

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Bowling Green Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 W Poe Rd Bowling Green, OH 43402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on medical record review and staff interview, the facility failed to ensure resident assessments were completed accurately. This affected one (#73) of 19 residents reviewed for assessments. The facility census was 93. Findings include: Review of the medical record revealed Resident #73 was admitted on [DATE]. Diagnoses included late onset Alzheimer's disease, dementia, anxiety, lumbosacral disc degeneration, abnormalities of gait and mobility, oropharyngeal dysphagia, hypertension, and peripheral vascular disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, revealed Resident #73 required a mechanically altered diet and did not take scheduled pain medication. Review of Resident #73's physician orders revealed an order dated 08/21/23 for Oxycodone with acetaminophen 5-325 milligrams (mg), one pill by mouth twice daily for moderate pain. Further review revealed an order dated 10/10/23 for a regular texture and regular consistency diet. Interview on 02/18/25 at 8:30 A.M. with Registered Nurse (RN) #532 verified Resident #73's MDS assessment was incorrectly coded and further confirmed the resident did not require a mechanically altered diet and received scheduled pain medication.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, resident interview, medical record review, staff interview and review of facility policy, the facility failed to ensure resident care plans were comprehensive and included care needs related to smoking for two (#38 and #88) residents and for one (#61) resident for edema care. This affected three residents (#38, #88 and #61) of 19 residents reviewed for comprehensive care planning. The facility census was 93. Findings include: 1. Review of Resident #38's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes, anxiety disorder, adult failure to thrive and nicotine dependence. Review of the Minimum Data Set (MDS) assessment, dated 01/28/25, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review revealed Resident #38 was dependent on staff for transfers and putting on footwear, required maximal assistance with parts of dressing, utilized a manual wheelchair for mobility and displayed verbal behavioral symptoms directed toward others one to three days during the review period. Review of the care plan revealed no supports or interventions related to nicotine dependence or smoking were in place for Resident #38 until the care plan was revised on 02/11/25. Interview on 02/11/25 at 7:53 A.M. with Resident #38 revealed he smoked cigarettes. Concurrent observation revealed the resident had cigarettes and a lighter in his coat pocket. Observation on 02/11/25 at 7:56 A.M. of Resident #38 revealed he was smoking in the parking lot of the facility. Interview on 02/13/25 at 1:20 P.M. with the Director of Nursing (DON) verified Resident #38 smoked and his care plan was not updated to include smoking interventions until 02/11/25. 2. Review of Resident #88's medical record revealed an admitted [DATE]. Diagnoses included peripheral vascular disease, anxiety disorder, cannabis abuse, type II diabetes, cocaine abuse, and nicotine dependence. Review of the MDS assessment, dated 12/27/24, revealed Resident #88 had a BIMS score of 15, indicating the resident was cognitively intact. Further review revealed Resident #88 was dependent on staff for putting on footwear, required moderate assistance with parts of dressing, maximal assistance with transfers, utilized a manual wheelchair for mobility and displayed rejection of care behaviors one to three days during the review period. Review of the care plan revealed Resident #88 had no supports or interventions in place related to smoking or nicotine dependence until the care plan was revised on 02/11/25. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/11/25 at 7:43 A.M. of Resident #88 revealed he was off to the side of the facility parking lot smoking. Interview on 02/13/25 at 1:20 P.M. with the DON verified Resident #88 smoked and his care plan was not updated to include smoking interventions until 02/11/25. 47057 3. