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	04/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of Self-Reported Incident (SRI) #268530, the state survey agency database for SRI reporting, the facility investigation and facility policy, the facility failed to ensure residents were free from sexual abuse. This affected three residents (Resident #22, #53 and #54) out of six residents reviewed for abuse. The facility census was 50.Findings include: 1. Review of the medical record for Resident #22 revealed she had an admission date of 06/06/25 and her diagnoses included Alzheimer's disease, hypertension, and major depression. She had a friend listed as Power of Attorney (POA) for finance and per the facility the friend did not want involvement in her healthcare decisions. There was not a POA of healthcare and/or guardian listed. There was nothing in her medical record regarding if Resident #22 was evaluated whether she had the capacity to consent to sexual activity. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] (prior to incident) revealed Resident #22's Brief Interview for Mental Status (BIMS) was zero indicating severe cognitive impairment. She required partial to moderate staff assistance with dressing. She was independent with transfers and required supervision with ambulation. Review of the care plan dated 06/30/25 revealed Resident #22 had impaired cognition and impaired thought processes related to Alzheimer's disease. Interventions included asking her yes or no questions to determine needs; cue, reorient and supervise as needed; and keeping her routine consistent. Additional review of the care plan dated 06/30/25 revealed Resident #22 had tearful episodes and was crying out. On 07/25/25 Resident #22 was observed in an inappropriate situation with a male resident. On 12/12/25 Resident #22 was observed in an inappropriate situation with a male resident. There was nothing in her care plan regarding whether she had the capacity to consent to sexual activity or not. Interventions included adjusting voice tone; administering medications as ordered; engaging in activities; leaving over the bed light on for reassurance; psychological consult as needed; frequent observation throughout the shift (added 11/03/25); and checking the resident every 15 minutes (added 12/12/25).Review of nursing note dated 07/25/25 at 4:45 P.M. completed by Agency Licensed Practical Nurse (LPN) #615 revealed prior to dinner the aide informed her that she discovered Resident #22 in bed with another resident. The aide had stated she was checking rooms and looking for Resident #22 and upon walking into Former Resident #53's room she had observed Resident #22 laying beneath Former Resident #53 in the bed and both residents' pants were down. The residents were separated. Review of nursing note dated 12/11/25 at 10:30 P.M. completed by LPN #617 revealed he was notified that when the aides were doing rounds they had noticed Resident #22 was not in her room and they immediately looked in other rooms to find her. Resident #22 was found in another resident's bed (Former Resident #54) with Former Resident #54 sitting beside her. The note revealed both residents were naked with their clothing on the floor. Former Resident #54 had several fingers in her vaginal area and Resident #22 had her legs open allowing access. Both residents were separated and Resident #22 was dressed and taken to her room. Both residents were checked, no injuries were noted and both residents were placed on 15-minute checks. Primary Care Physician (PCP) #610 was notified. Review of Kardex (a brief overview/guideline of a resident) for Resident #22 (continued on next page)

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

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	04/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	dated 04/23/26 revealed under behaviors staff were to distract from wandering by offering pleasant diversions, structured activities, food conversation, and television. Other interventions included adjusting voice and tone; behavior monitoring (no specifics identified); and reapproaching as needed. There was nothing on the Kardex regarding 15-minute checks as per the care plan and there was nothing on the Kardex about sexual inappropriate behaviors. 2. Review of the closed medical record for Former Resident #53 revealed he was admitted on [DATE] and discharged on 09/26/25. His diagnoses included dementia, viral hepatitis C (a liver disease caused by a virus that spreads when blood from an infected person enters another), antisocial personality disorder, and high risk of heterosexual behavior (sexual practices that significantly increase likelihood of sexually transmitted infections) which was added on 07/29/25. He was assigned by the courts a legal guardian and there was nothing in his medical record regarding if Former Resident #53 was evaluated whether he had the capacity to consent to sexual activity. Review of the care plan dated 11/20/24 revealed Former Resident #53 had impaired cognition related to dementia. Interventions included approaching the resident to maximize involvement daily and communicating with the resident regarding his needs. There was nothing in his care plan regarding whether he had the capacity to consent to sexual activity or not. Review of the Quarterly MDS dated [DATE] revealed Former Resident #53 had cognitive impairment as his BIMS was 11. He was independent and/or only required set-up with his activities of daily living tasks including dressing, transfers and ambulation. Review of nursing note dated 07/25/25 at 4:45 P.M. completed by LPN #615 revealed she was informed by the aide prior to dinner upon checking rooms that Resident #22 was discovered in Former Resident #53's room with him lying on top of her in his bed. The two residents were immediately separated and the Director of Nursing (DON) contacted. Former Resident #53 had stated Resident #22 had come into his room, sat on his bed, he rubbed her leg and the aide came in. 3. Review of the closed medical record for Former Resident #54 revealed an admission date of 11/22/25 and he was discharged home on [DATE]. His diagnoses included brief psychotic disorder, dementia, agitation, and hypertension. There was nothing in his medical record regarding if Former Resident #54 was evaluated whether he had the capacity to consent to sexual activity. Review of the Medicare Five Day MDS dated [DATE] revealed Former Resident #54 had impaired cognition as his BIMS score was three. Review of the nursing note dated with a late entry of 12/12/25 at 9:58 A.M. completed by LPN #617 revealed he was notified that when the aides were doing rounds they had noticed Resident #22 was not in her room and they immediately looked in other rooms to find her. Resident #22 was found in another resident's bed (Former Resident #54) with Former Resident #54 sitting beside her. Both residents were naked with their clothing on the floor. Former Resident #54 had several fingers in her vaginal area and Resident #22 had her legs open allowing access. Both residents were separated and Resident #22 was dressed and taken to her room. Both residents were checked, no injuries were noted and both residents were placed on 15-minute checks. PCP #610 was notified. 4. Review of the state survey agency database for SRI reporting from 07/25/25 to 04/21/26 revealed the facility had not filed an SRI regarding the alleged sexual abuse incident that had occurred on 07/25/26 between Resident #22 and Former Resident #53. Review of witness statement dated 07/25/25 completed by Agency Certified Nursing Assistant (CNA) #614 revealed she came off break at 3:45 P.M., Resident #22 had walked up to her at the nursing station, and she also had seen Former Resident #53. She started her rounds, taking residents into the dining room and then started to look for Resident #22 room to room. She walked into Former Resident #53's room at 4:40 P.M. and Former Resident #53 was on top of Resident #22 on his bed with both their pants down. Agency CNA #614 did not see Resident #53's genitals inside her vagina and she had separated the residents immediately. Review of witness statement dated 07/25/25 completed by Agency CNA #616 revealed she was the second CNA on the floor on 07/25/25 at the time of incident but was on break and did not witness the incident between Residents #22 and Former Resident #53. Review of witness statement dated 07/25/25 completed by Agency LPN #615 revealed the CNA reported to her that upon looking for Resident #22 that she walked past Former Resident #53's room (continued on next page)

