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	05/29/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, staff interview, record review, and review of facility policy, the facility failed to ensure call lights were within reach of Resident #3, #27, #34 and #43. This affected four residents of 19 residents reviewed for accommodation of need. The facility census was 47. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 11/07/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke), hemiplegia affecting right dominant side, major depressive disorder, and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 05/13/25, revealed Resident #3 was moderately impaired cognitively, had upper and lower extremity impairment on one side, was dependent on staff for all activities of daily living except required substantial/maximum assistance from staff for eating, required substantial/maximum assistance to roll left and right, was independent for maneuvering his motorized wheelchair, was always incontinent of bowel and bladder and had two or more falls without major injury since the previous assessment. Review of the care plan, date initiated 11/07/24, revealed Resident #3 was at risk for falls. Interventions included to ensure call light was available to resident. An observation on 05/27/25 at 9:37 A.M. revealed Resident #3 was awake and lying in his bed with the call light out of his reach. The call button was clipped half way down the privacy curtain located to the right of the resident and out of arms reach from the bed. An observation was conducted on 05/27/25 at 9:46 A.M. of Resident #3 in his room with Certified Nursing Assistant (CNA) #214 present during the observation. The call light remained out of reach and an interview with CNA #214 at the time of the observation verified Resident #3 was not able to reach the call light because it was clipped to the privacy curtain. 2. Review of the medical record for Resident #27 revealed an admission date of 11/27/20 with diagnoses including senile degeneration of brain, vascular dementia, anxiety disorder, delirium due to known physiological condition, major depressive disorder, and insomnia. Review of the quarterly MDS 3.0 assessment, dated 05/08/25, revealed Resident #27 was severely impaired cognitively, was independent for mobility except required supervision or touch assistance from staff for tub/shower transfer, had an indwelling catheter, was always incontinent of bowel, and had one fall since prior assessment. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #27, date initiated 12/10/20, revealed Resident #27 was at risk for falls due to altered mental status, cognition, and psychotropic medication use. Interventions included to be sure call light was within reach and encourage him to use it for assistance as needed. An observation on 05/27/25 at 9:32 A.M. revealed Resident #27 was awake and was lying on his bed. Resident #27's call light was clipped to the call light cord coming out of the wall and not within reach of Resident #27. An interview on 05/27/25 at 9:32 A.M. with Housekeeping Supervisor (HS) #225 at the time of the observation revealed HS #225 verified Resident #27 could not reach his call light to call for help if he needed it. 3. Review of the medical record for Resident #43 revealed an admission date of 11/06/24 with diagnoses including dementia, gastro-esophageal reflux disease (GERD), and liver disease. Review of the quarterly MDS 3.0 assessment, dated 04/15/25, revealed Resident #43 was moderately impaired cognitively and was independent for all activities of daily living except required setup or cleanup assistance from staff for shower/bathe self and personal hygiene. The resident was independent for mobility which included walking independently up to 150 feet. Review of the care plan, date initiated 11/12/24, revealed Resident #43 was at risk for falls due to a dementia diagnosis. Interventions included be sure call light was within reach and encourage him to use it for assistance as needed. An observation on 05/27/25 at 9:29 A.M. revealed Resident #43 was awake and was lying on his bed. The call light button was clipped to the call light cord coming out of the wall behind the headboard of Resident #43's bed where it could not be reached by the resident. An observation on 05/27/25 at 9:46 A.M. with HS #225 present in Resident #43's room revealed the call light remained out of reach. An interview with HS #225 at the time of the observation verified Resident #43 was not able to reach his call light. 