. RRN #609 stated the facility had recently revised their mentor program for new nursing staff to ensure they were competent to care for their residents. Review of the Facility Assessment, updated 06/30/25, revealed on page 11: Training and Competencies for the nursing department would include monthly education for nurses by the Director of Nursing, and new hires would participate in orientation and training in their fields. On page nine and 10, identification of resident change in condition utilizing assessments and diabetic blood glucose testing were listed under competency skills sets. This deficiency represents non-compliance investigated under Complaint Number 2571934 and 2581134.

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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** Based on observation, interview, record review and review of facility policy, the facility failed to ensure staff followed proper infection control procedures during incontinence care for Resident #55. The affected one resident (#55) of three residents reviewed for incontinence care. The facility census was 77.Findings include: Review of the medical record for Resident #55 revealed admission to the facility on [DATE] with diagnoses including hemiplegia of right side, dementia and bowel and urine incontinence.Review of the minimum data set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #55 was not able to vocalize her care needs and unable to complete the brief interview for mental status. Further review of the MDS revealed Resident #55 was dependent on staff for all personal care including showering/bathing, dressing, mobility with a wheelchair, and transfers with a mechanical lift. Resident #55 required a feeding tube for nutrition.Observation on 06/23/26 at 1:30 P.M. of incontinence care provided to Resident #55 by certified nursing assistant (CNA) #595 and CNA #592 revealed both CNA's donned gown and gloves per enhanced barrier protocol (EBP) and gathered wash clothes and soap and began performing incontinence care. Resident #55 began having a bowel movement during care and CNA's cleaned up stool from the resident with disposable cloths. After using disposable cloths to removal stool, CNA #595 used a soapy wash cloth and cleansed rectal area then immediately applied a barrier cream then placed an adult brief under Resident #55 and rolled her onto her back. CNA #595 did not remove her gloves or wash her hands and proceeded to obtain a new clean soapy washcloth with the same contaminated, gloved hands and cleansed the pubic area and labia of Resident #55. CNA #592 did not remove her gloves or wash her hands after assisting with incontinence care and then proceeded to reposition Resident #55 making direct contact with her head then placing a C shaped pillow. Resident # 55 then began moving her bowels again prior to CNA #595 securing the adult brief. CNA #595 and CNA #592 voiced they would need to start the process again, so both CNA #595 and #592 did not remove gloves or wash hands before starting perineal care again. Both CNA's were stopped by the surveyor at the time to ask why they had at no time changed their gloves nor performed hand hygiene. An immediate interview with CNA #595 revealed she was educated that once she put on her gown and gloves and entered a resident room with EBP she could not remove her gloves at all because she could only remove everything (gown and gloves) at one time when she left the room and that is why she did not change her gloves after cleaning the rectal area of stool then returning to the front to clean Resident #55's labia area. CNA #592 reported she was just in CNA training and was never taught to remove or change gloves during incontinence care. CNA #595 verified that she did not change her dirty gloves prior cleanings the labial area of Resident #55. CNA #592 verified she also did touch Resident #55 head to place the C shaped pillow without removing her dirty gloves and washing hands. An interview on 06/23/26 at 1:10 P.M. with the Director of Nursing (DON) revealed that she had started her current position in January 2026 and had been overseeing the infection control program for past few months until a new infection preventionist was designated about 2 weeks ago. The DON stated she had not completed any training with the facility staff regarding incontinence care since starting her position. The DON stated she had not had a chance to look, and she was not sure what type of training was used to educate the staff on proper incontinence care. A follow-up interview on 06/23/26 at 2:38 P.M. with the DON revealed when asked what the proper procedure was for hand hygiene and glove usage during perineal care she would not confirm the appropriate process for performing incontinence care and just stated she would have to reference the facility policy to determine if the CNA's completed it appropriately. Review of the facility policy titled, Perineal Care, revised 10/2010, revealed for female residents, wash perineal area wiping front to back. Wash the labia area first using a downward front to back motion then moving from inside outward toward thigh. Have the residents turn to side and then wash rectal area. Do not reuse the same washcloth or water to clean the labia. Following cleaning of the rectum discard (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365665	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Wind Health Care Center	300 23rd Street NE Massillon, OH 44646

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disposable items and remove gloves and wash and dry hands prior to touching resident's environment including bed covers and call light.This deficiency represents non-compliance identified under Complaint Number 2581134, 2571934 and 2705905.