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	04/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	to find Former Resident #53 on top of Resident #22 and both their pants were down. The CNA immediately separated the residents, and she contacted the Former Director of Nursing (DON) #625. Review of witness statement dated 07/25/25 completed by Infection Control/Assistant Director of Nursing (ADON) #609 revealed she completed a full body assessment for Resident #22 and there was no blood in her brief. There was no bruising, abrasion, skin laceration, and when asked if she was having pain and/or if it hurt she only smiled. She completed a vaginal assessment and no penetration was noted. Review of witness statement dated 07/25/25 completed by Former Administrator #626 and MDS/Registered Nurse (RN) #627 revealed they interviewed Former Resident #53, and he had stated he was sitting on his bed when the lady came into his room and sat on his bed. He stated she did not say anything, she was just looking at him, and he was rubbing her leg. He stated she had black pants on, and a top and the aide came in and said, Both y'all get up. He denied kissing her and stated that both of their pants were on. Interview on 04/22/26 at 12:45 P.M. with Regional Director #612, Regional Nurse/Registered Nurse (RN) #600, and Infection Control/ADON #609 verified Former Resident #53 was on top of Resident #22 in Resident #53's bed and both of their pants were down. They verified Former Resident #53 had a diagnosis of Hepatitis C and as precaution PCP #610 had ordered lab testing for Resident #22. They also verified the police were not contacted regarding the incident and that there was no documentation Former Resident #53's guardian was asked regarding police involvement. They verified Resident #22 had a friend listed as her POA of finance, but the friend did not want anything to do with her healthcare. When asked who made Resident #22's decisions since she had severe cognitive impairment they stated that nobody did right now. They verified the incident was not reported to the state agency including making a self-reported incident and they had only completed an internal investigation. Interview on 04/22/26 at 3:47 P.M. with the DON and Infection Control/ADON #609 verified there was not an assessment/evaluation completed prior to the incident on 07/25/25 and/or after it for either Resident #22 or Former Resident #53 whether they had the capacity to consent to sexual activity. They stated they only go by the BIMS score and if the resident scored 12 or above then they would be able to give consent and if they scored below they were not able. They stated they felt both residents, Resident #22 and Former Resident #53 could not give consent for sexual activity based on their BIMS score. Interview on 04/22/26 at 4:21 P.M. with Agency CNA #614 revealed she no longer went to the facility because of the incident on 07/25/25 as she stated it was disturbing it just was not right. She revealed she had walked in and found Former Resident #53 on top of Resident #22 in his bed, and they did not have any clothing on below the waist. She yelled get off of her and he jumped up. She was unsure if sexual activity had occurred as when she yelled he jumped up fast. She assisted Resident #22 off his bed and walked her to the nurse. She stated it was difficult to know if Resident #22 was affected by the incident as she always had a distressed look on her face. 5. Review of SRI #268530 dated 12/11/25 for alleged sexual abuse with another resident revealed on 12/11/25 at 10:30 P.M. an aide observed two residents, Former Resident #54 and Resident #22, engaged in inappropriate touch on the secured dementia unit. The residents were immediately separated, assessed by the nurse and placed on 15-minute checks. No injuries were identified. On 12/13/25, Former Resident #54 was discharged home with his wife. The facility unsubstantiated the SRI for sexual abuse. Review of witness statement dated 12/11/25 completed by LPN #617 revealed during rounds, the aides noticed that Resident #22 was not in her room and found her in Former Resident #54's room. Both residents were naked and their clothing was on the floor. The aide observed Former Resident #54 with his hand in Resident #22's groin region. The aide immediately separated them and called for assistance. Skin checks were completed, 15-minute checks were implemented, and PCP #610 was notified. Review of witness statement dated 12/11/25 completed by CNA #619 revealed on 12/11/25 around 10:30 P.M. they were completing rounds and when checking, Resident #22 was not in her bed. Another aide went into Former Resident #54's room, hollered out for her and saw Resident #22's pants and incontinent pull-up was off and Former Resident #54 naked. Former Resident #54 had stated, she wanted. Both (continued on next page)

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	04/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	residents were separated and they got the nurse. Review of witness statement dated 12/11/25 and completed by CNA #618 revealed on 12/11/25 at 10:30 P.M. she was doing rounds and could not find Resident #22. She went looking room to room and walked into Former Resident #54's room and he had the curtain pulled. She walked over, pulled the curtain and saw Resident #22 with her pants and incontinent pull-up off and Former Resident #54 naked. Former Resident #54 had his fingers in her vagina and stated she wanted it. She pulled him away and called for help. Interview on 04/23/26 at 7:58 A.M. with CNA #603 revealed she worked on the second floor Monday through Thursday where Resident #22 resided and was not aware of anyone on special checks including 15-minute checks. She checked on each resident every hour including Resident #22. Interview on 04/23/26 at 8:03 A.M. with Agency RN #620 revealed it was his first time at the facility, and he was assigned to the second floor where Resident #22 resided. He was not aware of any residents on the unit that were on special monitoring including 15-minute checks and had not received anything in report. Interview on 04/23/26 at 8:06 A.M. with CNA #605 revealed she worked on the second floor Monday through Thursday, where Resident #22 resided and was not aware of anyone on special checks including 15-minute checks. She routinely checked all residents but there were no formal checks that she was aware of. Interview on 04/23/26 at 9:53 A.M. with PCP #610 revealed she was the PCP for Resident #22 and Former Resident #53. This surveyor read the nursing note dated 07/25/25 regarding the incident to PCP #610 and in response she stated she was not aware of the explicit details of the incident but she was aware of a potential sexual encounter and they were not sure if penetration had occurred which was why she had ordered the Hepatitis C testing for Resident #22 as Former Resident #53 had a diagnosis of Hepatitis C. She stated Resident #22 could not give informed consent as when she attempted to ask Resident #22 any questions, the resident just looked in her eyes with a blank stare and did not communicate. She felt Former Resident #53 was able to give informed consent for sexual activity as he could verbalize that he wanted to have sex and could give consent. PCP #610 was asked what preventative interventions were ordered after the incident on 07/25/25 and she stated there was a facility protocol they followed for a sexually inappropriate incident, but she did not know it off hand and would have to get it from the facility. She was not sure what monitoring standards they had in place. This surveyor read the incident that had occurred on 12/11/25 and PCP #610 stated the incident did not sound familiar and did not feel she was notified. She was not familiar with who Former Resident #54 was and did not feel she ever met him, so she was unable to provide whether he was able to give informed consent for sexual activity. She revealed after both incidents were reviewed what recommendations and/or interventions were needed to ensure safety. She stated if she had known about the second incident, to be honest it was not feasible to keep Resident #22 and other residents safe especially with only having two aides on the second floor. Resident #22 almost needed one-on-one because whenever she was at the facility, Resident #22 ambulated all over, and was fast as she had to chase her around just to get an assessment completed. She stated either one-on-one or a facility with all women as, I do not see how to keep her and others safe otherwise. Interview on 04/23/26 at 10:15 A.M. with Regional Nurse/RN #600, DON and Infection Control/ADON #609 verified they were not aware of a protocol that the facility implemented if an incident of alleged sexual abuse occurred or standard protocols that were to be implemented including specific monitoring. They verified per the care plan Resident #22 was to be on 15-minute checks but on staff interviews staff were not completing it. They revealed they felt it was a documentation error as Resident #22 was to be no longer on 15-minute checks and that was why staff were not doing them. They stated they were unaware PCP #610 was not aware of the incident on 12/11/25 involving Resident #22 and Former Resident #54, and unaware PCP #610 felt the only way to keep Resident #22 safe, as well as others, was with one-on-one or a facility with all women since PCP #610 had not shared that with them. Review of facility policy labeled, Identifying Types of Abuse last revised 2022 revealed sexual abuse was non-consensual sexual conduct of any type with a resident. Sexual abuse incidents included but not limited to unwanted intimate touching of any kind especially breasts and (continued on next page)

