

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365902	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Meadowbrook Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  3090 Five Points Hartford Fowler, OH 44418	

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)
<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570</b></p> <p>Based on record review and interview the facility did not ensure a complete summary of discharge was provided to Resident #27 for continuation of necessary care and services at home. This effected one resident (Resident #27) of three residents reviewed for discharge. The facility census was 26.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] and discharged home on 08/28/24. Medical diagnoses included pressure induced deep tissue damage of the back, buttocks and hip, paraplegia, immobile, bacteremia, pressure ulcer right heel stage four, chronic pain, neuromuscular dysfunction of bladder, anemia, sacral ulcer stage four, hip dislocation, anxiety, protein calorie malnutrition, sepsis, colostomy, and need for assistance for personal care.</p> <p>Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #27 entered the facility on 07/19/24 from a hospital. Resident #27 had good cognition. Lower extremity range of motion was impaired on both sides and the resident required set up assistance for eating, moderate assistance for oral hygiene and toilet hygiene, dependent for bathing, moderate assistance for upper body dressing and maximal assistance for lower body dressing, moderate assistance to roll left and right in bed, sit on the side of bed and lie back in bed. Resident #27 did not sit to stand, was dependent to transfer to chair and toilet transfer. Resident #27 did not walk ten feet. Resident participated in goal setting. There was no legal guardian or representative. Overall goal was discharge to the community.</p> <p>Review of the care plan dated 08/01/24 revealed Resident #27 intended to return home after completing skilled stay. Interventions included make arrangements with required community resources to support independence post discharge such as home care, physical therapy, occupational therapy, doctors, wound nurse and to make necessary referrals as needed.</p> <p>Review of the physician treatment order dated 08/14/24 revealed Resident #27 was ordered barrier cream to the sacrum and scrotum every shift and as needed.</p> <p>Review of the Physical Therapy Discharge Summary dated 08/15/24 written by Physical Therapist (PT) #337 revealed discharge recommendations included a home exercise program, in-home aid twenty-four care and an air mattress.</p> <p>(continued on next page)</p>

