STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366252	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows of Leipsic	901 East Main Street Leipsic, OH 45856

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of facility's Legionella plan and documentation, staff interviews, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to develop and implement a comprehensive and effective infection control/water management plan to prevent the risk of Legionella. This had the possible affect all residents in the facility. The facility census was 44.Findings include:Review of the facility's Legionella Water Management Plan, updated 08/04/25, revealed Legionella could grow and spread in common areas including sinks, showers, water fountains, standing water on washing tables, spa tub and ice machines. There were no records of flushing of low-flow or dead-leg pipes by the facility. The facility had a written description of the building's water system but failed to have a flow diagram.Interview on 01/22/26 at 2:22 P.M. with the Administrator verified the facility did not document or complete flushes of the dead-leg and low flow areas. The facility did not complete a flow diagram. The Administrator stated their policy said they did not have to complete any flushes and a flow diagram was not completed because it was not written out on it.Review of the CDC guidance titled Controlling Legionella dated 03/15/24 revealed to flush low-flow plumbing runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits.

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident interview, and staff interview, the facility failed to ensure resident requests for bed accommodations were honored. This affected one (Resident #4) of two residents reviewed for accommodation of needs. The facility census was 44. Findings Include:Review of Resident #4's medical record revealed an admission date of 10/22/24. Diagnoses included fracture of right femur (subsequent encounter) with orthopedic surgery, type I diabetes mellitus, osteoporosis, anxiety disorder, chronic pain, and muscle weakness.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact. Resident #4 was independent with toilet use, bed mobility, transfer, and required set up assistance with bathing. Resident #4 displayed no behaviors during the review period. Review of Resident #4's care plan revised 01/20/26 revealed supports and interventions for behaviors of hyper fixation on condition bed frame and mattress (12/09/25). Interventions included to determine the cause for inappropriate behavior, observe for triggers of inappropriate behaviors and alter environment as needed. Observation on 01/21/26 at 8:12 A.M. revealed Resident #4 was sleeping in bed on a regular mattress. Resident #4 had the head of the bed raised, her right leg straight, her left leg bent slightly and her torso twisted so she was laying partially on her left hip. The positioning did not appear to be comfortable.Interview on 01/21/26 at 9:49 A.M. with Resident #4 reported her bed was uncomfortable and it bothered her enough that it was affecting her sleep. Resident #4 explained she had a surgery to repair a broken femur and had a rod in her leg that caused her discomfort when lying in her bed. Resident #4 reported she had complained about the regular bed being uncomfortable, but they told her there was nothing wrong with it and had just given her another regular mattress or topper. Other types of mattresses had not been tried. Interview on 01/21/26 at 9:54 A.M. with Certified Nursing Assistant (CNA) #527 verified Resident #4 had reported her bed was uncomfortable and reported it dipped in the center. CNA #527 reported the concerns were passed on to the Maintenance Director but CNA #527 was not sure if another bed was provided as Resident #4 continued to have a regular bed and continued to voice concerns of being uncomfortable.Interview on 01/21/26 at 10:22 A.M. with Maintenance Director #501 revealed he was aware of Resident #4's concerns for her bed being uncomfortable. He reported this was at least the third bed she had. He reported the way she slept her butt sinks in, and the bed gets uncomfortable for her. He stated her family had even brought in toppers to try and help. The toppers worked for a while but she complained again about the bed poking her and being uncomfortable. Maintenance Director #501 reported the bed was switched out a number of times but he did not have record of when this was done. Review of maintenance log revealed it was documented Resident #4 had her bed replaced on 08/29/25 and her bed frame replaced on 12/01/25. There was no indication as to what type of bed was used as a replacement. Interview on 01/22/26 at 7:32 A.M. with the Administrator revealed Resident #4's standard mattress had been changed out a number of times. The Administrator reported the regular mattresses were evaluated, flipped or taken out when Resident #4 had complained. The regular mattresses which were removed were then used in other residents rooms and the other residents never reported any concerns. The Administrator verified there was no additional documentation or evidence to show when the mattresses were changed or if other types of mattresses were tried to improve Resident #4's comfort.Interview on 01/22/26 at 8:54 A.M. with Resident #4 reported again she had not been provided any other types of mattress to see if they would be more comfortable to her. She stated she had been provided a few different mattress toppers but not a different type of mattress. Resident #4 reported again she was uncomfortable in the regular style mattress, and she was unable to get a good nights sleep because of it. Interview on 01/22/26 at 9:19 A.M. with Licensed Social Worker (LSW) #500 revealed she was aware of Resident #4 concerns regarding her bed being uncomfortable. LSW #500 reported being aware of an air mattress being tried by Resident #4 but was unable to provide supporting evidence this trial had actually been completed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical review, observation, and staff interviews, the facility failed to ensure the resident's bed sheets were clean and sanitary. This affected one (Resident #50) of 21 residents reviewed for clean and homelike environment. The facility census was 44.Findings include:Medical record review revealed Resident #50 was admitted on [DATE] with diagnoses including acute kidney failure with tubular necrosis, dementia, and obstructive and reflux uropathy,The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #50 had impaired cognition. Resident #50 was dependent with toileting. Observation on 01/22/26 at 10:07 A.M. of catheter care revealed Resident #50 had a bowel movement at the start of catheter care. The Director of Nursing (DON) and Certified Nursing Assistant (CNA) #584 completed incontinence care on Resident #50. There was fecal matter on the lift sheet due to CNA #584 wiping across lift sheet with fecal matter on it. Lift sheet was not changed and the soiled lift sheet remained under the resident.Interview on 01/22/26 at 10:17 A.M. with CNA #584 verified DON and CNA #584 did not change the lift shift after incontinence care and a small amount of fecal matter was on the lift sheet under Resident #50.

