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 07/18/2024
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview and facility policy review, the facility failed to notify the physician when a resident's medication was not administered as physician ordered. This affected one (#15) of four residents reviewed for medication administration. The facility census was 51. Findings include: Review of Resident #15's medical record revealed the resident was admitted to the facility on [DATE]. Diagnosis included type II diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition and received insulin injections. Review of Resident #15's physician order dated 05/16/24 revealed an order for the administration of Novolog (Insulin Aspart) to inject eight units subcutaneously before meals for blood sugar (BS) control and call physician (MD) if BS was less than 70. Observation on 07/15/24 at 4:40 P.M. noted Licensed Practical Nurse (LPN) #308 obtaining Resident #15's BS reading, which resulted with a BS level of 99. LPN #308 returned to the medication cart and obtained medications. None of the medications included Insulin. LPN #308 proceeded to administer the medications to Resident #15 and proceeded to another resident. Subsequent review of the medication administration record noted on 07/15/24 at 5:00 P.M. revealed the Novolog eight units injection was held with a code 5 indicating a nurses note was documented related to the insulin administration. According to a nurse's note entry dated 07/15/24 at 4:40 P.M., revealed Medication Administration Note documenting Novolog Injection Solution Inject eight units subcutaneously before meals for Blood Sugar Control CALL MD IF BS LESS THEN 70. Medication held due to resident's BS being 99. Resident provided applesauce. On 07/16/24 at 7:11 A.M., an interview with LPN #308 verified Resident #15's Novolog eight units of insulin were held on 07/15/24 for the 5:00 P.M. administration due to a BS result of 99. LPN #308 confirmed the physician was not notified and the Insulin was to be administered according to the physician order. On 07/16/24 at 7:20 A.M., an interview with the Director of Nursing (DON) confirmed LPN #308 did not notify the physician when Resident #15's Novolog insulin was held on 07/15/24 at 4:40 P.M. (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

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 07/18/2024
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Administering Medications policy revised December 2012 noted medications must be administered in accordance with the orders, including required time frame. Medications must be administered in within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the residents Attending Physician or the facility's Medical Director to discuss the concerns. Review of the facility's Change in Resident's Condition or Status policy, revised February 2021, revealed the facility will promptly notify the resident, his or her attending physician, and resident representative of changes in the residents' medical/mental condition and/or status. The nurse will notify the residents attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, resident and staff interview, and review of the facility policy, the facility failed to ensure a resident who required assistance from staff with activities of daily living (ADL) was provided with hygiene care regarding nail trimming. This affected one (#21) of two residents reviewed for ADLs. The facility census was 51. Findings include: Review of the medical record revealed Resident #21 admitted to the facility on [DATE]. Diagnoses included muscle weakness, morbid obesity, and hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #21 had intact cognition and required staff assistance for personal hygiene. Observation and interview on 07/15/24 at 9:57 A.M. revealed Resident #21 was sitting up in their wheelchair in their room. Resident #21 was not wearing any socks or shoes and several of the resident's toenails were grown out past the tips of their toes with several curled over and touching the floor. Resident #21 stated they had been trimming their own toenails previously but that it had been tough. Resident #21 reported an aide had asked the resident if they wanted to see a podiatrist, the resident agreed, but the resident had not seen one. Resident #21 reported no one had offered to assist with trimming their toenails. During an interview on 07/16/24 at 9:29 A.M., State tested Nurse Aide (STNA) #212 reported STNAs were responsible for checking and providing assistance with trimming of toenails as needed on scheduled shower days, which were typically twice per week for all residents. STNA #212 reported the only residents this did not apply to were those who were diabetic or had another reason which required their toenails to be trimmed by a podiatrist. During an interview and observation on 07/16/24 at 4:10 P.M. STNA #257 reported Resident #21 used to trim their own toenails but was no longer able to. STNA #257 verified the resident's toenails needed trimmed and reported they would be trimmed immediately. Review of the facility's undated policy titled Activities of Daily Living (ADL), Supporting revealed residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34745 Based on record review, observation, resident interview, staff interview and review of the facility policy, the facility failed to ensure the resident who smoked did not have possession of smoking materials in their room and were properly supervised. This affected four (Residents #6, #17, #42, and #158) of four residents who required supervision for smoking. The facility census was 51. Findings include: 1. Review of the medical record for Resident #6 revealed a re-admitted [DATE]. Diagnoses included cognitive communication deficit, schizoaffective, nicotine dependent and morbid obesity. