STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, resident interview, staff interview, and policy review, the facility failed to ensure resident medications were administered per physician orders. This affected two (#31, #19) of three residents reviewed for medications administration. The facility census was 55.Findings include:1. Review of the medical record for Resident #31 revealed an admission date of 02/08/26. Diagnoses included hypertension, type two diabetes mellitus, osteoarthritis, heart failure, generalized anxiety disorder, and chronic obstructive pulmonary disease.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment. The resident required substantial/maximal assistance from staff for activities of daily living. Review of the hospital discharge physician medication orders revealed orders for furosemide 40 milligrams (mg) by mouth twice daily, gabapentin 100 mg three times per day, guaifenesin 600 mg 12-hour tablet twice daily, metformin 500 mg twice daily, oxycodone 5 mg as needed every eight hours for severe pain, and zolpidem 10 mg as needed at bedtime. Further review of the orders revealed six medications including buspirone 30 mg, dapagliflozin propanediol 10 mg, lorazepam 0.5 mg every eight hours as needed, polyethylene glycol 17 grams, sennosides 8.6 mg, and tramadol 50 mg were paused with orders to wait to take the medications until a physician or other care provider instructed to start the medications again. Review of the physician orders dated 02/09/26 revealed the resident was ordered furosemide 40 mg twice daily for edema, gabapentin 100 mg three times a day for neuropathy, guaifenesin 12 hour 600 mg twice daily, lorazepam 0.5 mg every eight hours as needed for anxiety, metformin 500 mg twice daily for diabetes mellitus, oxycodone 5 mg every eight hours as needed for post-surgical pain for three days, tramadol 50 mg every eight hours as needed for pain, and senna plus 8.6/50 mg four times a day for constipation.Review of the facility contingent medication supply document revealed medications available on hand included gabapentin 100 mg, furosemide 40 mg, guaifenesin 600 mg, metformin 500 mg, lorazepam 0.5 mg, oxycodone 5 mg, and zolpidem 5 mg tablets. Review of the medication administration record (MAR) for 02/08/26 revealed the resident was administered no medications per physician orders on 02/08/26. Interview on 03/16/26 at 9:14 A.M., Resident #31 revealed he had not received any evening medications on 02/08/26 including his anxiety medication which was really needed. Interview on 03/16/26 at 1:24 P.M., Unit Manager Licensed Practical Nurse (UMLPN) #222 revealed the floor nurse was responsible for reviewing medication orders with the physician and entering the orders. UMLPN #222 revealed for new admissions the nurse should first address the medication orders. UMLPN #222 verified Resident #31 had not received medications per physician orders on 02/08/26. UMLPN #222 verified the nurse should have pulled the medications available from the facility contingent supply. UMLPN #222 verified the resident could have received the gabapentin, furosemide, guaifenesin, metformin, oxycodone, and zolpidem as the medications were available. UMLPN #222 revealed the resident could have also received the lorazepam for anxiety had the nurse clarified the paused medication orders with the physician. UMLPN #222 further revealed Resident #31 had voiced concerns about not receiving all his medications and she later clarified the orders with the physician.2. Review of the medical record for (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19 revealed an admission date of 01/23/26. Diagnoses included schizoaffective disorder, dementia, chronic pain, anxiety, chronic obstructive pulmonary disease, hypothyroidism, gastroesophageal reflux disease (GERD), and epilepsy.Review of the admission MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the 02/2026 physician orders revealed orders revealed the resident had orders for lacosamide 100 mg at bedtime for seizures, levothyroxine 50 micrograms (mcg) daily for thyroid, pantoprazole 20 mg daily for GERD, trazodone 100 mg at bedtime, lamotrigine 100 mg give with 25 mg to equal 125 mg twice daily for epilepsy, buspirone 10 mg three times a day for anxiety, acetaminophen 500 mg three times a day for pain, and rosuvastatin 10 mg by mouth at bedtime for cholesterol. Review of the MAR dated 02/01/26 through 02/28/26 revealed the resident was not administered the lacosamide 100 mg on 02/05/26 and 02/10/26, the levothyroxine 50 mcg on 02/02/26, 02/05/26, 02/10/26, and 02/11/26, the pantoprazole 20 mg on 02/02/26, the 02/05/26, 02/10/26, 02/11/26, and 02/27/26, the rosuvastatin 10 mg on 02/04/26, 02/10/26, the trazodone 100 mg on 02/04/26 and 02/10/26, the lamotrigine 100 mg with an additional 25 mg at 4:00 A.M. on 02/02/26, 02/05/26, 02/10/26, 02/11/26, and 02/27/26, the acetaminophen 500 mg at 7:00 P.M. on 02/04/26 and 02/10/26, and the buspirone 10 mg at 7:00 P.M. on 02/04/26 and 02/10/26.Review of the nursing notes dated 02/01/26 through 02/28/26 revealed no documentation the resident had refused the medications.Interview on 03/17/26 at 7:46 A.M., Resident #19 revealed the nurse was not waking her up to give her medications. Resident #19 further revealed some nurses just do not give me my medications.Interview on 03/17/26 at 2:03 P.M., the Regional Director of Clinical Services (RDCS) #700 verified Resident #19 was not administered medications per physician orders. RDCS #700 revealed the resident had no changes in condition since admission. RDCS #700 revealed she could not find any documentation the resident had refused the medications. Review of the facility policy Administering Medications, revised 04/2019, revealed medication would be administered per physician orders, including any required time frame.This deficiency represents non-compliance investigated under Complaint Number 2796620.