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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 0684 Level of Harm - Minimal harm or potential for 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 observation, record review, and resident and staff interview, the facility failed to timely assess and obtain a physician order to treat the resident's wounds. This affected one (Resident #21) of three residents reviewed for skin conditions. The facility census was 44. Findings include:Review of Resident #21's medical record revealed an admission date of 11/10/23. Diagnoses included heart failure, sepsis, obesity, acquired absence of right leg above the knee, convulsions, depression, type II diabetes, and peripheral vascular disease. Review of Resident #21's care plan revised 11/30/25 revealed supports and interventions for self-care deficit, risk for excessive bleeding and bruising related to medications, risk for injury related to seizures, pain, and risk for skin breakdown. Interventions for risk for skin breakdown included weekly skin assessments, keep linens clean and dry, and avoid shearing skin during positioning, turning and transferring. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 had no skin concerns at the time of the review and displayed no behaviors.Review of Resident #21's physician orders revealed an order dated 12/29/25 and discontinued 01/20/26 to wrap left lower leg daily off at night. There were was no assessment of any wounds on Resident #21's left lower leg nor a physician order to treat any wounds on Resident #21's left lower leg prior to 01/20/26. Observation and interview on 01/20/26 at 9:56 A.M. revealed Resident #21 had three two inch by two inch white bandages on his left lower leg. There were no initials or dates on the dressings indicating when the dressings were applied. The bandage on the left lower extremity on the left side of the lower leg had dried blood with yellow fluid on it and was partially separating from Resident #21's skin. Resident #21 verified he had a weeping wounds and the one on the side of his leg needed the dressing to be changed. Interview on 01/20/26 at 10:21 A.M. with Registered Nurse (RN) #543 reviewed Resident #21's physician orders and verified there were no orders in place for dressing changes to be done to Resident #21's left lower leg. There was just an order for wrapping the left lower leg at night,.Observation and interview on 01/20/26 at 10:25 A.M. of Resident #21's left lower extremity with RN #543 verified Resident #21 had three undated bandages in place on his left lower extremity. RN #543 stated the dressings should have been dated when applied. Resident #21 reported he thought they were put on sometime yesterday and restated to RN #543 there were areas that were weeping. RN #543 removed the bandages and there were red areas on Resident #21's leg where the adhesive came in contact with his skin. RN #543 stated she would talk with the physician and get an order put in place for the areas.