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was assessed as having intact cognition, there was no impairment to upper extremities, and required set-up or clean-up assistance for upper extremities tasks. Review of Resident #6's smoking plan of care dated 10/12/23 revealed cigarettes and lighters will be confiscated from resident if they were in the resident's possession, instruct the resident about the facility policy on smoking: locations, times, safety concerns, observe clothing and skin for signs of cigarette burns and resident cannot have cigarettes and or lighters in his or her possession outside of smoking times. Review of the Smoking assessment dated [DATE] revealed Resident #6 was assessed as having cognitive loss, smokes five to 10 times per day, was able to light own cigarette, does require supervision, needs facility to store lighter and cigarettes, and had a plan of care to assure safe smoking. Interview on 07/16/24 at 1:15 P.M. with the Activity Director #400 stated she keeps Resident #6's lighter and cigarettes in the lock box, but it was not locked because there was only one key for it. Interview on 07/16/24 at 3:35 P.M. with Resident #6 stated they were supposed to be under supervision for smoking. Resident #6 stated they kept their own cigarettes and lighters in their rooms. Observations of Resident #6 on 07/17/24 at 3:20 P.M. and 07/18/24 at 11:20 A.M. revealed there was one pack of cigarettes and one lighter on Resident #6's seated walker. 2. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included post-polio syndrome and nicotine dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact, had impairments to bilateral upper extremities, and was dependent on staff for activity of daily living (ADL). Review of the Smoking assessment dated [DATE] revealed Resident #17 had a dexterity problem, smokes one to two times a day, in the afternoon, resident not able to light own cigarettes', resident needs adaptive equipment of cigarette holder, and supervision, the resident needs the facility to store lighter and cigarette and has plan of care to ensure the resident's safety while smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's smoking plan of care revealed the resident was at risk for injury related to smoking. Interventions included the resident will comply with facility smoking policy by target date, educate as to the benefits of quitting and the risks associated with smoking, always provide supervision for smoking, smoking cigarette holder when smoking and smoking items to be kept in the activities office. Interview with Resident #17 on 07/16/24 at 10:10 A.M. revealed the smoking was supposed to be supervised and they leave them outside for another resident who helps her and three other residents. They have their own cigarettes and lighters so no one can steal them. Resident #17 stated she stores her cigarettes and lighter in her nightstand. Observations of Resident's #17 room on 07/17/24 at 1:00 P.M. and 3:15 P.M. and 07/18/24 at 9:15 A.M. revealed she had her cigarettes and lighter in her top drawer of her nightstand. Interview on 07/16/24 at 1:15 P.M. with the Activity Director #400 verified she did not store Resident #17's lighter and cigarettes in the activity room. Activities Director #400 stated she only locks up two residents' lighter and cigarettes (Residents #6 and #42). 3. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses which included cerebral infarction and schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was moderately cognitively impaired, did not have any impairment of the upper extremities and was assessed as set-up or clean-up assistance from staff for oral care and eating. Review of Resident #42's plan of care dated 02/13/24 revealed the interventions included cigarettes and lighters will be confiscated from resident if they are in resident's possession, instruct the resident about the facility policy on smoking: locations, times, safety concerns, notify charge nurse immediately if it is suspected the resident has violated facility smoking policy, observe clothing and skin for signs of cigarette burns, and the resident cannot have cigarettes and or lighters in his or her possession outside of smoking times. Review of the Smoking assessment dated [DATE] revealed Resident #42 had cognitive loss, visual defect, smokes five to 10 times per day, the resident was able to light his own cigarette, and requires supervision. The facility needs to store lighter, and cigarettes and a plan of care was used to assure the resident was safe while smoking. Interview on 07/16/24 at 1:15 P.M. with the Activity Director #400 verified she keeps Resident #42's lighter and cigarettes in the lock box, but it was not locked because there was only one key for it. Interview on 07/16/24 at 3:35 P.M. with Resident #42 stated they were supposed to be under supervision for smoking. Resident #42 stated they kept their own cigarettes and lighters in their rooms. 