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included subdural hemorrhage (bleeding in the brain), and brain tumor. Further medical record review revealed Resident #61 was hospitalized in October 2024 and, upon return from the hospital, was found to have edema (swelling) of the left upper arm and left hand. Review of the physician progress note dated 10/24/24 revealed Resident #61 was finishing a course of Lasix (used to treat edema) and no improvement was noted to the left hand edema. A Doppler (ultrasound) was completed on 10/14/2024, which was negative for deep vein thrombosis (DVT). The physical examination revealed the left upper extremity and hand continued with edema and the plan was to start a lymphedema sleeve (applies pressure to reduce swelling) to the left upper extremity, on in the morning and off at bedtime or may wear at all times if the resident preferred Review of the quarterly MDS assessment, dated 12/02/24, revealed Resident #61 was cognitively impaired and dependent on staff for dressing. Review of the February 2025 physician orders revealed Resident #61 had an order for a lymphedema sleeve to the left upper extremity. Review of the care plan, revised December 2024, revealed no care plan supports or interventions related to edema/lymphedema sleeve were implemented for Resident #61. Interview on 02/13/25 at 1:02 P.M. with the DON verified there was no care plan in place for Resident #61's edema or use of a lymphedema sleeve. Review of the facility policy titled, Comprehensive Care Plan, revised November 2016, revealed the facility would develop a comprehensive person centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.		

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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** 37451 Based on medical record review, staff interview and review of the facility's bowel protocol, the facility failed to ensure residents at risk for constipation had bowel interventions implemented as directed. This affected one (#64) of one resident reviewed for constipation. The facility census was 93. Findings include: Review of Resident #64's medical record revealed an admitted [DATE]. Diagnoses included dementia, anxiety disorder, depression, altered mental status, muscle weakness, cognitive communication deficit, and prostate cancer. Review of the Minimum Data Set (MDS) assessment, dated 01/16/25, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of nine, indicating the resident was moderately cognitively impaired. Further review revealed Resident #64 required touching assistance with toilet use, dressing and transfers and was always continent of bowel. Review of the care plan, revised 02/09/25, revealed Resident #64 was at risk for constipation. Interventions included administer medications and treatments as ordered, assess bowel sounds, and monitor for bowel movements (BM). Review of the Certified Nursing Assistant (CNA) task documentation revealed Resident #64's BMs were tracked daily. Further review revealed from 01/27/25 through 02/03/25 (total of eight days), no BM was documented. Review of Resident #64's physician orders revealed an order dated 06/24/24, and discontinued 02/06/25, for Docusate Sodium (laxative) 100 milligrams (mg), one capsule by mouth two times a day for constipation. Review of the corresponding Medication Administration Record (MAR) revealed Resident #64's scheduled medication was administered as ordered. Further review revealed on 01/24/25, Resident #64 received as needed (PRN) Maalox Plus 30 milliliters (ml) for indigestion. Additional review revealed no other PRN interventions were implemented to address Resident #64 not having a BM for the eight days between 01/27/25 to 02/03/25. Attempted interview on 02/11/25 at 9:39 A.M. with Resident #64 found him anxious, restless, and confused. Resident #64 was not able to be interviewed. Interview on 02/12/24 at 7:50 A.M. with Registered Nurse (RN) #410 revealed the facility had a bowel protocol in place. RN #410 explained that if a resident did not have a BM in three days, the staff implemented a progressive protocol until the resident had a BM, beginning with prune juice, then milk of magnesia, followed by a Dulcolax (laxative) tab, then a rectal suppository, and the final step would be an enema. RN #410 verified Resident #64 was at risk for constipation and added Resident #64 was not on the list generated in the electronic medical record (EMR) for a bowel protocol. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 9:19 A.M. with the Director of Nursing (DON) verified there was no documentation Resident #64 had a bowel movement from 01/27/25 through 02/03/25 and further confirmed there was no evidence bowel protocol interventions were implemented during that time. Interview on 02/12/25 with CNA #504 revealed Resident #64's BMs were tracked in the care tracker (tasks). CNA #504 reported Resident #64 had been declining and was no longer able to take himself to the bathroom, resulting in staff checking and changing or toileting the resident every two hours. Prior to electing hospice services (02/06/25), CNA #504 stated Resident #64 was able to take himself to the bathroom, but still required staff assistance with clean up following a BM. CNA #504 confirmed staff would be aware when Resident #64 had a BM and documented it in care tracker. CNA #504 stated if a BM was not documented in a few days, the system would alert the nurse and the nurse would take care of it from that point. CNA #504 confirmed the documentation for Resident #64's BM tracking was accurate. Review of the facility's undated Bowel Protocol revealed if the resident had no BM in three days, start bowel protocol/prune juice, then milk of magnesia, Dulcolax tabs, rectal suppository, and enema.