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	04/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	perineal area, and all types of sexual assault or battery. Sexual contact was nonconsensual if the residents appeared to want the contact to occur but lacked the cognitive ability to consent. Residents had the right to engage in consensual activity however anytime there was reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility would take steps to ensure the resident was protected from abuse including evaluating whether the resident had the capacity to consent to sexual activity. Review of facility policy labeled, Residents Right to Freedom from Abuse, Neglect, and Exploitation dated 2025 revealed the purpose of the policy was to ensure residents were free from abuse. Residents had the right to engage in consensual sexual activity; however, anytime the facility had reason to suspect that a resident may not have the capacity to consent to sexual activity the facility would take steps to ensure that the resident was protected from abuse. These steps shall include evaluating whether the resident had capacity to consent to sexual activity. When the facility identified abuse, the facility would take all appropriate steps to remediate the noncompliance and protect residents from additional abuse. The policy revealed the facility would report the alleged violation and investigate within the required timeframes pursuant to Federal and State statutes and regulations. The policy revealed the facility would report the results of all investigation to the Administrator or designee and to other officials including the state survey agency within five working days of the incident.

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	04/28/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of Self-Reported Incident (SRI) #268530, the state survey agency database for SRI reporting, the facility investigation and facility policy, the facility failed to report to the state survey agency and/or local law enforcement an allegation of sexual abuse. This affected two residents (Residents #22 and #53) out of six residents reviewed for abuse. The facility census was 50.Findings include: 1. Review of the medical record for Resident #22 revealed she had an admission date of 06/06/25 and her diagnoses included Alzheimer's disease, hypertension, and major depression. She had a friend listed as Power of Attorney (POA) for finance and per the facility the friend did not want involvement in her healthcare decisions. There was not a POA of healthcare and/or guardian listed. There was nothing in her medical record regarding if Resident #22 was evaluated whether she had the capacity to consent to sexual activity. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] (prior to incident) revealed Resident #22's Brief Interview for Mental Status (BIMS) was zero indicating severe cognitive impairment. She required partial to moderate staff assistance with dressing. She was independent with transfers and required supervision with ambulation. Review of the care plan dated 06/30/25 revealed Resident #22 had impaired cognition and impaired thought processes related to Alzheimer's disease. Interventions included asking her yes or no questions to determine needs; cue, reorient and supervise as needed; and keeping her routine consistent. Additional review of the care plan dated 06/30/25 revealed Resident #22 had tearful episodes and was crying out. On 07/25/25 Resident #22 was observed in an inappropriate situation with a male resident. There was nothing in her care plan regarding whether she had the capacity to consent to sexual activity or not. Review of nursing note dated 07/25/25 at 4:45 P.M. completed by Agency Licensed Practical Nurse (LPN) #615 revealed prior to dinner the aide informed her that she discovered Resident #22 in bed with another resident. The aide had stated she was checking rooms and looking for Resident #22 and upon walking into Former Resident #53's room she had observed Resident #22 laying beneath Former Resident #53 in the bed and both residents' pants were down. The residents were separated. 2. Review of the closed medical record for Former Resident #53 revealed he was admitted on [DATE] and discharged on 09/26/25. His diagnoses included dementia, viral hepatitis C (a liver disease caused by a virus that spreads when blood from an infected person enters another), antisocial personality disorder, and high risk of heterosexual behavior (sexual practices that significantly increase likelihood of sexually transmitted infections) which was added on 07/29/25. He was assigned by the courts a legal guardian and there was nothing in his medical record regarding if Former Resident #53 was evaluated whether he had the capacity to consent to sexual activity. Review of the care plan dated 11/20/24 revealed Former Resident #53 had impaired cognition related to dementia. Interventions included approaching the resident to maximize involvement daily and communicating with the resident regarding his needs. There was nothing in his care plan regarding whether he had the capacity to consent to sexual activity or not. Review of the Quarterly MDS dated [DATE] revealed Former Resident #53 had cognitive impairment as his BIMS was 11. He was independent and/or only required set-up with his activities of daily living tasks including dressing, transfers and ambulation. Review of nursing note dated 07/25/25 at 4:45 P.M. completed by LPN #615 revealed she was informed by the aide prior to dinner upon checking rooms that Resident #22 was discovered in Former Resident #53's room with him lying on top of her in his bed. The two residents were immediately separated and the Director of Nursing (DON) contacted. Former Resident #53 had stated Resident #22 had come into his room, sat on his bed, he rubbed her leg and the aide came in. 3. Review of the state survey agency database for SRI reporting from 07/25/25 to 04/21/26 revealed the facility had not filed an SRI regarding the alleged sexual abuse incident that had occurred on 07/25/26 between Resident #22 and Former Resident #53. Review of (continued on next page)

