STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365902	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility self-reported incident (SRI) and investigation review, the facility failed to ensure a SRI was thoroughly investigated related to an allegation of resident-to-resident sexual abuse. This affected two residents (#16 and #49) of five residents reviewed for abuse. The facility census was 47. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 05/06/24. Diagnoses included dementia, diabetes, chronic obstructive pulmonary disease (COPD), kidney disease, restlessness and agitation, and anxiety. Review of the care plan dated 05/01/25 revealed Resident #16 wandered up and down hallways and into other resident's rooms. Interventions included engaging the resident in activities, moving him into a less stimulating area and redirecting him as needed. Resident #16 also made sexually inappropriate advances towards staff members and mistook a female resident as his wife, becoming verbally and physically aggressive when redirected. Interventions included analyzing key times, places, circumstances, and triggers and documenting, assessing, and anticipating the residents' needs, administering medication as ordered and psychiatric consultations as needed. Review of the nursing dated 06/21/25 at 6:15 P.M. revealed Resident #16 was noted to be completely naked sitting on the side of his bed. The behavior was identified as new for the resident, and he was placed on 15-minute checks while he was in his room. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was severely cognitively impaired. He required setup help for eating, oral hygiene, toileting, supervision for showering and substantial or maximum assistance for personal hygiene. He displayed behaviors including but not limited to hitting or scratching himself, pacing, public sexual acts, and disrobing in public. Review of the Psychiatric Nurse Practitioner (NP) #202's note dated 07/02/25 revealed she was asked to see Resident #16 due to an episode of sexually inappropriate behavior. According to facility staff, Resident #16 was found nude and exposed himself to another resident. The Director of Nursing (DON) revealed Resident #16 had been on medication in the past for sexually inappropriate behaviors. She placed Resident #16 on Tagamet for sexually inappropriate behavior. Review of the physicians' orders for August 2025 revealed an order for Tagamet 200 milligrams (mg) at bedtime for unspecified mood disorder. The order began on 07/04/25. 2. Review of the medical record for Resident #49 revealed an admission date of 08/18/21 and a discharge date of 08/18/25. Diagnoses included dementia, anxiety, insomnia, depression and a need for assistance with personal care. Review of the care plan dated 06/10/25 revealed Resident #49 had a communication problem and was able to respond with general, yes or no responses. Interventions included anticipating the resident's needs, encouraging the resident to state her thoughts even if having difficulty, asking yes or no questions, and monitoring for physical or nonverbal indicators of distress. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #49 was severely cognitively impaired. She was dependent on staff for all activities of daily living and displayed no behaviors. Review of the nursing note dated 08/13/25 at 9:00 P.M. revealed Resident #16 was observed in Resident #49's room sitting on her bed. Resident #49's incontinence brief was opened and down. Resident #16 was observed rubbing Resident #49's private area inappropriately. Resident #16 was asked to leave the room and placed on one-to-one supervision. Both Resident #16 and Resident #49's physicians and responsible parties were notified. Review of SRI tracking number 264021 dated 08/13/25 revealed on 08/13/25 at approximately 9:00 P.M., Licensed Practical Nurse (LPN) #200 observed Resident #16 in Resident #49's room sitting on her bed. Resident #16 was observed rubbing Resident #49's private area inappropriately. LPN #200 asked Resident #16 to leave the room, and he was placed on one-to-one supervision. The Administrator and DON were notified. LPN #200 and the DON performed a full body assessment on Resident #49, and no injuries were noted. Resident #49's physician was notified, and she was placed on 15-minute checks. Witness statements obtained in the investigation revealed no evidence when Resident #16 was last seen or checked on by staff prior to the incident to determine how long the Resident #16 was in Resident #49's room. Interview on 08/26/25 at 10:14 A.M. with the DON revealed he received a call from LPN #200 on 08/13/25 informing him Resident #16 was sitting on Resident #49's bed. Resident #49 was described as sitting on the edge of her bed with her incontinence brief down. Resident #16 was touching her private area. LPN #200 immediately separated the residents and assessed Resident #49; no negative findings were discovered. Resident #16 was placed on one-to-one supervision, and Resident #49 was placed on 15-minute checks. Both residents' physicians and families were notified. A referral was made to a psychiatric inpatient facility for Resident #16; Resident #16

