

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Edgewood Manor Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S Fulton St Port Clinton, OH 43452	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</b></p> <p>Based on observation, medical record review, and staff interview the facility failed to ensure timely interventions were provided to address resident incontinence patterns. This affected one (#5) of four residents reviewed for incontinence care. The facility census was 66.</p> <p>Findings include:</p> <p>Resident #5 admitted to the facility on [DATE] with the diagnoses including, right rib fracture, cognitive communication deficit, fibromyalgia, hypertension, cerebral infarction with left side hemiplegia and hemiparesis, and polyneuropathy. According to the most current minimum data set assessment dated [DATE] Resident #5 was assessed with intact cognition, no history of refusal or behavior, required substantial to maximal assistance with activities of daily living, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no skin breakdown.</p> <p>On 12/11/24 a nursing plan of care was implemented to address Resident #5's risk for impaired skin integrity related to hemiparesis, hemiplegia, incontinent of bladder, incontinent of bowel, pain, and status post cerebral vascular accident with intervention to include providing incontinence care as needed (PRN). In addition on 12/17/24 a nursing plan of care was revised to address Resident #5's episodes of bladder and bowel incontinence related to diuretic use, generalized weakness, impaired mobility, pain, and physical limitations. Interventions included; administer medications per physician order. Assist resident with toileting needs. Monitor peri-area for redness, irritation, skin excoriation/breakdown. Provide disposable incontinence products. Provide peri care after each incontinent episode; and apply house barrier after incontinence care.</p> <p>On 12/24/24 a bowel and bladder assessment scored Resident #5 with a 17, indicating candidate for bladder retraining.</p> <p>Review of the medical record noted Resident #5 to be diagnosed with a urinary tract infection and receive antibiotic therapy 02/17/25 and 02/24/25 for the treatment of Escherichia coli (E.coli). On 02/17/25 a physician order was initiated for the administration of Ciprofloxacin 500 milligrams (mg) one tablet by mouth twice daily for urinary tract infection E.coli for seven (7) days.</p> <p>(continued on next page)</p>

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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/13/25 at 5:41 A.M. noted Certified Nurse Aide (CNA) #302 indicate Resident #5 was last checked for incontinent at 12:30 A.M. CNA #302 removed Resident #5 blankets and discovered Resident #5 was heavily soiled through an adult brief and onto bed linen. CNA #302 proceeded to provide incontinence care and applied a new adult brief. At 5:51 A.M. interview with CNA #302 verified Resident #5 is to be checked for incontinence every two hours.</p> <p>On 03/13/25 at 6:45 A.M. interview with the Director of Nursing (DON) during review of Resident #5 medical record confirmed the resident is to be checked and changed for incontinence every two hours. DON verified Resident #5 had experienced a recent urinary tract infection.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00162732.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15816</p> <p>Based on observation, medical record review, staff interview and facility policy review the facility failed to ensure medications were maintained and administered in a secure manner. This affected one resident (#4) observed with medications unattended at the bedside. The facility identified five cognitively impaired independently mobile residents(#19, #24, #25, #26, #27) with a total facility census of 66.</p> <p>Findings include;</p> <p>Resident #4 admitted to the facility on [DATE] with the diagnosis including, psychosis, anxiety disorder, depression, paranoid schizophrenia, auditory hallucinations, type two diabetes mellitus, hypertension, and chronic kidney disease. According to the most current minimum data set assessment dated [DATE] Resident #4 had intact cognition, no recorded behavior or rejection of care, required partial to moderate assistance with activities of daily living, was incontinent of bladder, and received antipsychotic, antianxiety, and hypoglycemic medications.</p> <p>Observation on 03/12/25 at 9:09 A.M. noted Resident #4 in bed and on the overbed table next to the bed was a medication cup containing five different pills/tablets. Interview with Resident #4 stated he forgot to take the medication before going to breakfast which was approximately one hour ago. Resident #4 was unable to identify the medications.</p> <p>On 03/12/25 at 9:11 A.M. interview with Licensed Practical Nurse (LPN) #400 verified she handed Resident #4 the medications before he went to breakfast. LPN #400 was unaware Resident #4 did not take the medications and did not observe medications were consumed. Observation of the electronic medication administration record (EMAR) with LPN #400 at the time of interview noted the were initialed as administered.</p> <p>On 03/13/25 at 9:40 A.M. the director of nursing (DON) provided a list of five residents(#19, #24, #25, #26, #27) assessed to be cognitively impaired and independently mobile.</p> <p>Review of facility Administering Medications Policy undated. Medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one hour of their prescribed time. The individual administering the medication must initial on the resident's medication administration record (MAR) after giving the medication.</p>		