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, resident interview, medical record review, staff interview and review of the facility Admission Agreement, the facility failed to maintain safe smoking practices. This affected two residents (#38 and #88) of two residents reviewed for smoking. The facility census was 93. Findings include: 1. Review of Resident #38's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes, anxiety disorder, adult failure to thrive, and nicotine dependence. Review of the Minimum Data Set (MDS) assessment, dated 01/28/25, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review revealed Resident #38 was dependent on staff for transfers and putting on footwear, required maximal assistance with parts of dressing, utilized a manual wheelchair for mobility, and displayed verbal behavioral symptoms directed toward others one to three days during the review period. Review of the care plan, revised 02/11/25, revealed Resident #38 had supports and interventions for admission adjustment issues, impaired cognitive function, potential for verbally abusive behaviors, and non-compliance with smoking policy (updated 02/11/25). Further review of the medical record revealed no evidence a smoking assessment was completed to determine Resident #38's ability to independently smoke safely. Interview on 02/11/25 at 7:52 A.M. with Resident #38 verified he smoked and kept his cigarettes and lighter with him in his room. Coinciding observation revealed Resident #38 had his smoking materials in the left pocket of his winter coat. Resident #38 reported he went out when he wanted and went to smoke at the neighboring church. Observation on 02/11/25 at 7:53 A.M. of Resident #38 revealed he went out the front door of the facility. Resident #38 propelled himself in his wheelchair to edge of the facility's parking lot. Continuous observation revealed at 7:55 A.M., Resident #38 pulled a cigarette and lighter out of his coat pocket, lit the cigarette, and proceeded to smoke on the facility's smoke-free campus. Interview on 02/11/25 at 7:56 A.M. with the Administrator verified Resident #38 was smoking on facility property. The Administrator reported they were aware Resident #38 smoked, and he had been directed to go over to the church parking lot to smoke. The Administrator stated he would remind Resident #38 to go off the property to smoke. 2. Review of Resident #88's medical record revealed an admitted [DATE]. Diagnoses included peripheral vascular disease, anxiety disorder, cannabis abuse, type II diabetes, cocaine abuse, and nicotine dependence. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 12/27/24, revealed Resident #88 had a BIMS score of 15, indicating the resident was cognitively intact. Further review revealed Resident #88 was dependent on staff for putting on footwear, required moderate assistance with parts of dressing, maximal assistance with transfers, utilized a manual wheelchair for mobility, and displayed rejection of care behaviors one to three days during the review period. Review of the care plan, revised 02/11/25, revealed Resident #88 had supports and interventions in place for emphysema related to smoking, occasional noncompliance with care, and refusal to follow the smoking policy. Further review of the medical record revealed no evidence a smoking assessment was completed to determine Resident #88's ability to independently smoke safely. Observation on 02/11/25 at 7:43 A.M. of Resident #88 revealed he was sitting in his wheelchair outside in the facility parking lot and appeared to be smoking. Further observation revealed Resident #88 was wearing a hat and winter coat. While observation did not reveal a cigarette being lit, white plumes of smoke were observed rising from Resident #88's mouth. Concurrent interview with an unidentified housekeeping staff verified Resident #88 was smoking in the facility's parking lot. Interview on 02/11/25 at 7:46 A.M. with the Administrator revealed he was aware Resident #88 smoked. The Administrator reported Resident #88 actually vaped and the arrangement for smoking or vaping was the residents were to sign out and go over to the church parking lot to smoke. The Administrator verified smoking assessments were not completed for Resident #38 and Resident #88 due to it being a non-smoking facility. The Administrator confirmed smoking supplies were to be kept locked/secured by staff. Review of the facility's Admission Agreement, dated January 2018, revealed the facility was smoke-free. Residents and visitors were not permitted to smoke in any area or around the facility campus. By signing the agreement the resident agreed to not smoke at any time or any location on the facility's campus including property attached to the surrounding facility.