4. Review of the medical record for Resident #34 revealed an admission date of 05/06/24 with diagnoses including metabolic encephalopathy (brain dysfunction), lack of coordination, cognitive communication deficit, reduced mobility, dementia, need for assistance with personal care, insomnia, and anxiety disorder. Review of the MDS 3.0 assessment, dated 05/01/25, revealed Resident #34 was severely impaired cognitively, was independent for mobility except required supervision or touch assistance for tub/shower transfer and was continent of bowel and bladder. Review of the care plan, date initiated 05/14/24, revealed Resident #34 was at risk for falls. Interventions included to be sure call light was within reach and encourage him to use it for assistance as needed. An observation on 05/27/25 at 9:35 A.M. revealed Resident #34 was sleeping in his bed. The call light button was clipped to the cord coming out of the wall and was not within reach of Resident #34. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 05/27/25 at 9:47 A.M. with HS #225 present in Resident #34's room revealed the call light remained out of reach. An interview with HS #225 at the time of the observation verified Resident #34 was not able to reach his call light. Review of the facility policy titled Call System, Residents, undated, revealed each resident would be provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review, interview and policy review, the facility failed to refund resident funds within 30 days of discharge. This affected two residents (#253 and #254) of six residents (#2, #5, #15, #24, #253 and #254) reviewed for resident funds. The facility census was 47. Findings include: 1. Review of resident records for Resident #253 revealed an initial admission date of 09/12/14 and a discharge date of 11/15/24. Diagnosis included schizoaffective disorder bipolar type. A review of the face sheet for Resident #253 revealed they had a court appointed guardian. Review of the discharge Minimum Data Set (MDS) assessment revealed Resident #253 had severe cognitive impairment. Review of the facility document titled Resident Fund Authorization revealed resident #253 authorized the facility to hold, safeguard and account for personal funds. The document was signed by Resident #253 on 09/08/15. On 05/28/25 at 11:00 A.M. a review of the resident fund account for Resident #253 revealed on 01/07/25 the facility distributed check #1901 in the amount of $5,588.60 to the guardian of Resident #253 to close the resident fund account. However, deposits and withdrawls from the account continued as followed: • 02/03/25 a deposit from Social Security (SS) in the amount of $917.30. • 02/28/25 an interest deposit of $1.69. • 03/03/25 a SS deposit of $917.30 • 03/12/25 check #1917 in the amount of $1836.29 was issued to the guardian of Resident #253. • 04/01/25 a deposit labeled pension in the amount of $917.30. • 04/03/25 a SS deposit in the amount of $2556.00. • (continued on next page)

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/30/25 an interest deposit of $5.17. • 05/01/25 a deposit labeled pension in the amount of $917.30. • 05/02/25 check #1925 in the amount of $2561.17 was issued as a return to SS and check #1924 for $1834. 60 issued as a return to Railroad Retirement Fund. • 05/15/25 check #1927 for $852.00 issued to SS and SS was notified in writing that Resident #253 was discharged from the facility on 11/15/24. On 05/28/25 at 12:30 P.M. an interview with the Administrator verified the aforementioned accounting for Resident #253, and stated Social Security kept making deposits. The Administrator also verified the notification to Social Security regarding the discharge of Resident #253 did not occur until 05/15/25. The Administrator also verified the closure of the resident fund account occurred past 30 days post discharge for Resident #253. 2. Review of resident records for Resident #254 revealed an admission date of 11/07/24 and a discharge date of 11/09/24. Significant diagnoses included schizoaffective disorder, bipolar type, anxiety, and major depression. A review of the face sheet for Resident #254 revealed they were their own responsible party. The face sheet also listed a daughter as power of attorney for financial matters. A clinical admission note dated 11/07/24 revealed Resident #254 to be alert and oriented to person, place and time. A review of the facility document titled Resident Fund Authorization revealed resident #254 authorized the facility to hold, safeguard and account for personal funds. The document was signed by Resident #254 on 09/30/20. On 05/28/25 at 11:15 A.M. a review of resident fund accounts revealed on 01/03/25 the facility issued check #1898 in the amount of $1975.07 to the nursing facility where Resident #254 transferred to on 11/09/24. On 05/28/25 at 12:30 P.M. an interview with the Administrator revealed the date of 09/30/20 on the fund authorization for Resident #254 was correct as Resident #254 had transferred from a sister facility that closed. The Administrator verified the closure of the account for Resident #254 occurred 01/03/25 and past 30 days post discharge. A review of the document titled Resident admission Agreement revealed on page 20 funds to be disbursed within 30 days of discharge or death. A review of the document titled Resident Fund Authorization revealed upon discharge account will be closed and funds returned.