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	04/28/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	witness statement dated 07/25/25 completed by Agency Certified Nursing Assistant (CNA) #614 revealed she came off break at 3:45 P.M., Resident #22 had walked up to her at the nursing station, and she also had seen Former Resident #53. She started her rounds, taking residents into the dining room and then started to look for Resident #22 room to room. She walked into Former Resident #53's room at 4:40 P.M. and Former Resident #53 was on top of Resident #22 on his bed with both their pants down. Agency CNA #614 did not see Resident #53's genitals inside her vagina and she had separated the residents immediately. Review of witness statement dated 07/25/25 completed by Agency CNA #616 revealed she was the second CNA on the floor on 07/25/25 at the time of incident but was on break and did not witness the incident between Residents #22 and Former Resident #53. Review of witness statement dated 07/25/25 completed by Agency LPN #615 revealed the CNA reported to her that upon looking for Resident #22 that she walked past Former Resident #53's room to find Former Resident #53 on top of Resident #22 and both their pants were down. The CNA immediately separated the residents, and she contacted the Former Director of Nursing (DON) #625. Review of witness statement dated 07/25/25 completed by Infection Control/Assistant Director of Nursing (ADON) #609 revealed she completed a full body assessment for Resident #22 and there was no blood in her brief. There was no bruising, abrasion, skin laceration, and when asked if she was having pain and/or if it hurt she only smiled. She completed a vaginal assessment and no penetration was noted. Review of witness statement dated 07/25/25 completed by Former Administrator #626 and MDS/Registered Nurse (RN) #627 revealed they interviewed Former Resident #53, and he had stated he was sitting on his bed when the lady came into his room and sat on his bed. He stated she did not say anything, she was just looking at him, and he was rubbing her leg. He stated she had black pants on, and a top and the aide came in and said, Both y'all get up. He denied kissing her and stated that both of their pants were on. Interview on 04/22/26 at 12:45 P.M. with Regional Director #612, Regional Nurse/Registered Nurse (RN) #600, and Infection Control/ADON #609 verified Former Resident #53 was on top of Resident #22 in Resident #53's bed and both of their pants were down. They verified Former Resident #53 had a diagnosis of Hepatitis C and as precaution PCP #610 had ordered lab testing for Resident #22. They also verified the police were not contacted regarding the incident and that there was no documentation Former Resident #53's guardian was asked regarding police involvement. They verified Resident #22 had a friend listed as her POA of finance, but the friend did not want anything to do with her healthcare. When asked who made Resident #22's decisions since she had severe cognitive impairment they stated that nobody did right now. They verified the incident was not reported to the state agency including making a self-reported incident and they had only completed an internal investigation. Interview on 04/22/26 at 3:47 P.M. with the DON and Infection Control/ADON #609 verified there was not an assessment/evaluation completed prior to the incident on 07/25/25 and/or after it for either Resident #22 or Former Resident #53 whether they had the capacity to consent to sexual activity. They stated they only go by the BIMS score and if the resident scored 12 or above then they would be able to give consent and if they scored below they were not able. They stated they felt both residents, Resident #22 and Former Resident #53 could not give consent for sexual activity based on their BIMS score. Interview on 04/22/26 at 4:21 P.M. with Agency CNA #614 revealed she no longer went to the facility because of the incident on 07/25/25 as she stated it was disturbing it just was not right. She revealed she had walked in and found Former Resident #53 on top of Resident #22 in his bed, and they did not have any clothing on below the waist. She yelled get off of her and he jumped up. She was unsure if sexual activity had occurred as when she yelled he jumped up fast. She assisted Resident #22 off his bed and walked her to the nurse. She stated it was difficult to know if Resident #22 was affected by the incident as she always had a distressed look on her face. Interview on 04/23/26 at 9:53 A.M. with PCP #610 revealed she was the PCP for Resident #22 and Former Resident #53. This surveyor read the nursing note dated 07/25/25 regarding the incident to PCP #610 and in response she stated she was not aware of the explicit details of the incident but she was aware of a potential sexual (continued on next page)

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	04/28/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	encounter and they were not sure if penetration had occurred which was why she had ordered the Hepatitis C testing for Resident #22 as Former Resident #53 had a diagnosis of Hepatitis C. She stated Resident #22 could not give informed consent as when she attempted to ask Resident #22 any questions, the resident just looked in her eyes with a blank stare and did not communicate. She felt Former Resident #53 was able to give informed consent for sexual activity as he could verbalize that he wanted to have sex and could give consent. Review of facility policy labeled, Identifying Types of Abuse last revised 2022 revealed sexual abuse was non-consensual sexual conduct of any type with a resident. Sexual abuse incidents included but not limited to unwanted intimate touching of any kind especially breasts and perineal area, and all types of sexual assault or battery. Sexual contact was nonconsensual if the residents appeared to want the contact to occur but lacked the cognitive ability to consent. Residents had the right to engage in consensual activity however anytime there was reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility would take steps to ensure the resident was protected from abuse including evaluating whether the resident had the capacity to consent to sexual activity. Review of facility policy labeled, Residents Right to Freedom from Abuse, Neglect, and Exploitation dated 2025 revealed the purpose of the policy was to ensure residents were free from abuse. Residents had the right to engage in consensual sexual activity; however, anytime the facility had reason to suspect that a resident may not have the capacity to consent to sexual activity the facility would take steps to ensure that the resident was protected from abuse. These steps shall include evaluating whether the resident had capacity to consent to sexual activity. When the facility identified abuse, the facility would take all appropriate steps to remediate the noncompliance and protect residents from additional abuse. The policy revealed the facility would report the alleged violation and investigate within the required timeframes pursuant to Federal and State statutes and regulations. The policy revealed the facility would report the results of all investigation to the Administrator or designee and to other officials including the state survey agency within five working days of the incident.

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	04/28/2026

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 Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of Self-Reported Incident (SRI) #268530, the facility investigation and facility policy, the facility failed to ensure preventative measures were implemented to prevent sexual abuse. This affected three residents (Residents #22, #53 and #54) out of six residents reviewed for abuse. The facility census was 50. Findings include: 1. Review of the medical record for Resident #22 revealed she had an admission date of 06/06/25 and her diagnoses included Alzheimer's disease, hypertension, and major depression. She had a friend listed as Power of Attorney (POA) for finance and per the facility the friend did not want involvement in her healthcare decisions. There was not a POA of healthcare and/or guardian listed. There was nothing in her medical record regarding if Resident #22 was evaluated whether she had the capacity to consent to sexual activity. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] (prior to incident) revealed Resident #22's Brief Interview for Mental Status (BIMS) was zero indicating severe cognitive impairment. She required partial to moderate staff assistance with dressing. She was independent with transfers and required supervision with ambulation. Review of the care plan dated 06/30/25 revealed Resident #22 had impaired cognition and impaired thought processes related to Alzheimer's disease. Interventions included asking her yes or no questions to determine needs; cue, reorient and supervise as needed; and keeping her routine consistent. Additional review of the care plan dated 06/30/25 revealed Resident #22 had tearful episodes and was crying out. On 07/25/25 Resident #22 was observed in an inappropriate situation with a male resident. On 12/12/25 Resident #22 was observed in an inappropriate situation with a male resident. There was nothing in her care plan regarding whether she had the capacity to consent to sexual activity or not. Interventions included adjusting voice tone; administering medications as ordered; engaging in activities; leaving over the bed light on for reassurance; psychological consult as needed; frequent observation throughout the shift (added 11/03/25); and checking the resident every 15 minutes (added 12/12/25).Review of nursing note dated 07/25/25 at 4:45 P.M. completed by Agency Licensed Practical Nurse (LPN) #615 revealed prior to dinner the aide informed her that she discovered Resident #22 in bed with another resident. The aide had stated she was checking rooms and looking for Resident #22 and upon walking into Former Resident #53's room she had observed Resident #22 laying beneath Former Resident #53 in the bed and both residents' pants were down. The residents were separated. Review of nursing note dated 12/11/25 at 10:30 P.M. completed by LPN #617 revealed he was notified that when the aides were doing rounds they had noticed Resident #22 was not in her room and they immediately looked in other rooms to find her. Resident #22 was found in another resident's bed (Former Resident #54) with Former Resident #54 sitting beside her. The note revealed both residents were naked with their clothing on the floor. Former Resident #54 had several fingers in her vaginal area and Resident #22 had her legs open allowing access. Both residents were separated and Resident #22 was dressed and taken to her room. Both residents were checked, no injuries were noted and both residents were placed on 15-minute checks. Primary Care Physician (PCP) #610 was notified. Review of Kardex (a brief overview/guideline of a resident) for Resident #22 dated 04/23/26 revealed under behaviors staff were to distract from wandering by offering pleasant diversions, structured activities, food conversation, and television. Other interventions included adjusting voice and tone; behavior monitoring (no specifics identified); and reapproaching as needed. There was nothing on the Kardex regarding 15-minute checks as per the care plan and there was nothing on the Kardex about sexual inappropriate behaviors. 2. Review of the closed medical record for Former Resident #53 revealed he was admitted on [DATE] and discharged on 09/26/25. His diagnoses included dementia, viral hepatitis C (a liver disease caused by a virus that spreads when blood from an infected person enters another), antisocial personality disorder, and high risk of heterosexual behavior (sexual practices that significantly increase likelihood of sexually transmitted (continued on next page)