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, resident interview, staff interview, and policy review, the facility failed to ensure residents were free of significant medication errors. This affected two (#31, #19) of three residents reviewed for medication administration. The facility census was 55.Findings include:1. Review of the medical record for Resident #31 revealed an admission date of 02/08/26. Diagnoses included hypertension, type two diabetes mellitus, osteoarthritis, heart failure, generalized anxiety disorder, and chronic obstructive pulmonary disease.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment. The resident required substantial/maximal assistance from staff for activities of daily living. Review of the hospital discharge physician medication orders revealed orders for furosemide 40 milligrams (mg) by mouth twice daily, gabapentin 100 mg three times per day, guaifenesin 600 mg 12-hour tablet twice daily, metformin 500 mg twice daily, oxycodone 5 mg as needed every eight hours for severe pain, and zolpidem 10 mg as needed at bedtime. Further review of the orders revealed six medications including buspirone 30 mg, dapagliflozin propanediol 10 mg, lorazepam 0.5 mg every eight hours as needed, polyethylene glycol 17 grams, sennosides 8.6 mg, and tramadol 50 mg were paused with orders to wait to take the medications until a physician or other care provider instructed to start the medications again. Review of the physician orders dated 02/09/26 revealed the resident was ordered furosemide 40 mg twice daily for edema, gabapentin 100 mg three times a day for neuropathy, guaifenesin 12 hour 600 mg twice daily, lorazepam 0.5 mg every eight hours as needed for anxiety, metformin 500 mg twice daily for diabetes mellitus, oxycodone 5 mg every eight hours as needed for post-surgical pain for three days, tramadol 50 mg every eight hours as needed for pain, and senna plus 8.6/50 mg four times a day for constipation.Review of the facility contingent medication supply document revealed medications available on hand included gabapentin 100 mg, furosemide 40 mg, guaifenesin 600 mg, metformin 500 mg, lorazepam 0.5 mg, oxycodone 5 mg, and zolpidem 5 mg tablets. Review of the medication administration record (MAR) for 02/08/26 revealed the resident was administered no medications per physician orders on 02/08/26. Interview on 03/16/26 at 9:14 A.M., Resident #31 revealed he had not received any evening medications on 02/08/26 including his anxiety medication which was really needed. Interview on 03/16/26 at 1:24 P.M., Unit Manager Licensed Practical Nurse (UMLPN) #222 revealed the floor nurse was responsible for reviewing medication orders with the physician and entering the orders. UMLPN #222 revealed for new admissions the nurse should first address the medication orders. UMLPN #222 verified Resident #31 had not received medications per physician orders on 02/08/26. UMLPN #222 verified the nurse should have pulled the medications available from the facility contingent supply. UMLPN #222 verified the resident could have received the gabapentin, furosemide, guaifenesin, metformin, oxycodone, and zolpidem as the medications were available. UMLPN #222 revealed the resident could have also received the lorazepam for anxiety had the nurse clarified the paused medication orders with the physician. UMLPN #222 further revealed Resident #31 had voiced concerns about not receiving all his medications and she later clarified the orders with the physician.2. Review of the medical record for Resident #19 revealed an admission date of 01/23/26. Diagnoses included schizoaffective disorder, dementia, chronic pain, anxiety, chronic obstructive pulmonary disease, hypothyroidism, gastroesophageal reflux disease (GERD), and epilepsy.Review of the admission MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the 02/2026 physician orders revealed orders revealed the resident had orders for lacosamide 100 mg at bedtime for seizures, levothyroxine 50 micrograms (mcg) daily for thyroid, pantoprazole 20 mg daily for GERD, trazodone 100 mg at bedtime, lamotrigine 100 mg give with 25 mg to equal 125 mg twice daily for epilepsy, buspirone 10 mg three times a day for anxiety, acetaminophen 500 mg three times a day for pain, and rosuvastatin 10 mg by mouth at bedtime for cholesterol. Review of the MAR dated 02/01/26 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through 02/28/26 revealed the resident was not administered the lacosamide 100 mg on 02/05/26 and 02/10/26, the levothyroxine 50 mcg on 02/02/26, 02/05/26, 02/10/26, and 02/11/26, the pantoprazole 20 mg on 02/02/26, the 02/05/26, 02/10/26, 02/11/26, and 02/27/26, the rosuvastatin 10 mg on 02/04/26, 02/10/26, the trazodone 100 mg on 02/04/26 and 02/10/26, the lamotrigine 100 mg with an additional 25 mg at 4:00 A.M. on 02/02/26, 02/05/26, 02/10/26, 02/11/26, and 02/27/26, the acetaminophen 500 mg at 7:00 P.M. on 02/04/26 and 02/10/26, and the buspirone 10 mg at 7:00 P.M. on 02/04/26 and 02/10/26.Review of the nursing notes dated 02/01/26 through 02/28/26 revealed no documentation the resident had refused the medications.Interview on 03/17/26 at 7:46 A.M., Resident #19 revealed the nurse was not waking her up to give her medications. Resident #19 further revealed some nurses just do not give me my medications.Interview on 03/17/26 at 2:03 P.M., the Regional Director of Clinical Services (RDCS) #700 verified Resident #19 was not administered medications per physician orders. RDCS #700 revealed the resident had no changes in condition since admission. RDCS #700 revealed she could not find any documentation the resident had refused the medications. Review of the facility policy Administering Medications, revised 04/2019, revealed medication would be administered per physician orders, including any required time frame.This deficiency represents non-compliance investigated under Complaint Number 2796620.