4. Review of the medical record for Resident #158 revealed a re-admitted [DATE]. Diagnoses included spondylitis of lumbar region, contracture of left hand, stiffness of left and right wrist, and quadriplegia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #158 was cognitively intact, had impairment to both upper extremities and dependent on staff for all activities of daily living care (ADL) care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Smoking assessment dated [DATE] revealed Resident #158 smokes 10 plus times per day, unable to light own cigarette, uses a smoking apron and does not need the facility to store lighter and cigarettes and had a plan of care to ensure the resident was safe when smoking. Review of Resident #158's plan of care last updated 02/04/24 revealed the resident was non-compliant at ties with the smoking apron and not smoking outside of smoking times. The interventions included for cigarettes and lighters to be confiscated from the resident if they were in the residents' possession, resident cannot have cigarettes and or lighters in his or her possession outside of smoking times dated 02/13/24, and the resident requires assistance with lighting cigarette. The resident requires a smoking apron while smoking or he requires his flame-retardant flannel jacket. The resident requires supervision while smoking and the resident's smoking supplies were stored in the activities room during regular business hours, otherwise they were stored at the nursing station. Interview on 07/16/24 at 1:15 P.M. with the Activity Director #400 verified she did not store Resident #158's lighter and cigarettes in the activity room. Activities Director #400 stated she only locks up two residents' lighter and cigarettes (Residents #6 and #42). Interview on 07/16/24 at 3:35 P.M. with Resident #158 stated they were supposed to be under supervision for smoking. Resident #158 stated they kept their own cigarettes and lighters in their rooms. Review of the facility's smoker list revealed there were 10 residents who have the privileges to smoke. There were four residents (#6, #17, #42, and #158) who needed to be supervised with cigarettes and lighters to be held by staff and six residents who were independent with smoking and not need supervision. Review of the facilities smoking times revealed the smoking times were 6:00 A. M. to 6:15 A.M., 10:15 A.M. to 10:30 A.M., 1: 30 P. M. to 1:45 P.M., 4:00 P.M. to 4:15 P.M., and 8:30 P.M. to 8:45 P.M. Review of the facility policy for Ridgewood Manor Resident Smoking Policy and Agreement dated 01/22/15 revealed the residents are notified upon admission that the facility allows smoking in designated areas, and they must adhere to the Smoking policy. Smoking materials will be retained by the nursing staff for all residents who have been granted smoking privileges. No fire-igniting materials (matches or lighters) will be in possession at any time and strictly prohibited. Designated staff will supervise residents during assigned smoking times. Visitors may assist residents with smoking needs and only if they receive written permission from facility management.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered in accordance with physician orders and within prescribed time frames resulting in a medication error rate exceeding five percent (%). 25 opportunities were observed with two medication errors, resulting in a medication error rate of 8.0%. This affected one (#15) of four residents reviewed for medication administration. The facility census was 51. Findings include: Review of Resident #15's medical record revealed the resident was admitted to the facility on [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #15's physician order dated 05/16/24 revealed an order for the administration of Novolog (Insulin Aspart) to inject eight units subcutaneously before meals for blood sugar (BS) control and call physician (MD) if BS was less than 70. On 01/10/23, there was an order for Gabapentin (treats nerve pain) 400 milligrams (mg) three times daily scheduled for 7:00 A.M., 2:00 P.M. and 7:00 P.M. Observation on 07/15/24 at 4:40 P.M. revealed Licensed Practical Nurse (LPN) #308 obtained Resident #15's blood sugar level reading of 99. LPN #308 returned to the medication cart and obtained medications. One medication included Gabapentin (treats nerve pain) 400 milligrams (mg). None of the medications included Insulin. LPN #308 proceeded to administer the medications to Resident #15 and proceeded to another