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	04/28/2026

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 Note: The nursing home is disputing this citation.	infections) which was added on 07/29/25. He was assigned by the courts a legal guardian and there was nothing in his medical record regarding if Former Resident #53 was evaluated whether he had the capacity to consent to sexual activity. Review of the care plan dated 11/20/24 revealed Former Resident #53 had impaired cognition related to dementia. Interventions included approaching the resident to maximize involvement daily and communicating with the resident regarding his needs. There was nothing in his care plan regarding whether he had the capacity to consent to sexual activity or not. Review of the Quarterly MDS dated [DATE] revealed Former Resident #53 had cognitive impairment as his BIMS was 11. He was independent and/or only required set-up with his activities of daily living tasks including dressing, transfers and ambulation. Review of nursing note dated 07/25/25 at 4:45 P.M. completed by LPN #615 revealed she was informed by the aide prior to dinner upon checking rooms that Resident #22 was discovered in Former Resident #53's room with him lying on top of her in his bed. The two residents were immediately separated and the Director of Nursing (DON) contacted. Former Resident #53 had stated Resident #22 had come into his room, sat on his bed, he rubbed her leg and the aide came in. 3. Review of the closed medical record for Former Resident #54 revealed an admission date of 11/22/25 and he was discharged home on [DATE]. His diagnoses included brief psychotic disorder, dementia, agitation, and hypertension. There was nothing in his medical record regarding if Former Resident #54 was evaluated whether he had the capacity to consent to sexual activity. Review of the Medicare Five Day MDS dated [DATE] revealed Former Resident #54 had impaired cognition as his BIMS score was three. Review of the nursing note dated with a late entry of 12/12/25 at 9:58 A.M. completed by LPN #617 revealed he was notified that when the aides were doing rounds they had noticed Resident #22 was not in her room and they immediately looked in other rooms to find her. Resident #22 was found in another resident's bed (Former Resident #54) with Former Resident #54 sitting beside her. Both residents were naked with their clothing on the floor. Former Resident #54 had several fingers in her vaginal area and Resident #22 had her legs open allowing access. Both residents were separated and Resident #22 was dressed and taken to her room. Both residents were checked, no injuries were noted and both residents were placed on 15-minute checks. PCP #610 was notified. 4. Review of witness statement dated 07/25/25 completed by Agency Certified Nursing Assistant (CNA) #614 revealed she came off break at 3:45 P.M., Resident #22 had walked up to her at the nursing station, and she also had seen Former Resident #53. She started her rounds, taking residents into the dining room and then started to look for Resident #22 room to room. She walked into Former Resident #53's room at 4:40 P.M. and Former Resident #53 was on top of Resident #22 on his bed with both their pants down. Agency CNA #614 did not see Resident #53's genitals inside her vagina and she had separated the residents immediately. Review of witness statement dated 07/25/25 completed by Agency LPN #615 revealed the CNA reported to her that upon looking for Resident #22 that she walked past Former Resident #53's room to find Former Resident #53 on top of Resident #22 and both their pants were down. The CNA immediately separated the residents, and she contacted the Former Director of Nursing (DON) #625. Review of witness statement dated 07/25/25 completed by Former Administrator #626 and MDS/Registered Nurse (RN) #627 revealed they interviewed Former Resident #53, and he had stated he was sitting on his bed when the lady came into his room and sat on his bed. He stated she did not say anything, she was just looking at him, and he was rubbing her leg. He stated she had black pants on, and a top and the aide came in and said, Both y'all get up. He denied kissing her and stated that both of their pants were on. Interview on 04/22/26 at 12:45 P.M. with Regional Director #612, Regional Nurse/Registered Nurse (RN) #600, and Infection Control/ADON #609 verified Former Resident #53 was on top of Resident #22 in Resident #53's bed and both of their pants were down. They verified Former Resident #53 had a diagnosis of Hepatitis C and as precaution PCP #610 had ordered lab testing for Resident #22. They also verified the police were not contacted regarding the incident and that there was no documentation Former Resident #53's guardian was asked regarding police involvement. They verified Resident #22 had a friend listed as her POA of finance, but the friend did not want anything to do with (continued on next page)

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	04/28/2026

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 Note: The nursing home is disputing this citation.	her healthcare. When asked who made Resident #22's decisions since she had severe cognitive impairment they stated that nobody did right now. They verified the incident was not reported to the state agency including making a self-reported incident and they had only completed an internal investigation. Interview on 04/22/26 at 3:47 P.M. with the DON and Infection Control/ADON #609 verified there was not an assessment/evaluation completed prior to the incident on 07/25/25 and/or after it for either Resident #22 or Former Resident #53 whether they had the capacity to consent to sexual activity. They stated they only go by the BIMS score and if the resident scored 12 or above then they would be able to give consent and if they scored below they were not able. They stated they felt both residents, Resident #22 and Former Resident #53 could not give consent for sexual activity based on their BIMS score. Interview on 04/22/26 at 4:21 P.M. with Agency CNA #614 revealed she no longer went to the facility because of the incident on 07/25/25 as she stated it was disturbing it just was not right. She revealed she had walked in and found Former Resident #53 on top of Resident #22 in his bed, and they did not have any clothing on below the waist. She yelled get off of her and he jumped up. She was unsure if sexual activity had occurred as when she yelled he jumped up fast. She assisted Resident #22 off his bed and walked her to the nurse. She stated it was difficult to know if Resident #22 was affected by the incident as she always had a distressed look on her face. 5. Review of SRI #268530 dated 12/11/25 for alleged sexual abuse with another resident revealed on 12/11/25 at 10:30 P.M. an aide observed two residents, Former Resident #54 and Resident #22, engaged in inappropriate touch on the secured dementia unit. The residents were immediately separated, assessed by the nurse and placed on 15-minute checks. No injuries were identified. On 12/13/25, Former Resident #54 was discharged home with his wife. The facility unsubstantiated the SRI for sexual abuse. Review of witness statement dated 12/11/25 completed by LPN #617 revealed during rounds, the aides noticed that Resident #22 was not in her room and found her in Former Resident #54's room. Both residents were naked and their clothing was on the floor. The aide observed Former Resident #54 with his hand in Resident #22's groin region. The aide immediately separated them and called for assistance. Skin checks were completed, 15-minute checks were implemented, and PCP #610 was notified. Review of witness statement dated 12/11/25 completed by CNA #619 revealed on 12/11/25 around 10:30 P.M. they were completing rounds and when checking, Resident #22 was not in her bed. Another aide went into Former Resident #54's room, hollered out for her and saw Resident #22's pants and incontinent pull-up was off and Former Resident #54 naked. Former Resident #54 had stated, she wanted. Both residents were separated and they got the nurse. Review of witness statement dated 12/11/25 and completed by CNA #618 revealed on 12/11/25 at 10:30 P.M. she was doing rounds and could not find Resident #22. She went looking room to room and walked into Former Resident #54's room and he had the curtain pulled. She walked over, pulled the curtain and saw Resident #22 with her pants and incontinent pull-up off and Former Resident #54 naked. Former Resident #54 had his fingers in her vagina and stated she wanted it. She pulled him away and called for help. Interview on 04/23/26 at 7:58 A.M. with CNA #603 revealed she worked on the second floor Monday through Thursday where Resident #22 resided and was not aware of anyone on special checks including 15-minute checks. She checked on each resident every hour including Resident #22. Interview on 04/23/26 at 8:03 A.M. with Agency RN #620 revealed it was his first time at the facility, and he was assigned to the second floor where Resident #22 resided. He was not aware of any residents on the unit that were on special monitoring including 15-minute checks and had not received anything in report. Interview on 04/23/26 at 8:06 A.M. with CNA #605 revealed she worked on the second floor Monday through Thursday, where Resident #22 resided and was not aware of anyone on special checks including 15-minute checks. She routinely checked all residents but there were no formal checks that she was aware of. Interview on 04/23/26 at 9:53 A.M. with PCP #610 revealed she was the PCP for Resident #22 and Former Resident #53. This surveyor read the nursing note dated 07/25/25 regarding the incident to PCP #610 and in response she stated she was not aware of the explicit details of the incident but she was aware of a (continued on next page)

