

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Morrow Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE St Rt 314 North Chesterville, OH 43317	
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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review the facility failed to ensure resident funds were timely dispersed to the resident's representative in a timely manner. This affected one resident (#34) of one reviewed for dispersed funds. The facility census was 28. Findings include: Review of Resident #34's closed medical records revealed an admission date of [DATE] and a deceased date of [DATE]. Interview on [DATE] at 2:12 P.M. with Business Office Manager (BOM) #145 revealed she had received information a check had been issued in the amount of \$6523.67 on [DATE] for Resident #34. BOM #145 stated she was unaware of the date when Resident #34's funds had been issued to her power of attorney (POA) and stated she had only been aware the funds had been dispersed. BOM #145 stated she was unaware of when funds were to be dispersed following a residents passing. Telephone interview on [DATE] at 2:36 P.M. with Corporate Accounts Receivable (CAR) #160 revealed she had created the paperwork for a refund of Resident #34's funds on [DATE] and had given the paperwork to the owner of the company. CAR #160 stated she had not received the paperwork back from the owner and stated she had turned it in again on [DATE] and stated she was then given authorization to disperse the funds on [DATE] in the amount of \$6253.67. CAR #160 stated she was unaware of a timeframe as to when funds were supposed to be dispersed following a residents death. Review of facility policy titled Resident Rights-Medicaid/Medicare Coverage/Liability Notice undated, revealed the facility must refund a residents representative any and all funds within thirty days from the residents' date of discharge. This deficiency represents non-compliance investigated under complaint 1395310.		

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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