

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 08/13/2025
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of medical record, review of hospital records, and review of facility policy, the facility failed to ensure wound care was timely ordered and implemented for one resident (#53) of three residents (#52, and #64) reviewed for wound care. The facility census was 62. Findings Include: Review of the medical record for Resident #53 revealed an admission date of 04/30/25 with diagnoses including anxiety, injury of unspecified kidney, hypothyroidism, altered mental status (AMS), osteoarthritis, asthma, benign prostatic hyperplasia (BPH), bipolar disorder, cellulitis, cerebral infarctions, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), depression, hyperlipidemia, diverticulitis of intestine, gastro-esophageal reflux disease (GERD), insomnia, suicidal ideations (SI), bipolar II disorder, and other long-term (current) drug therapy. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 08/05/25, revealed a Brief Interview of Mental Status (BIMS) assessment score of 14, indicating Resident #53 was cognitively intact. Review of the community based hospital records for Resident #53 revealed the resident was admitted to the hospital on [DATE] through 08/09/25. While at the hospital the resident had a wound on his left great toe cultured and was determined to contain Staphylococcus aureus (S. aureus). There was a physician ordered to take one tablet of the antibiotic Sulfamethoxazole-Trimethoprim, 800-160 milligrams (mg), by mouth (PO), twice daily, with eight doses remaining when the resident was discharged to the nursing facility. The discharge paperwork received by the facility from the hospital contained the laboratory results for the left great toe wound which showed it was positive for S. aureus. Review of the facility medical record for Resident #53 revealed no orders for wound care including dressing changes for the left great toe from 08/09/25 through 08/11/25. Interview on 08/11/25 at 3:19 P.M. with the Administrator and the Director of Nursing verified Resident #53 had no wound care or dressing change orders in place from 08/09/25 through 08/11/25. Review of the facility policy titled Wound Care, dated September 2021 revealed the purpose of wound care is to care for the wounds to promote healing. This deficiency represents non-compliance investigated under Complaint Number 1385721 (OH00165660).</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of medical record, and review of facility policy, the facility failed to ensure adequate infection control practices were implemented. This affected Resident #53 with the potential to affect all facility residents. The facility census was 62. Findings Include: Review of the medical record for Resident #53 revealed an admission date of 04/30/25 with diagnoses including anxiety, injury of unspecified kidney, hypothyroidism, altered mental status (AMS), osteoarthritis, asthma, benign prostatic hyperplasia (BPH), bipolar disorder, cellulitis, cerebral infarctions, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), depression, hyperlipidemia, diverticulitis of intestine, gastro-esophageal reflux disease (GERD), insomnia, suicidal ideations (SI), bipolar II disorder, and other long-term (current) drug therapy. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 08/05/25, revealed a Brief Interview of Mental Status (BIMS) assessment score of 14, indicating Resident #53 was cognitively intact. Review of the community based hospital records for Resident #53 revealed the resident was admitted to the hospital on [DATE] through 08/09/25. While at the hospital the resident had a wound on his left great toe cultured and was determined to contain Staphylococcus aureus (S. aureus). There was a physician ordered to take one tablet of the antibiotic Sulfamethoxazole-Trimethoprim, 800-160 milligrams (mg), by mouth (PO), twice daily, with eight doses remaining when the resident was discharged to the nursing facility. The discharge paperwork received by the facility from the hospital contained the laboratory results for the left great toe wound which showed it was positive for S. aureus. Observation on 08/11/25 at 10:04 A.M. of the signage by the door for Resident #53's room revealed he was in enhanced barrier precautions (EBP). Observation on 08/11/25 at 2:17 P.M. of the signage by the door for Resident #53's room revealed he was in contact precautions. Review of the medical record for Resident #53 revealed he had no physician orders for any type of isolation precautions until 08/11/25 at 9:40 A.M. when he was placed in EBP for an arterial ulcer. Review of the medical record for Resident #53 revealed on 08/11/25 at 11:26 A.M., the resident was ordered contact isolation precautions. Interview on 08/11/25 at 2:34 P.M. with the Director of Nursing (DON) and the Administrator revealed Resident #53 was placed in contact isolation precautions due to the results of the wound culture of his left great toe being positive for S. aureus. The DON and the Administrator verified the Resident #53 was admitted to the facility on [DATE] with the positive wound culture results included in his discharge paperwork from the hospital, and he was receiving treatment for a wound infection at the time of admission but was not placed into isolation precautions until two days later. The DON and Administrator stated it is the responsibility of the admitting nurse to verify laboratory results to ensure residents are placed into the correct isolation precautions as needed. Observation on 08/11/25 at 2:28 P.M. with the DON and Registered Nurse (RN) #200 of Resident #53's room revealed there was no waste receptacle to place discarded Personal Protective Equipment (PPE) into when exiting Resident #53's room. During a concurrent interview with the DON and RN #200 it was verified there was no waste receptacle to place used PPE into when exiting Resident #53's room. Observation on 08/12/25 at 9:59 A.M. revealed Licensed Practical Nurse (LPN) #134 entering Resident #53's room without donning PPE. Interview on 08/12/25 at 10:01 A.M. with LPN #134 verified she entered Resident #53's room without donning any PPE, stating she was not aware he was on isolation precautions. Review of the facility policy titled, Infection Prevention and Control Program, dated September 2022, revealed important facets of infection prevention include implementing appropriate isolation precautions when necessary. This deficiency represents non-compliance investigated under Complaint Number 1385721 (OH00165660).</p>		