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	04/28/2026

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 Note: The nursing home is disputing this citation.	potential sexual encounter and they were not sure if penetration had occurred which was why she had ordered the Hepatitis C testing for Resident #22 as Former Resident #53 had a diagnosis of Hepatitis C. She stated Resident #22 could not give informed consent as when she attempted to ask Resident #22 any questions, the resident just looked in her eyes with a blank stare and did not communicate. She felt Former Resident #53 was able to give informed consent for sexual activity as he could verbalize that he wanted to have sex and could give consent. PCP #610 was asked what preventative interventions were ordered after the incident on 07/25/25 and she stated there was a facility protocol they followed for a sexually inappropriate incident, but she did not know it off hand and would have to get it from the facility. She was not sure what monitoring standards they had in place. This surveyor read the incident that had occurred on 12/11/25 and PCP #610 stated the incident did not sound familiar and did not feel she was notified. She was not familiar with who Former Resident #54 was and did not feel she ever met him, so she was unable to provide whether he was able to give informed consent for sexual activity. She revealed after both incidents were reviewed what recommendations and/or interventions were needed to ensure safety. She stated if she had known about the second incident, to be honest it was not feasible to keep Resident #22 and other residents safe especially with only having two aides on the second floor. Resident #22 almost needed one-on-one because whenever she was at the facility, Resident #22 ambulated all over, and was fast as she had to chase her around just to get an assessment completed. She stated either one-on-one or a facility with all women as, I do not see how to keep her and others safe otherwise. Interview on 04/23/26 at 10:15 A.M. with Regional Nurse/RN #600, DON and Infection Control/ADON #609 verified they were not aware of a protocol that the facility implemented if an incident of alleged sexual abuse occurred or standard protocols that were to be implemented including specific monitoring. They verified per the care plan Resident #22 was to be on 15-minute checks but on staff interviews staff were not completing it. They revealed they felt it was a documentation error as Resident #22 was to be no longer on 15-minute checks and that was why staff were not doing them. They stated they were unaware PCP #610 was not aware of the incident on 12/11/25 involving Resident #22 and Former Resident #54, and unaware PCP #610 felt the only way to keep Resident #22 safe, as well as others, was with one-on-one or a facility with all women since PCP #610 had not shared that with them. Review of facility policy labeled, Residents Right to Freedom from Abuse, Neglect, and Exploitation dated 2025 revealed the purpose of the policy was to ensure residents were free from abuse. Residents had the right to engage in consensual sexual activity; however, anytime the facility had reason to suspect that a resident may not have the capacity to consent to sexual activity the facility would take steps to ensure that the resident was protected from abuse. These steps included evaluating whether the resident had the capacity to consent to sexual activity. When the facility identified abuse, the facility would take all appropriate steps to remediate the noncompliance and protect residents from additional abuse. The facility would develop written procedures to determine whether the resident was protected, risk factors that contributed to the abuse, whether there is further need for systemic action such as insight on needed revisions to procedures, increased training, measure and verify the implementation of corrective actions, and tracking patterns for similar occurrences.

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	04/28/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and review of staffing schedules, the staffing tool and the facility assessment, the facility failed to ensure a registered nurse (RN) was in the facility at least eight consecutive hours a day, seven days a week. This had the potential to affect all 50 residents residing at the facility.Findings include: Review of staffing schedules from 01/01/26 to 04/21/26 revealed there was no RN coverage for at least eight consecutive hours on 01/24/26 and 04/05/26. Review of the staffing tool from 04/05/26 to 04/11/26 completed on 04/21/26 at 12:00 P.M. with Administrator, Human Resource (HR) #624, and Scheduler/HR Assistant #623 revealed there was no RN coverage for at least eight consecutive hours on 04/05/26. Interview on 04/21/26 at 12:00 P.M. and 1:47 P.M. with Administrator, HR #624, and Scheduler/HR Assistant #623 verified per the staffing schedules from 01/01/26 to 04/21/26 and the staffing tool completed from 04/05/26 to 04/11/26, there was no RN coverage for at least eight consecutive hours for two days on 01/24/26 and 04/05/26.Review of the Facility assessment dated [DATE] revealed under the staffing plan there would be two RNs and/or Licensed Practical Nurses (LPN) for each shift. There was nothing per the assessment regarding ensuring there was a RN at least eight consecutive hours a day, seven days a week. This deficiency represents non-compliance investigated under Complaint Numbers 2966092, 2667528 and 2650567.

