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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows at Osborn Park	3916 Perkins Ave Huron, OH 44839

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, resident, family, staff, physician, and agency staff interviews, review of staff statements, and review of the facility policy, the facility failed to ensure safe mechanical lift transfers and further failed to adequately assess, timely notify the physician and resident representative, address resident pain, and conduct a thorough investigation following a fall from a mechanical lift. This resulted in Actual Harm to Resident #36 when on the morning of 04/22/26, the resident fell during a mechanical lift transfer and was found to have sustained a displaced fracture of the distal femur and a distal fifth metacarpal fracture of the left hand. Facility staff failed to thoroughly assess the resident at the time of the incident and the resident cried out in pain throughout the night. Subsequently, in the afternoon of 04/23/26, mobile X-rays were obtained. The facility did not review the X-ray findings until 04/24/26 which, based on a very limited study, showed a displaced fracture (a broken bone snapped into two or more pieces and moved to cause the ends to become misaligned) of the distal femur. Consequently, Resident #36 was transferred to the hospital on [DATE], at the request of her family, for further evaluation and treatment (two days after the initial injury). Further imaging at the hospital revealed Resident #36 had a closed displaced comminuted fracture (severe injury where the bone breaks in three or more pieces but does not break through the skin) of the left femur and a distal fifth metacarpal fracture of the left hand. Furthermore, the facility failed to ensure a complete, thorough, and accurate investigation was completed related to Resident #36's injury. This affected one (#36) of three residents reviewed for falls. The facility census was 122. Findings include:Review of Resident #36's medical record revealed an admission date of 05/19/23. Diagnoses included chronic kidney disease stage four, vascular dementia, presence of right artificial hip joint, and osteoarthritis. On 04/24/26, additional diagnoses of personal history of other diseases of the musculoskeletal system and connective tissue, age-related osteoporosis with current pathological fracture of the left femur and unspecified fracture of the fifth metacarpal bone of the left hand were added.Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/12/26, revealed Resident #36 had severe cognitive impairment. Further review revealed Resident #36 required the use of a mechanical lift for transfers and was unable to ambulate. Resident #36 was dependent on staff for activities of daily living (ADLs).Review of the care plan, initiated on 05/24/23, revealed Resident #36 had a focus area for an ADL self-care performance deficit related to dementia, impaired balance, limited mobility, musculoskeletal impairment, and shortness of breath. Interventions included extensive to dependent assistance by one to two staff to turn and reposition in bed and the resident was dependent on two staff to move between surfaces as necessary. On 10/22/25, and revised on 04/16/26, an intervention was implemented for Resident #36 to be transferred with a Hoyer (mechanical) lift with two staff assistance. Additionally, on 05/23/24 Resident #36 had a focus area related to limited physical mobility related to right artificial hip joint, weakness, and difficulty walking. Interventions included a wheelchair for locomotion, dependent on staff for locomotion in wheelchair, and monitor/document/report as needed any signs/symptoms of immobility: contractures forming or worsening, thrombus formation, skin breakdown, and fall related injury. Furthermore, on 04/24/26, a focus area was initiated for osteoporosis related to age and a pathological bone fracture (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0684 Level of Harm - Actual harm Residents Affected - Few	follow-up interview on 04/30/26 at 10:56 A.M. with CNA #300 confirmed Resident #36 fell from the mechanical lift during transfer on 04/22/26. CNA #300 stated she helped catch Resident #36 when she fell, but her legs still hit the floor. CNA #300 stated she did not hear the popping noise; it was CNA #501 who heard it. CNA #300 stated she was called to the DON's office on 04/24/26 and told to sign the statement written by the DON and dated 04/23/26. CNA #300 stated she was not asked by the DON what had occurred and the DON had the statement already written when she was called to sign it. CNA #300 stated she felt intimidated, scared, and feared retaliation because there were three additional nurses in the DON's office, so she signed the statement. CNA #300 verified the signed statement was not an accurate account of the incident.A follow-up telephone interview on 04/30/26 at 4:15 P.M. with CNA #501 confirmed Resident #36 fell from the mechanical lift on 04/22/26. Although she and CNA #300 caught the resident, the resident's legs still hit the floor, with her left leg bending behind her (CNA #501 was on the left side of Resident #36). CNA #501 was uncertain if the resident hit her hand. CNA #501 stated she was never interviewed about the incident. She worked at the facility on 04/24/26 and was called to the DON's office to sign a statement written by the DON. CNA #501 stated several other people were in the room. CNA #501 stated she did not know what to do and was scared, so she signed the statement. CNA #501 stated every sentence in the statement was false. On 04/27/26, she contacted the DON at the agency she worked for and reported what had occurred because she did not feel right about what was happening with the incident. Review of a text message sent to the State Surveyor on 04/30/25 at 1:05 P.M. from Physician #500 revealed he confirmed he was not contacted about any concerns with Resident #36 until 04/23/26 at 8:00 A.M. when he was contacted by LPN #208. Physician #500 did not clarify what LPN #208 contacted him about. The text message further stated the facility told him three nurses looked at Resident #36 on 04/22/26, with no other information provided.A telephone interview on 05/01/26 at 10:25 A.M. with Registered Nurse (RN) #503, the agency DON, revealed it was procedure for facilities to notify the agency any time an incident occurred that involved agency staff. She stated the facility did not report the incident involving CNA #501 to them. On 04/27/26, RN #503 stated CNA #501 called and reported an incident that occurred at the facility. CNA #501 reported she was told she could not tell the agency, but she did not feel right about it. CNA #501 reported to RN #503 that Resident #36 had fallen out of a mechanical lift on 04/22/26. On 04/23/26, CNA #501 returned to the facility and Resident #36 was in pain and crying and the facility had not done anything for the resident and the same scenario occurred on 04/24/26. RN #503 stated she had CNA #501 write a statement regarding the situation, which stated Resident #36 fell from the mechanical lift during transfer on 04/22/26. RN #503 stated she called the facility and talked to a unit coordinator, who was not giving her direct answers, and stated the DON was not available. RN #503 stated CNA #501 reported the facility made her sign a statement and she was nervous because she was not sure what she signed. On 04/27/26 at 11:52 A.M, the facility's DON returned RN #503's call and stated there were employees in the facility who were related to residents and the statement that CNA #501 signed was stating that CNA #501 had nothing to do with the incident and was dismissing her from the incident. RN #503 stated she requested a copy of the statement and she still had not received it. RN #503 stated on 04/29/26, she received a phone call from the Administrator of the facility requesting CNA #501's phone number because state was in the building. RN #503 stated on 05/01/26, the Administrator called her again and stated that CNA #501 spoke with the State Surveyor, but what she spoke about was not in the statement. RN #503 stated the Administrator further stated that he was physically sick over the situation and he should have listened to his staff, as he was unaware that the situation took place. RN #503 reported the Administrator stated, I thought the staff were just believing hearsay.Review of the facility policy titled, Physician Communication Guidelines, undated, revealed for falls with musculoskeletal deformity, hip or leg pain, the doctor should be notified within one hour.Review of the facility policy titled, [NAME][TRUNCATED]