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure Resident #16, who was cognitively impaired and had a history of wandering and sexually inappropriate behaviors, received appropriate supervision to ensure the safety of Resident #49. This affected two residents (#16 and #49) of five reviewed for abuse and behavior monitoring. The facility census was 47. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 05/06/24. Diagnoses included dementia, diabetes, chronic obstructive pulmonary disease (COPD), kidney disease, restlessness and agitation, and anxiety. Review of the care plan dated 05/01/25 revealed Resident #16 wandered up and down hallways and into other resident's rooms. Interventions included engaging the resident in activities, moving him into a less stimulating area and redirecting him as needed. Resident #16 also made sexually inappropriate advances towards staff members and mistook a female resident as his wife, becoming verbally and physically aggressive when redirected. Interventions included analyzing key times, places, circumstances, and triggers and documenting, assessing, and anticipating the residents' needs, administering medication as ordered and psychiatric consultations as needed. Review of the nursing dated 06/21/25 at 6:15 P.M. revealed Resident #16 was noted to be completely naked sitting on the side of his bed. The behavior was identified as new for the resident, and he was placed on 15-minute checks while he was in his room. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was severely cognitively impaired. He required setup help for eating, oral hygiene, toileting, supervision for showering and substantial or maximum assistance for personal hygiene. He displayed behaviors including but not limited to hitting or scratching himself, pacing, public sexual acts, and disrobing in public. Review of the psychiatric Nurse Practitioner (NP) #202's note dated 07/02/25 revealed she was asked to see Resident #16 due to an episode of sexually inappropriate behavior. According to facility staff, Resident #16 was found nude and exposed himself to another resident. The Director of Nursing (DON) revealed Resident #16 had been on medication in the past for sexually inappropriate behaviors. She placed Resident #16 on Tagamet for sexually inappropriate behavior. Review of the physicians' orders for August 2025 revealed an order for Tagamet 200 milligrams (mg) at bedtime for unspecified mood disorder. The order began on 07/04/25. 2. Review of the medical record for Resident #49 revealed an admission date of 08/18/21 and a discharge date of 08/18/25. Diagnoses included dementia, anxiety, insomnia, depression and a need for assistance with personal care. Review of the care plan dated 06/10/25 revealed Resident #49 had a communication problem and was able to respond with general, yes or no responses. Interventions included anticipating the resident's needs, encouraging the resident to state her thoughts even if having difficulty, asking yes or no questions, and monitoring for physical or nonverbal indicators of distress. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #49 was severely cognitively impaired. She was dependent on staff for all activities of daily living and displayed no behaviors. Review of the nursing note dated 08/13/25 at 9:00 P.M. revealed Resident #16 was observed in Resident #49's room sitting on her bed. Resident #49's incontinence brief was opened and down. Resident #16 was observed rubbing Resident #49's private area inappropriately. Resident #16 was asked to leave the room and placed on one-to-one supervision. Both Resident #16 and Resident #49's physicians and responsible parties were notified. Interview on 08/26/25 at 10:14 A.M. with the DON revealed he received a call from Licensed Practical Nurse (LPN) #200 on 08/13/25 informing him Resident #16 was sitting on Resident #49's bed. Resident #49 was described as sitting on the edge of her bed with her incontinence brief down. Resident #16 was touching her private area. LPN #200 immediately separated the residents and assessed Resident #49; no negative findings were discovered. Resident #16 was placed on one-to-one supervision, and Resident #49 was placed on 15-minute checks. Both residents' physicians and families were notified. A referral was made to a psychiatric inpatient facility for Resident #16; Resident #16 remained on one-to-one supervision until the transfer to the inpatient psychiatric facility took place. Resident #49 was seen by her psychiatric care team the following day and was assessed with no changes in psychiatric or mental status noted. The DON denied having any knowledge Resident #16 had any history of sexually inappropriate behaviors. Interview on 08/26/25 at 1:19 P.M. with LPN #203 revealed Resident #16 did have a history of wandering, he typically wandered into other people's bedrooms and bathrooms. She said the facility did the best they could in redirecting and monitoring him, but she had no knowledge of the resident being on any type of increased supervision prior to the incident with Resident #49