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	04/28/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of Self-Reported Incident (SRI) #268530 and the facility investigation, the facility failed to ensure Resident #22 was provided medically related social service to attain the highest practicable wellbeing by seeking guardianship to assist with decision making. This affected one resident (Resident #22) out of six residents reviewed for social service needs. This had the potential to affect four residents (Residents #15, #18, #22 and #37) who were identified by the facility as residents unable to make informed decisions without a guardian and/or responsible party. The facility census was 50. Findings include: Review of the medical record for Resident #22 revealed she had an admission date of 06/06/25 and her diagnoses included Alzheimer's disease, hypertension, and major depression. She had a friend listed as Power of Attorney (POA) for finance and per the facility the friend did not want involvement in her healthcare decisions. There was not a POA of healthcare and/or guardian listed.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] (prior to incident) revealed Resident #22's Brief Interview for Mental Status (BIMS) was zero indicating severe cognitive impairment. She required partial to moderate staff assistance with dressing. She was independent with transfers and required supervision with ambulation. Review of the care plan dated 06/30/25 revealed Resident #22 had impaired cognition and impaired thought processes related to Alzheimer's disease. Interventions included asking her yes or no questions to determine needs; cue, reorient and supervise as needed; and keeping her routine consistent. Additional review of the care plan dated 06/30/25 revealed Resident #22 had tearful episodes and was crying out. On 07/25/25 Resident #22 was observed in an inappropriate situation with a male resident. On 12/12/25 Resident #22 was observed in an inappropriate situation with a male resident. There was nothing in her care plan regarding whether she had the capacity to consent to sexual activity or not. Interventions included adjusting voice tone; administering medications as ordered; engaging in activities; leaving over the bed light on for reassurance; psychological consult as needed; frequent observation throughout the shift (added 11/03/25); and checking the resident every 15 minutes (added 12/12/25).Review of nursing note dated 07/25/25 at 4:45 P.M. completed by Agency Licensed Practical Nurse (LPN) #615 revealed prior to dinner the aide informed her that she discovered Resident #22 in bed with another resident. The aide had stated she was checking rooms and looking for Resident #22 and upon walking into Former Resident #53's room she had observed Resident #22 laying beneath Former Resident #53 in the bed and both residents' pants were down. The residents were separated. Review of witness statement dated 07/25/25 completed by Agency Certified Nursing Assistant (CNA) #614 revealed she came off break at 3:45 P.M., Resident #22 had walked up to her at the nursing station, and she also had seen Former Resident #53. She started her rounds, taking residents into the dining room and then started to look for Resident #22 room to room. She walked into Former Resident #53's room at 4:40 P.M. and Former Resident #53 was on top of Resident #22 on his bed with both their pants down. Agency CNA #614 did not see Resident #53's genitals inside her vagina and she had separated the residents immediately. Review of nursing note dated 12/11/25 at 10:30 P.M. completed by LPN #617 revealed he was notified that when the aides were doing rounds they had noticed Resident #22 was not in her room and they immediately looked in other rooms to find her. Resident #22 was found in another resident's bed (Former Resident #54) with Former Resident #54 sitting beside her. The note revealed both residents were naked with their clothing on the floor. Former Resident #54 had several fingers in her vaginal area and Resident #22 had her legs open allowing access. Both residents were separated and Resident #22 was dressed and taken to her room. Both residents were checked, no injuries were noted and both residents were placed on 15-minute checks. Primary Care Physician (PCP) #610 was notified. Review of SRI #268530 dated 12/11/25 for alleged sexual abuse with another resident revealed on 12/11/25 at 10:30 P.M. an (continued on next page)

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	04/28/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aide observed two residents, Former Resident #54 and Resident #22, engaged in inappropriate touch on the secured dementia unit. The residents were immediately separated, assessed by the nurse and placed on 15-minute checks. No injuries were identified. On 12/13/25, Former Resident #54 was discharged home with his wife. The facility unsubstantiated the SRI for sexual abuse. Review of witness statement dated 12/11/25 and completed by CNA #618 revealed on 12/11/25 at 10:30 P.M. she was doing rounds and could not find Resident #22. She went looking room to room and walked into Former Resident #54's room and he had the curtain pulled. She walked over, pulled the curtain and saw Resident #22 with her pants and incontinent pull-up off and Former Resident #54 naked. Former Resident #54 had his fingers in her vagina and stated she wanted it. She pulled him away and called for help. Review of Kardex (a brief overview/guideline of a resident) for Resident #22 dated 04/23/26 revealed under behaviors staff were to distract from wandering by offering pleasant diversions, structured activities, food conversation, and television. Other interventions included adjusting voice and tone; behavior monitoring (no specifics identified); and reapproaching as needed. There was nothing on the Kardex regarding 15-minute checks as per the care plan and there was nothing on the Kardex about sexual inappropriate behaviors. Interview on 04/22/26 at 12:45 P.M. with Regional Director #612, Regional Nurse/Registered Nurse (RN) #600, and Infection Control/ADON #609 verified Former Resident #53 was on top of Resident #22 in Resident #53's bed and both of their pants were down. They verified Former Resident #53 had a diagnosis of Hepatitis C and as precaution PCP #610 had ordered lab testing for Resident #22. They also verified the police were not contacted regarding the incident and that there was no documentation Former Resident #53's guardian was asked regarding police involvement. They verified Resident #22 had a friend listed as her POA of finance, but the friend did not want anything to do with her healthcare. When asked who made Resident #22's decisions since she had severe cognitive impairment they stated that nobody did right now. They verified the incident was not reported to the state survey agency including making a self-reported incident and they had only completed an internal investigation. Interview on 04/22/26 at 3:47 P.M. with the DON and Infection Control/ADON #609 verified there was not an assessment/evaluation completed prior to the incident on 07/25/25 and/or after it for either Resident #22 or Former Resident #53 whether they had the capacity to consent to sexual activity. They stated they only go by the BIMS score and if the resident scored 12 or above then they would be able to give consent and if they scored below they were not able. They stated they felt both residents, Resident #22 and Former Resident #53 could not give consent for sexual activity based on their BIMS score. They also verified after the incident on 12/11/25 Resident #22 was not assessed if she was able to consent for sexual activity. They revealed they did not have a policy regarding guardianship or residents with cognitive impairment and making informed decisions. Interview on 04/22/26 at 2:13 P.M. with Social Service Designee (SSD) #616 verified Resident #22 could not make her own decisions due to severe cognitive impairment and that she had scored a zero on her BIMS assessment. She revealed the current POA for finance did not want anything to do with her healthcare decisions and that Resident #22 needed a guardian. There was nothing documented regarding attempts at getting Resident #22 a guardian. She had just started in the position in February 2026 and was trying to figure things out but was not aware of any prior interventions trying to get a guardian for Resident #22. She was asked who then made Resident #22's healthcare decisions and she stated, I guess us, there is nobody else to make her decisions and she cannot make decisions. She stated the facility made her decisions for her. Interview on 04/23/26 at 9:53 A.M. with PCP #610 revealed Resident #22 could not give informed consent as when she attempted to ask Resident #22 any questions, the resident just looked in her eyes with a blank stare and did not communicate. She stated after review of both incidents on 07/25/25 and 12/11/25 and asked what recommendations and/or interventions were needed to ensure safety, to be honest it was not feasible to keep Resident #22 and other residents safe especially with only having two aides on the second floor. Resident #22 almost needed one-on-one because whenever she was at the facility, Resident #22 ambulated all (continued on next page)

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	04/28/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over, and was fast as she had to chase her around just to get an assessment completed. She stated either one-on-one or a facility with all women as, I do not see how to keep her and others safe otherwise.Interview on 04/23/26 at 10:15 A.M. with Regional Nurse/RN #600, DON and Infection Control/ADON #609 revealed they were unaware PCP #610 was not aware of the incident on 12/11/25 involving Resident #22 and Former Resident #54, and unaware PCP #610 felt the only way to keep Resident #22 safe, as well as others, was with one-on-one or a facility with all women since PCP #610 had not shared that with them.

