

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Ridgewood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, coroner interview, and policy review, the facility failed to ensure resident supervision through purposeful rounding every two hours per the facility's standard of care. This affected one (#01) of three residents reviewed for death. The facility census was 67. Findings include: Review of Resident #01's medical record revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included schizoaffective disorder, alcohol dependence with withdrawal delirium, narcolepsy without cataplexy, depression, type II diabetes mellitus, and attention-deficit hyperactivity disorder. Review of Resident #01's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision or touch assistance for toileting, moving to a standing position from a sitting position and transfers. The resident had no negative behaviors. Review of Resident #01's care plan dated [DATE] revealed the resident was a full code and had the potential for a psychosocial well-being problem related to current health status. Review of Resident #01's current physician orders revealed a physician order dated [DATE] stating that the resident was a full code. Review of Resident #01's vital signs report revealed vitals were last acquired on [DATE] at 9:06 P.M. and found to be within normal limits. Review of Resident #01's nursing progress note dated [DATE] at 11:45 A.M. revealed Registered Nurse (RN) #300 was at the resident's bedside with Licensed Practical Nurse (LPN) #400 and the resident was found to be absent of vital signs. Review of Resident #01's medication administration note dated [DATE] at 12:12 P.M. revealed RN #300 attempted to wake the resident for morning medication and the resident failed to respond. RN #300 inquired other staff if that was Resident #01's normal activity, RN #300's note stated she was told the resident preferred to sleep in, usually until around 10:30 A.M., and often skipped breakfast. Review of the facility investigation report dated [DATE] revealed Resident #01 did not receive the required purposeful rounding consistent with the facility's standard of care, for approximately 11.5 hours. Interview with the Director of Nursing (DON) at 8:20 A.M. on [DATE] revealed staff contacted her on [DATE] at approximately 11:45 A.M. and stated Resident #01 was deceased and was cold to the touch. The staff contacted emergency medical services (EMS) and the physician. The DON stated when EMS arrived, the paramedics did not initiate cardiopulmonary resuscitation as the resident was obviously deceased. The coroner was notified. An autopsy was scheduled for [DATE]. Telephone interview with RN #300 on [DATE] at 10:50 A.M. revealed she was an agency nurse, and it was her first time working at this facility. She arrived for her [DATE] shift at 7:00 A.M. claiming she found the facility to be unorganized. RN #300 verified a shift report was received from the night nurse who was also an agency nurse. Due to computer issues, she began (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	working the floor at 8:30 A.M. RN #300 stated she entered Resident #01's room at approximately 9:45 A.M. to administer morning medications and found the resident lying on her side facing the wall, covered with a black shawl and there was no response to verbal stimuli, so she assumed the resident was sleeping. RN #300 she inquired about Resident #01 with facility staff she was told the resident's routine was to not wake up until 10:30 A.M. most days. RN #300 stated she did not think anything more about it, discarded the medications she pulled and went on to take care of another resident. RN #300 stated around lunch she entered Resident #01's room to complete blood sugar testing at which time the aide was in the room passing lunch trays and informed the nurse that the resident was not moving and was cold to the touch. RN #300 stated she assessed the resident and it was obvious that the resident had been dead awhile and therefore no cardiopulmonary resuscitation (CPR) was initiated. RN #300 stated EMS was called and when EMS arrived they also did not start CPR due the residents' condition. The police were contacted and came to the facility and remained in the facility until Resident #01's son arrived. Interview with the DON and the Regional Director of Clinical Services on [DATE] at 2:27 P.M. revealed the facility conducted their investigation on [DATE] it was determined the last time Resident #01 was checked was at 11:30 P.M. on [DATE] after visitors (one woman and two men) who were thought to be family members left the facility. The DON stated per staff interviews the resident and family members ordered pizza, ate in the resident's room with the visitors leaving around 10:30 P.M. The DON stated Resident #01 had visitors often so there was nothing unusual about the evening. The Regional Director of Clinical Services verified Resident #01 had not been checked on for approximately 11.5 hours which she confirmed was not consistent with the facility's standard of care for resident supervision, stating residents should be checked every two hours. Telephone interview with the County Deputy Coroner on [DATE] at 3:22 P.M. revealed Resident #01's autopsy was completed on [DATE]. The Coroner stated that he was able to rule out sepsis and diabetic ketoacidosis, adding that the resident did have a fatty liver, pulmonary edema, and atrophy of the pancreas. The Coroner stated toxicology results were pending, adding that the pulmonary edema could have been caused by a drug overdose but stated that cannot be confirmed until the toxicology results are received. Review of the facility policy titled Accidents and Supervision, dated [DATE] revealed each resident will receive adequate supervision to prevent accidents and ensure the resident's environment is free of hazards. The facility shall establish and utilize a systematic approach to assess resident risk and environmental hazards. The facility will provide adequate supervision to prevent accidents. The deficient practice was corrected on [DATE] when the facility implemented the following corrective actions: -On [DATE] the DON notified the Medical Director of Resident 01's death. -On [DATE] the DON instructed nursing staff to call EMS and the sheriffs department of the incident. -On [DATE] the DON/designee contacted Resident 01's son and requested he come to the facility as soon as possible. -On [DATE] the DON instructed nursing staff to call the county coroner. -On [DATE] an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with the DON, Medical Director, Administrator, Activity Director, Human Resources and the Scheduler to discuss purposeful rounding and the failure of the facility to conduct safety checks of the resident population every two hours. An abatement plan was outlined. -On [DATE] at 1:59 P.M. the DON completed observational audits on all residents. -On [DATE] the Administrator reviewed the facility's policy on accidents and supervision. No revisions were needed. Quick reference guides for rounding were created. -On [DATE] the DON/designee educated all staff on the facility's purposeful rounding policy and documentation requirements, resident supervision responsibilities and expectations for notifications immediately if assigned rounds cannot be completed. Quick Reference guides were provided. -The DON/designee educated all licensed nurses on (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy on accidents and supervision. Quick reference guides were provided. Ongoing monitoring will include:-Starting [DATE] the DON/designee will complete random observational audits daily for two weeks then weekly for two weeks then randomly thereafter for continued compliance. Audits will be reviewed at QAPI.-Starting [DATE] Unit Managers will monitor compliance for purposeful rounding. Any non-compliance identified will be met immediately with disciplinary action.-Starting [DATE] the DON/designee will audit purposefully rounding documentation daily for four weeks. Audits will be reviewed at QAPI. This deficiency represents non-compliance investigated under Master Complaint Number 3090948.		