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on medical record review, staff interview and review of the facility's skills competency for pain management document, the facility failed to ensure pain assessments were completed with the administration of narcotic pain medications. This affected one (#73) of five residents reviewed for unnecessary medications. The facility census was 93. Findings include: Review of Resident #73's medical record revealed and admitted [DATE]. Diagnoses included late onset Alzheimer's disease, dementia, anxiety, lumbosacral disc degeneration, abnormalities of gait and mobility, oropharyngeal dysphagia, gastroesophageal reflux disease (GERD), hyperlipidemia, long term current drug therapy, hypertension, hypothyroidism, and peripheral vascular disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, revealed Resident #73 was cognitively impaired, used a manual wheelchair and was at risk for pressure ulcers. The assessment indicated Resident #73 did not take scheduled pain medication. Review of a physician order dated 08/21/23 revealed Resident #73 was ordered a scheduled dose of Oxycodone with acetaminophen (Percocet) 5-325 milligrams (mg), one pill by mouth twice daily for moderate pain. Review of the Medication Administration Record (MAR) for January 2025 and February 2025 revealed Resident #73 received the scheduled doses of Oxycodone as ordered. Further review of the MAR revealed no evidence a pain assessment was completed with the administrations. Additional review of the Treatment Administration Record (TAR) for January 2025 and February 2025 also revealed no evidence pain assessments were completed for Resident #73. Review of the progress notes from 12/01/24 to 02/13/25 revealed documentation related to three instances of pain assessments. On 12/11/24, Resident #73's pain was recorded as zero on a scale of zero to ten, with zero being no pain. Additional review revealed pain assessments dated 12/20/24 and 01/12/25 were completed in coordination with MDS assessments and pain intensity over the previous five days was identified as mild. Interview with the Director of Nursing (DON) on 02/12/25 at 1:30 P.M. confirmed pain assessments were not being completed with the administration of Resident #73's scheduled Oxycodone and further verified pain assessments should be completed and documented in the medical record in conjunction with the administration of pain medication. Review of the facility document titled, Skills Competency Checklist - Pain Management, dated April 2008, revealed the resident's response to analgesics (pain medication) would be evaluated.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41528 Based on observation, resident interview, staff interview and review of facility policy, the facility failed to ensure resident meals were palatable. This affected all residents, except 31(#6, #8, #10, #18, #22, #24, #25, #26, #35, #39, #40, #44, #49, #52, #58, #61, #65, #67, #71, #75, #77, #84, #90, #92, #95, #148, #152, #245, #246, #247, #248) residents the facility identified as not being served French fries. Additionally, the facility failed to ensure recipes for pureed diets were followed to maintain nutritive value. This affected four (#8, #39, #61 and #90) of four residents identified by the facility as receiving pureed meals. The facility census was 93. Findings include: 1. Interview on 02/10/25 at 8:15 P.M. with Resident #24 revealed the food at the facility was not good. Interview on 02/11/25 at 11:43 A.M. with Resident #52 revealed the only area of concern at the facility was the food, adding the vegetables were either under or overcooked and meals were not warm enough to be palatable. Interview on 02/11/25 at 12:33 P.M. with Resident #80 revealed her lunch meal was cold and the French fries were not cooked. Concurrent observation revealed the French fries appeared white and flimsy. Interview on 02/11/25 at 12:35 P.M. with Resident #9 revealed the French fries served for lunch were not edible. Interview on 02/11/25 at 2:15 P.M. with Resident #73's family representative revealed most of the food served at the facility was not palatable. Observation on 02/11/25 at 12:37 P.M. revealed a test plate of the French fries, served from the steam table the lunch meal was served from. The French fries appeared white and unappetizing, were cold, unflavored, and had an unfavorable texture. Interview on 02/11/25 at 12:38 P.M. with [NAME] #439 revealed salt was added to the French fries prior to baking. Further interview with [NAME] #439 confirmed the French fries did not have a taste and were not palatable. Interview on 02/11/25 at 12:39 P.M. with Dietary Manager #546 verified the French fries were not cooked appropriately. Review of the facility policy titled, Nutrition Services Policy and Procedure Objectives, dated January 2018, revealed the objectives of the nutrition services department was to provide nutritious, palatable, and attractive meals to meet and satisfy individual needs. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 02/12/25 at 10:20 A.M. of pureed meal preparation revealed [NAME] #439 added hamburger patties and an unknown amount of hot water to the puree blender. Concurrent interview with [NAME] #439 verified she added an unknown amount of water to the hamburger patties to puree and added she always used hot water to puree food, unless the meal was pot roast and there was gravy available. Dietetic Technician (DT) #592 intervened and added gravy to the hamburger and water in the puree blender. Review of the undated pureed hamburger recipe revealed to place sandwich filler in the blender or food processor, add condiments/gravy, and blend until pudding like consistency was reached.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41528 Based on observation, staff interview, review of the pureed food recipe and review of facility policy, the facility failed to ensure pureed foods were prepared to an appropriate consistency. This affected four (#8, #39, #61, and #90) of four residents identified by the facility as receiving pureed food. The facility census was 93. Findings include: Observation on 02/12/25 at 10:20 A.M. of pureed meal preparation revealed [NAME] #439 added hamburger patties and hot water to the puree blender. At 10:24 A.M., [NAME] #439 stopped the blender, took off the lid, and used her gloved fingers to test the texture of the pureed meat. Concurrent interview with [NAME] #439 revealed the expected texture of the meat should be a honey thick texture and she determined the meat was of an appropriate consistency. After further observation, it was determined the hamburger was not appropriately pureed and [NAME] #439 continued to blend. Interview on 02/12/25 at 10:27 A.M. with Dietetic Technician (DT) #592 revealed the hamburger meat seemed to be pureed to a pudding like texture and stated it was ready to be served. Coinciding observation of the pureed hamburger, with DT #592, revealed small, chewable pieces of hamburger. Further interview with DT #592 verified there were pieces of hamburger in the pureed meat and the hamburger was not fully pureed to a smooth texture. Observation on 02/12/25 at approximately 10:40 A.M. revealed the hamburger was further pureed to a smooth, pudding-like consistency. Review of the undated pureed hamburger preparation recipe revealed to blend the hamburger until it was smooth and pudding-like consistency. Review of the facility policy titled, Nutrition Services Meal Service, dated October 2017, revealed food was served in accordance with diet texture modifications prescribed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on observation, staff interview and review of facility policy, the facility failed to ensure food was properly labeled and dated and further failed to remove items from stock when expired. Additionally, the facility failed to ensure kitchen staff performed adequate hand hygiene. This had the potential to affect all residents, except one (#248) resident identified by the facility as receiving no nutrition from the kitchen. Lastly, the facility failed to ensure meals were distributed in a manner that protected against contamination. This affected three (#32, #57, and #69) of 17 residents who received meal trays on the B Hall. The facility census was 93. Findings include: 1. Observations on [DATE] between 6:25 P.M. and 7:24 P.M. of the reach-in refrigerator, located in the main kitchen, revealed the following unlabeled food items: two clear gallon pitchers with orange liquid, two uncovered one-cup sized bowls filled with diced peaches and an unopened piping bag of whipped topping that did not have an expiration date. Additional observation of the walk-in refrigerator revealed one plastic bowl of uncovered and unlabeled shredded greens on a white tray, one clear gallon pitcher of ranch dressing with a use by date of [DATE], on three-cup plastic container of tuna covered with torn aluminum foil and dated [DATE] and one 12 quart bucket filled with unlabeled individual zipper baggies containing one slice of bread and one single serve butter packet. Further observation of the dry storage area revealed one 12 count package