

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 725004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Meadows of Marion Health and Rehabilitation The		STREET ADDRESS, CITY, STATE, ZIP CODE 155 Marion Cardington Road West Marion, OH 43302	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 725004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Meadows of Marion Health and Rehabilitation The		STREET ADDRESS, CITY, STATE, ZIP CODE 155 Marion Cardington Road West Marion, OH 43302	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, facility failed to ensure resident falls were thoroughly investigated and documented and interventions were appropriate and followed for two residents (#5 and #28) of three reviewed for falls. Facility census was 76. Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 07/29/25. Diagnoses included Parkinson's, diabetes, malignant neoplasm of lip pharynx and oral cavity, dysphagia, muscle weakness, hernia, edema, pneumonitis, abnormal involuntary movements, hypotension repeated falls and impulse disorder. Review of the daily census record for Resident #5 revealed the resident was discharged on 07/31/25 and readmitted on [DATE], discharged on 08/21/25 and readmitted on [DATE], discharged on 09/14/25 and readmitted on [DATE], discharged on 09/22/25 and readmitted on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition and required extensive maximum assistance for activities of daily living and partial /moderate assistance for bed mobility and transfers. The MDS assessment revealed prior falls. Review of the plan of care initiated 07/30/25 revealed the resident was at risk for falls with interventions to ensure call light was in reach, the environment to be free of clutter, commonly used items within reach, maintain a clear pathway and monitor for side effects of psychiatric medications were initiated on 07/30/25. Intervention to encourage the resident to change position slowly and low bed were initiated on 08/08/25. Intervention for bed alarm, chair alarm, frequent visualization, verbally encourage to use call light and visual reminders were initiated on 08/20/25. Intervention to move the resident's room closer to the nursing station was initiated on 08/29/25. Intervention to wear non-skid socks was initiated on 09/11/25. Intervention during ambulation follow behind with wheelchair was initiated on 09/14/25. Intervention to add non-skid strips to both sides of the bed, provide staff education, provide 1-2 person assist with all transfers was initiated on 09/21/25. Intervention to encourage the resident to wear hip protectors (to prevent injury) and offer toileting at regular intervals to prevent unassisted attempts was initiated on 09/22/25. Intervention for communication board, medication review, and bed in lowest position was initiated on 09/29/25. Intervention for floor mat to both sides was initiated on 09/30/25. Intervention for call don't fall sign was initiated on 10/04/25. Review of the progress notes dated 07/30/25 at 11:45 P.M. revealed the resident was found on the floor on his back on the right side of the bed in front of his chair and doorway to the bathroom. The resident was unable to tell what he was doing and what caused the fall. The fall was unwitnessed, and no injuries were identified. The resident reported he hit the back of his head, and no injuries were noted. The resident was assisted back to bed and neuro checks were initiated. Review of fall risk investigation and interdisciplinary team (IDT) fall investigation dated 07/30/25 found resident was a new to the facility and a bed alarm was put in place. Review of the progress note dated 08/07/25 (untimed) of the interdisciplinary team (IDT) related to fall on 07/30/25 revealed the new intervention included a bed alarm. This is not documented on care plan for 07/30/25. Review of the progress note dated 08/08/25 at 10:48 P.M. revealed that Certified Nursing Aide (CNA) was assisting the resident from the bathroom back to bed, the resident lost his footing and tripped over his feet, the CNA lowered the resident to floor. The resident was assessed with no injuries or pain. The resident was assisted back to bed call light in reach and bed in low position. Medical doctor and family notified. Review of fall risk investigation and interdisciplinary team (IDT) fall investigation dated 08/08/25 found resident fell while being assisted by staff. The investigation reported he tripped over his feet but did not specify how that occurred and what footwear was in place. The new intervention included educating the resident to turn and change positions slowly. Review of the progress note dated 08/20/25 revealed the bed and chair alarm were discontinued after a nursing assessment found resident was able to demonstrate safe transfers without the need for alarms. Visual reminders were placed in his room to remind Resident #5 to use the call light. Review of the progress note dated 08/20/25 at 3:30 P.M. revealed the resident was observed on bathroom floor by a certified nursing aide. Resident #5 was assessed and found two abrasions. Review of fall risk investigation and interdisciplinary team (IDT) fall investigation dated 08/20/25 found resident had an unwitnessed fall in the bathroom. The investigation did not include information about the last time resident had been toileted or went to the bathroom. The new intervention included educating the resident on use of the call light. Review of the progress note dated 08/20/25 at 11:45 P.M. revealed the resident was found on floor laying on his left side by the shower floor. The resident stated he was heading to the bathroom at the time of the fall. The resident was transferred to the emergency</p>		