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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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician treatment order dated 08/22/24 revealed Resident #27 had orders to cleanse coccyx with Vashe, pat dry, apply small amount of zinc to peri wound. Pack wound bed with collagen and silver and calcium alginate and cover with dry dressing.</p> <p>Review of the physician treatment orders dated 08/28/24 revealed Resident #27 had an order to cleanse right hip with twenty-five percent Dakins, apply skin preparation to outer edges of wound. Pack with silver alginate and cover with dry dressing.</p> <p>Review of the progress note dated 08/28/24 revealed the resident was sent home via personal vehicle with a seven day supply of medication and palliative care.</p> <p>Review of physician orders dated 08/29/24 revealed an order for Resident #27 to be discharged home.</p> <p>Review of the facility document titled IDT Discharge Summary V-2 dated 08/27/24 and provided by the Administrator revealed under section B1 Treatments it was indicated the resident had a pressure ulcer to his sacrum and for a right hip wound the type was listed as other. There were no measurements listed and treatments said to see orders. Under section C Appointments there were no names, phone numbers or date/time of follow up appointments listed for continuation of care after discharge. Under the Physical Therapy section it was indicated N/A for physical therapy and stated resident has specialty equipment at home, but no specific equipment was listed such as the air mattress that was recommended in the Physical Therapy Discharge Summary. At the bottom of the last page (page eight) was written 08/12 met with resident concerning discharge. Resident did not want any services. Stated I already have help in place. This was signed by the Administrator. There was no signature from the resident on this document, and this document was in the electronic medical record.</p> <p>Review of a second facility document provided to the surveyor and titled IDT-Discharge Summary V-2 dated 08/27/24 (this was provided after the first IDT Discharge Summary V-2 from the electronic medical record) and revealed under section B1 Treatments it was indicated the resident had a pressure ulcer to his sacrum and the right hip area wound type listed as other. There were no measurements listed and treatments said to see orders. Under section C Appointments there were no names, phone numbers or date/time of follow up appointments listed for continuation of care after discharge. Under the Physical Therapy section it was indicated N/A for physical therapy and stated resident has specialty equipment at home, but no specific equipment was listed such as the air mattress that was recommended in the Physical Therapy Discharge Summary. On the last page (page eight) there was a signature from the resident dated 08/28/24 instead of the written statement from the Administrator as noted prior. This discharge summary was located from the paper hard chart and did not have an attached list of treatment orders for his wound care.</p> <p>Interview on 10/08/24 at 2:30 P.M. with the Director of Nursing (DON) revealed the facility was to verify if the resident was safe for discharge. Resident #27 threatened to leave against medical advice so the facility had to provide a quick discharge.</p> <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/08/24 at 3:31 P.M. with Social Service Designee (SSD) #309 revealed no referrals were made by the facility for wound care or other home-based services on the Discharge Summary because Resident #27 left before discharge plans were put in place. SSD #309 stated the Administrator was the interim social worker before SSD #309 started at the facility two months ago. SSD #309 said the Administrator met with Resident #27 on 08/12/24 to discuss discharge but did not document in the progress notes. SSD #309 stated Resident #27 had stated to the facility he had planned for wound care and nurse assistance at home so the facility did not follow up with wound care needs and nurse care needs for discharge home.</p> <p>Interview on 10/08/24 at 3:36 P.M. with the DON revealed Resident #27 did not give the name of his preferred wound care provider or nurse provider, therefore the facility did not follow up or make arrangements for wound care needs at discharge.</p> <p>Interview on 10/09/24 at 8:23 A.M. with Resident #27's mother, who was his primary contact, revealed Resident #27 did not have wound care or nurse care set up at home after discharge so he was going to have to do his own wound care.</p> <p>Interview on 10/09/24 at 11:00 A.M. with Occupational Therapist #338, who worked with Resident #27, revealed Resident #27 wound not be able to care for his wounds on his own at home.</p> <p>Interview on 10/09/24 at 11:34 A.M. revealed the Administrator verified she did not document discharge planning in the electronic medical record progress notes while acting as the interim social service designee but did document in her personal notebook which was not part of the legal medical record. The Administrator also verified the paper copy of the Discharge Summary document with the resident's signature did not have physician treatment orders attached to it, and verified the electronic copy of the Discharge Summary did not have the resident's signature on it.</p> <p>Interview on 10/09/24 at 12:09 P.M. with PT #337, who worked with Resident #27, revealed Resident #27 would need a home health care agency nurse for wound care to ensure the correct procedure was done.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158232.</p>		

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<p>F 0921</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>47570</p> <p>Based on observation, staff interview and document review, the facility failed to maintain a sanitary environment. This had the potential to effect all 26 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the document titled State of Ohio Food Inspection Report, dated 09/20/24, revealed there was several spots on the wall in the back storage room, near the mop closet and near the stairway that had dark colored growth on the walls. It was noted the inspector was concerned the water that leaked from the ceiling or walls caused the dark colored growth in the kitchen area.</p> <p>An observation on 10/08/24 at 11:24 A.M. with the Maintenance Director (MD) #330 revealed a black-like substance resembling mold growth on the lower northwest wall leading into the kitchen. Additionally, the facility stored resident service wear on plastic shelves and a freezer was positioned in front of this wall.</p> <p>An Interview conducted on 10/08/24 at 11:26 A.M. with MD #330 confirmed the presence of a black-like substance on the wall leading to the kitchen, as well as behind the plastic shelving and a freezer.</p> <p>An interview with the Director of Nursing and the Administrator on 10/08/24 revealed they were aware of the results of the local county health inspection since 09/20/24 regarding the dark colored growth on the wall leading into the kitchen.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158268.</p>		