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	04/28/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to ensure residents were free of significant medication errors by providing residents with antibiotic (ATB) therapy in a timely manner and in accordance with physician orders. This affected two residents (Residents #39, and #51) out of three residents reviewed for ATB therapy. The facility census was 50.Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 10/16/25 and he was discharged to the hospital on [DATE]. His diagnoses on admission included enterocolitis due to Clostridium Difficile (C-Diff) (a highly contagious bacterium that causes severe diarrhea and inflammation of colon), hypertension, malignant neoplasm of the prostate, and chronic kidney disease.Review of October 2025 physician orders revealed Resident #51 had an order dated 10/16/25 for fidaxomicin (ATB) oral tablet 200 milligram (mg) give one tablet by mouth every morning and at bedtime for five days due to C-Diff. Review of October 2025 Medication Administration Record (MAR) revealed Resident #51 had an order for fidaxomicin oral tablet 200 mg give one tablet by mouth every morning and at bedtime for five days due to C-Diff and the MAR indicated the following doses were not given: the 10/16/25 bedtime dose; the 10/17/25 morning and bedtime dose; and the 10/18/25 morning dose (a total of four doses).Review of Hospital Discharge Medication List for Resident #51 dated 10/16/25 revealed upon discharge from the hospital he had an order for fidaxomicin oral tablet 200 mg give one tablet by mouth every morning and at bedtime for five days due to C-Diff. The last dose he received in the hospital was on 10/16/25 at 7:29 A.M.Review of nursing note dated 10/16/25 at 5:55 P.M. completed by Licensed Practical Nurse (LPN) #617 revealed Resident #51 was admitted to the facility. Review of the Medicare Five Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had severe cognitive impairment as he was rarely and/or never understood. Review of nursing note dated 10/18/25 at 6:00 P.M. completed by LPN #629 revealed Resident #51's daughter came into the facility on [DATE] at approximately 10:30 A.M. inquiring about his ATB therapy (fidaxomicin) and the nurse informed the daughter that the medication was not in from pharmacy and that she would get more information as to why the medication was not available. The nurse informed the daughter that the facility had received an Expensive Medication Authorization Form, and they were reaching out to Primary Care Physician (PCP) #610 to see what medication she wanted the fidaxomicin changed to. The note then revealed Resident #51's daughter requested Resident #51 be sent to the ER. Review of emergency room (ER) progress note dated 10/18/25 completed by ER Physician #628 revealed Resident #51 was in the ER for medication administration as he had not received his ATB for C-Diff in two days because the nursing home stated it was too expensive to be given. The note revealed Resident #51 had been in the hospital prior from 10/09/25 to 10/16/25 and was diagnosed with C-Diff and ordered fidaxomicin per infectious disease. The ER had administered his fidaxomicin on 10/18/25 at 6:24 P.M. and he was discharged home with family and a prescription for the remaining doses of fidaxomicin. Interview on 04/21/26 at 2:53 P.M. with Infection Control/Assistant Director of Nursing (ADON) #609 revealed she received a call from the facility nurse on 10/18/25 that Resident #51's daughter was upset that he had not started his ATB. She contacted pharmacy and the medication was not covered and would have cost over two thousand dollars for ten tablets. She contacted PCP #610 who was going to look at researching why the medication was ordered from the hospital but before she was able Resident #51's daughter requested he be sent to the hospital because he had not received his ATB since admission [DATE]). Interview on 04/21/26 at 3:05 P.M. with PCP #610 revealed he was ordered fidaxomicin by infectious disease through the hospital for C-Diff. She stated usually any resident ordered this medication needed the medication because they most likely already had trialed a course of a different ATB that was not effective. She felt infectious disease had ordered Resident #51 the medication because they felt he needed it despite how expensive the medication was. She felt where it went wrong was prior to admission the (continued on next page)

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	04/28/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility needed to review Resident #51's medications and make the decision prior to admission if they were able to accommodate including the cost of his medication or if not then they should not have admitted him. She stated the facility should have been prepared and the medication given in a timely manner after he was admitted . She was not aware he had missed doses until Resident #51's daughter was upset and requested he was sent to the ER.Interview on 04/21/26 at 3:15 A.M. with Regional Nurse/RN #600, Director of Nursing (DON), and Infection Control/ADON #609 revealed the last dose of fidaxomicin Resident #51 had received was on 10/16/25 at 7:29 A.M. in the hospital and verified he was to receive it by mouth every morning and at bedtime for five days due to C-Diff. They verified Resident #51 did not receive the following doses of medication: the 10/16/25 bedtime dose; the 10/17/25 morning and bedtime dose; and the 10/18/25 morning dose. They had no documentation PCP #610 was aware he had missed the doses until Resident #51's daughter requested he was sent to the ER due to the missed doses. 2. Review of the medical record for Resident #39 revealed an admission date of 05/06/24 and her diagnoses included chronic obstructive pulmonary disease with acute exacerbation, schizoaffective disorder, and bipolar disorder. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #39 had intact cognition but had delusions.Review of progress note dated 03/27/26 at 4:28 P.M. completed by Nurse Practitioner (NP) #630 revealed Resident #39 was examined due to sinus symptoms and acute cough. Resident #39 had stated she had sinus pressure, nasal congestion and a nonproductive cough. NP #630 ordered Augmentin (ATB) 500-125 mg by mouth twice a day for seven days. Review of March 2025 Physician Orders revealed Resident #39 had an order dated 03/28/26 for Augmentin 500-125 mg tablet give one tablet by mouth two times a day for seven days for acute frontal sinusitis. Review of March 2025 MAR revealed an order for Augmentin 500-125 mg give one tablet by mouth two times a day for acute frontal sinusitis dated 03/28/26 at 8:00 A.M. The MAR was blank on 03/28/26 at 8:00 A.M. and 4:00 P.M., and 03/29/26 at 8:00 A.M. and 4:00 P.M. which indicated Resident #39 did not receive the medication. The first dose of Augmentin Resident #39 received was on 03/30/26 at 8:00 A.M.Interview on 04/21/26 at 8:38 A.M. with Resident #39 denied any concerns with medication administration. Interview on 04/22/26 at 3:47 P.M. and 4:15 P.M. with DON and Infection Control/ADON #609 verified Resident #39 was ordered Augmentin 500-125 mg by mouth twice a day for seven days per NP #630's progress note dated 03/27/26 and she had not received the first dose until 03/30/26 at 8:00 A.M. They revealed NP #630 had put the order in her progress note on 03/27/26 but the facility was not aware. They verified an order was written on 03/28/26 at 8:00 A.M. for Augmentin but stated most likely because it was the weekend the nurse did not take the initiative to follow through. They revealed most weekends the facility staffs the facility with agency nurses, and they do not have access to the emergency medication box (a box the facility had at the facility of common medication including ATBs) and that was the reason the medication was not pulled from the emergency medication box to start it on time and/or the agency nurse did not contact pharmacy to check on the delivery. They verified the Augmentin was in the emergency medication box. They confirmed all ATBs were to be administered right away unless there was an order from the physician approving the ATB to be given later. Review of facility policy labeled, Administering Medication dated 2001 revealed medications were to be administered in a safe and timely manner as prescribed. Medications were administered in accordance with orders including required time frame including within one hour of prescribed time unless otherwise specified. If the drug was withheld, refused or given at a time other than scheduled time the individual administering the medication would initial and circle the MAR space provided. There was nothing in the policy regarding notifying the physician of withheld doses of medications. This deficiency represents non-compliance investigated under Complaint Number 2655931.