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the facility failed to ensure a bed alarm assessment was completed prior to implementing a bed alarm for Resident #46. This affected one resident (Resident #46) of two residents reviewed for bed alarms. The facility identified two residents (#46 and #33) ordered bed alarms. The facility census was 47. Findings include: A review of medical records for Resident #46 revealed an admission date of 02/20/25 with pertinent diagnoses including Alzheimer's disease, major depressive disorder, repeated falls, vascular dementia and anxiety. Significant Review of physician orders included Buckeye Hospice admission dated 05/27/25 and bed alarm to remind resident not to get up unassisted dated 05/23/25. Review of an admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 had severe cognitive impairment. The MDS also revealed a history of falls in the last month prior to admission. There was no alarm usage noted within the MDS. Review of the care plan dated 05/30/25 revealed Resident #46 had actual falls. Interventions included perimeter defined mattress dated 05/18/25 and bed alarm to remind resident not to get up unassisted dated 05/23/25. Review of a device decision assessment dated [DATE] for Resident #46 revealed no bed alarm in use and no need for further restraint assessment. Further review of the medical record for Resident #46 revealed a device decision assessment had not been completed for the bed alarm intervention dated 05/23/25. On 05/28/25 at 2:15 P.M. an observation of Resident #46 revealed them in bed with the bed alarm in use. On 05/29/25 at 8:15 A.M. an observation of Resident #46 revealed them in bed with the bed alarm in use. An interview conducted on 05/29/25 at 8:15 A.M. with Licensed Practical Nurse (LPN) #227 verified Resident #46 was in bed with a bed alarm in use at the time of the observation. On 05/29/25 at 12:30 P.M. an interview with the Administrator verified the lack of an assessment for bed alarm use for Resident #46. The Administrator stated it was missed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled Physical Restraint Application dated 10/2010 revealed the purpose of the procedure was to provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints. The policy also revealed physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement. The definition of restraints was based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review, interviews and observation, the facility did not ensure Resident #1, Resident #20 and Resident #37 were explicitly informed of their right to not sign a binding arbitration agreement and were given the option to not sign the binding arbitration agreement. This affected three residents (#1, #20 and #37) out of five residents reviewed for arbitration agreements. The facility identified 35 residents (#1, #2, #3, #5, #6, #8, #10, #11, #13, #17, #18, #19, #20, #21, #22, #23, #25, #27, #30, #32, #33, #34, #37, #38, #39, #41, #42, #43, #45, #46, #47, #49, #50, #103, and #104) with a binding arbitration agreement. The facility census was 47. Findings include: 1. Review of the medical record for Resident #37 revealed an admission date of 01/02/25. Diagnoses included transverse myelitis in demyelinating disease of the central nervous system, type two diabetes, functional quadriplegia, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, anxiety disorder, and persistent mood disorders. Review of Resident #37's Minimum Data Set (MDS) 3.0 assessment, dated 04/05/25, revealed the resident was cognitively intact. Review of Resident #37 admission paperwork revealed on page 30 of the admission packet was a document titled Optional Arbitration Agreement which indicated the facility and Resident #37 agreed that any and all disputes of any kind between the resident and family would be submitted to binding arbitration and by signing the arbitration agreement the resident and the facility were waiving the right to a jury trial for any dispute disagreement, controversy, demand, or claim and agree that the arbitrator's decision would bind both parties and was final. The resident or representative could rescind the agreement within 30 days from the date of when the agreement was signed. After 30 days, the agreement would remain in effect for all care and services at the facility. On page 32 of the admission packet, Resident #37 electronically signed his name on 01/06/25 indicating he had accepted the arbitration agreement. There was no area on the agreement that gave an option to decline it. Interview on 05/28/25 at 3:52 P.M. with Resident #37 revealed he knew what an arbitration agreement was, and the resident hadn't recalled signing an arbitration agreement. He stated he was told nothing about an arbitration agreement and went on to state he would have liked to have known he was signing an arbitration agreement because he wouldn't have signed it. 2. Review of the medical record for Resident #20 revealed an admission date of 01/28/25. Pertinent diagnoses included dementia, injury of head, major depressive disorder, major depressive disorder, and repeated falls. Review of quarterly MDS 3.0 assessment, dated 05/07/25, revealed Resident #20 was severely impaired cognitively. The resident's son was listed as the responsible party. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's admission paperwork revealed on page 30 of the admission packet was a document titled Optional Arbitration Agreement which indicated the facility and Resident #20 agreed that any and all disputes of any kind between the resident and family would be submitted to binding arbitration and by signing the arbitration agreement the resident and the facility were waiving the right to a jury trial for any dispute disagreement, controversy, demand, or claim and agree that the arbitrator's decision would bind both parties and was final. The resident or representative could rescind the agreement within 30 days from the date of when the agreement was signed. After 30 days, the agreement would remain in effect for all care and services at the facility. On page 32 of the admission packet Resident #20's responsible party electronically signed his name on 02/04/25 indicating he had accepted the arbitration agreement. There was no area on the agreement that gave an option to decline it. 3. Review of the medical record for Resident #1 revealed an admission date of 04/04/25. Pertinent diagnoses included cerebral infarction (stroke), schizophrenia, and attention and concentration deficit. Review of admission MDS 3.0 assessment, dated 04/11/25, revealed the resident was cognitively intact and exhibited behavioral symptoms not directed toward others four to six days and rejected care one to three days during the assessment reference period. Further review of the medical record revealed a guardian had been appointed for Resident #1. Review of Resident #1's admission paperwork revealed on page 30 of the admission packet was a document titled Optional Arbitration Agreement which indicated the facility and Resident #1 agreed that any and all disputes of any kind between the resident and family would be submitted to binding arbitration and by signing the arbitration agreement the resident and the facility were waiving the right to a jury trial for any dispute disagreement, controversy, demand, or claim and agree that the arbitrator's decision would bind both parties and was final. The resident or representative could rescind the agreement within 30 days from the date of when the agreement was signed. After 30 days, the agreement would remain in effect for all care and services at the facility. On page 32 of the admission packet Resident #1's guardian had electronically signed her name on 04/25/25 indicating she had accepted the arbitration agreement. There was no area on the agreement that gave an option to decline it. Interview and observation of the facility electronic admission packet with admission Director (AD) #205 revealed the program being used for the electronic admission packet would have the resident/resident representative adopt an electronic signature in the beginning and the program would then prompt the resident/ resident representative where to sign throughout the admission paperwork. She stated the optional arbitration agreement was included in the admission packet. When reviewing an example of an electronic admission packet on the admission Director's computer, when it came to the arbitration agreement, the program prompted the resident/resident representative to sign the arbitration agreement. There was no option to decline the agreement. AD #205 confirmed there was no option to decline the arbitration agreement and stated it had been that way since she started in August 2024. She stated in order for the admission paperwork to be completed, the resident/resident representative would have to sign to agree to an arbitration agreement. She confirmed Resident #1, Resident #20 and Resident #37 or their responsible party would have had to sign the arbitration agreement in order for the admission paperwork to be completed therefore they had no choice but to agree to it. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/29/25 at 10:41 A.M. with the Administrator revealed she had been made aware that there was no option to decline the arbitration agreement when it was signed electronically and in order for the admission paperwork to be completed the person had to sign to agree to the arbitration agreement.