of hoagie buns covered with what appeared to be mold and one eight count package of Italian split-top buns with an approximately three inch circle of what appeared to be mold. Concurrent interview with Nutrition Services Assistant (NSA) #419 and [NAME] #513 verified the above findings, with [NAME] #513 adding the tuna dated [DATE] should have been used or thrown away within three days. Observation on [DATE] at 7:50 A.M. of the refrigerator located in the activities room revealed the following undated items: four bottles of mustard, three bottles of mayonnaise, three bottles of ketchup, two bottles of coffee creamer, two bottles of salad dressing, three two-liter bottles of pop, one take out container, one container of french onion dip, one bottle of ice cream syrup, and one gallon of rainbow sherbet. Interview on [DATE] at 7:54 A.M. with Activity Assistant (AA) #403 confirmed the items in the activity room refrigerator were undated. Further interview revealed the refrigerator was used for staff lunches and resident activities. Review of the facility policy titled, Food Safety Code Regulations - OH, dated [DATE], revealed food would be discarded when expired or within three days of preparation. 2. Observation on [DATE], beginning at 7:57 A.M., of meal tray service to the B Hall revealed Certified Nursing Assistant (CNA) #487 delivered a meal tray to Resident #25. CNA #487 set up the meal tray, touched Resident #25's bedside tray table and reclining chair remote, and put a clothing protector on Resident #25. Without performing hand hygiene, CNA #487 continued with meal tray service and meal set-up to Residents #32, #57, and #69. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Bowling Green Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 W Poe Rd Bowling Green, OH 43402	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 8:07 A.M. with CNA #487 confirmed she touched multiple surfaces in multiple resident rooms and did not perform hand hygiene between delivering and setting up meal trays for Residents #32, #57, and #69. 41528 3. Observation on [DATE] at 10:50 A.M. of the kitchen revealed Dietary Manager (DM) #546 donned gloves, without performing hand hygiene prior donning the gloves. Continued observation revealed DM #546 proceeded to wipe her nose on her forearm, then placed her gloved hand in a pan with cooked food to pull out a thermometer that had fallen in the pan. Interview on [DATE] at 10:54 A.M. with DM #546 verified she donned gloves without performing hand hygiene, touched her nose to her forearm, then put her gloved hand in the food to take out a thermometer that had fallen in. Review of the facility policy titled, Handwashing, dated [DATE], revealed proper handwashing techniques were to be practiced by Nutrition Services employees. Further review revealed hands were the point of contact with bacteria, that may contaminate the food, or equipment. Proper handwashing techniques were the key to eliminating the source of some bacteria, and preventing the spread of infection in the Nutrition Services Department. Food handlers must wash their hands before starting to work and after performing activities including, but not limited to, touching the hair, face, or body; sneezing, coughing, or using a tissue; touching clothing; and touching anything else that may contaminate hands, such as dirty equipment, work surfaces, or towels.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47057 Based of review of the Quality Assessment and Assurance (QAA) committee meeting sign in sheets, staff interview and review of facility policy, the facility failed to ensure the required personnel were in attendance at the quarterly QAA meetings and further failed to maintain documentation of personnel in attendance at all QAA meetings This had the potential to affect all residents. The facility census was 93. Findings include: Review of the first quarter QAA meeting sign in sheet, dated 05/02/24, revealed no evidence the Medical Director (MD) was in attendance at the meeting. Further review of documentation for the second quarter QAA meeting, held in July 2024, and the third quarter QAA meeting, held in October 2024, revealed no evidence of who was in attendance at the meetings. Interview on 02/18/25 at 1:34 P.M. with the Administrator verified there was no signature, or other evidence of the MD's attendance, at the the first quarter 2024 QAA meeting and further confirmed there were no sign in sheets or other evidence for the second and third quarter QAA meetings to verify those personnel in attendance. Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI), dated 2018, revealed the QAA committee would meet at least quarterly with the required personnel and as needed to coordinate and evaluate activities under the QAPI program.		