STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365265	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piqua Manor	1840 West High Street Piqua, OH 45356

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to notify the physician of a change in condition in a timely manner. This affected two (#106 and #96) of two residents reviewed for change in condition. The facility census was 87.Findings include:1. Review of the medical record for Resident #106 revealed an admission date of 07/19/24 with diagnoses including centrilobular emphysema, chronic obstructive pulmonary disease (COPD), and essential hypertension.Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 was cognitively intact. Resident required set-up assistance with eating, oral hygiene, bathing, personal hygiene, and required partial assistance with toileting hygiene, dressing, bed mobility, transfers, and ambulation. The resident was dependent on staff assistance with wheelchair mobility.Review of the physician order dated 07/19/24 revealed Resident #106 wore oxygen via nasal canula at three liters continuously.Review of the care plan dated 07/19/24 revealed Resident #106 used oxygen therapy relate to COPD with interventions to monitor for signs or symptoms of respiratory distress and report to the physician, such as respiration rate increase, increased heart rate, restlessness, lethargy, and accessory muscle usage.Review of the notification note dated 01/02/26 at 9:39 A.M. revealed Resident #106 was sent to hospital per family request. Further review of the medical record revealed no documentation of vital signs, assessments, or notification to the physician of a change in condition or hospitalization.Interview on 03/25/26 at 3:04 P.M. with the Director of Nursing (DON) confirmed she remembered on 01/02/26 Resident #106 was having trouble breathing in the middle of the night but refused to go to the hospital. The DON stated the resident's daughter came in to visit that morning, she convinced the resident to go to the hospital. The DON confirmed the staff nurse (Licensed Practical Nurse (LPN) #160) working the night of the change in condition did not document the resident's change in respiratory status. The DON confirmed there was no documentation of the physician being notified of the change in condition or of the physician being notified of the transfer to the hospital. The DON stated it was the expectation of the nurse to document all changes in condition, and to notify the physician and family when the change occurs. 2. Record review for Resident #96 revealed the resident was admitted to the facility on [DATE] with diagnoses including disruption of external operation surgical wound, infection following a procedure, acute and chronic combined systolic congestive and diastolic congestive heart failure, and type two diabetes mellitus with diabetic polyneuropathy.Review of the MDS assessment dated [DATE] revealed Resident #96 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 14. The resident was assessed to be taking antidepressant, hypnotic, diuretic, antiplatelet, insulin, and anticonvulsant medications, and received a therapeutic diet including low salt, diabetic, and low cholesterol.Review of the care plan dated 02/09/26 revealed Resident #96 was at risk for alteration in nutrition/hydration status related to a surgical wound, infection, respiratory failure, type two diabetes, congestive heart failure, heart disease, and chronic kidney disease. Resident #96 was on a therapeutic diet, which may impact weight and/or fluid balance. Interventions included to monitor weight per facility protocol and as needed per order; notify the physician of any significant weight (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change; and monitor, document, and report to the physician changes in lung sounds on auscultation, edema, shortness of breath, vital signs, and changes in weight.Review of the medical record for Resident #96 revealed a physician order dated 11/12/25 directing staff to notify the physician of a weight gain of two or more pounds in one day or five pounds in one week.Review of weight records revealed Resident #96 was noted to have a weight increase from 219.2 pounds (lbs.) on 03/20/26 to 223.2 lbs. on 03/21/26, totaling a gain of 4.0 lbs. Further review revealed Resident #96 also experienced a weight increase from 220.4 lbs. on 03/24/26 to 223.8 lbs. on 03/25/26, totaling a gain of 3.4 lbs. There was no documentation of the physician being notified of the weight gain in the medical record.Interview on 03/25/26 at 2:30 P.M. with Regional Clinical Nurse (RCN) #1 verified the physician was not notified on 03/21/26 or 03/25/26 regarding Resident #96's weight gain per physician order.Review of facility policy titled, Notification of Changes Policy, dated 11/02/16, revealed the facility will inform the resident, the attending physician, and the resident's representative or interested family member of changes which affect the resident.This deficiency represents non-compliance related to Complaint Number 2708212.