resident. Subsequent review of the medication administration record (MAR) noted on 07/15/24 at 5:00 P.M. revealed the Novolog eight units injection was held with a code 5 indicating a nurses note was documented related to the insulin administration. According to a nurse's note entry dated 07/15/24 at 4:40 P.M., revealed a Medication Administration Note documenting Novolog Injection Solution Inject eight units subcutaneously before meals for Blood Sugar Control 'CALL MD IF BS LESS THEN 70'. Medication was held due to resident's BS being 99. Resident provided applesauce. On 07/16/24 at 7:11 A.M., an interview with LPN #308 verified Resident #15's Novolog eight units of insulin were held on 07/15/24 for the 5:00 P.M. administration due to a blood sugar result of 99. LPN #308 also verified the medication Gabapentin 400 mg dose for 2:00 P.M. was given outside of physician prescribed time frames. On 07/16/24 at 7:20 A.M., an interview with the Director of Nursing (DON) confirmed LPN #308 should not have held Resident #15's Novolog insulin per physician order. The DON confirmed the order stated to notify the physician if the BS was less than 70. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Administering Medications policy last revised December 2012 revealed medications must be administered in accordance with the orders, including required time frame. Medications must be administered in within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the residents' attending physician or the facility's Medical Director to discuss the concerns.

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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** 15816 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered to the residents without any significant medication error. This affected one (Resident #15) of four residents reviewed for medication administration. The facility census was 51. Findings include: Review of Resident #15's medical record revealed the resident was admitted to the facility on [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #15's physician order dated 05/16/24 revealed an order for the administration of Novolog (Insulin Aspart) to inject eight units subcutaneously before meals for blood sugar (BS) control and call physician (MD) if BS was less than 70. Observation on 07/15/24 at 4:40 P.M. revealed Licensed Practical Nurse (LPN) #308 obtained Resident #15's blood sugar level reading of 99. LPN #308 returned to the medication cart and obtained medications. None of the medications included Insulin. LPN #308 proceeded to administer the medications to Resident #15 and proceeded to another resident. Subsequent review of the medication administration record (MAR) noted on 07/15/24 at 5:00 P.M. revealed the Novolog eight units injection was held with a code 5 indicating a nurses note was documented related to the insulin administration. According to a nurse's note entry dated 07/15/24 at 4:40 P.M., revealed a Medication Administration Note documenting Novolog Injection Solution Inject eight units subcutaneously before meals for Blood Sugar Control 'CALL MD IF BS LESS THEN 70'. Medication was held due to resident's BS being 99. Resident provided applesauce. On 07/16/24 at 7:11 A.M., an interview with LPN #308 verified Resident #15's Novolog eight units of insulin were held on 07/15/24 for the 5:00 P.M. administration due to a blood sugar result of 99. On 07/16/24 at 7:20 A.M., an interview with the Director of Nursing (DON) confirmed LPN #308 should not have held Resident #15's Novolog insulin per physician order. The DON confirmed the order stated to notify the physician if the BS was less than 70. Review of the facility's Administering Medications policy last revised December 2012 revealed medications must be administered in accordance with the orders, including required time frame. Medications must be administered in within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the residents' attending physician or the facility's Medical Director to discuss the concerns.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on medical record review, staff interview, and review of the facility's clinical protocol, the facility failed to ensure laboratory blood testing was obtained as ordered by the physician. This affected three (#19, #25, and #42) of five residents reviewed for laboratory (lab) blood test monitoring. The facility census was 51. Findings include: 1. Review of Resident #19's medical record revealed the resident was admitted [DATE]. Diagnoses included hyperlipidemia, type II diabetes mellitus (DM), protein calorie malnutrition (PCM), hypertension (HTN), major depression, benign prostatic hyperplasia, and neuropathy. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #19 had intact cognition and rejected care four to six days of the lookback period. Review of Resident #19's physician orders dated 05/27/24 revealed an order to obtain laboratory blood testing including a complete blood count, and basic metabolic profile once weekly every Wednesday starting on 05/29/24. Review of the nursing plan of care dated 07/07/24 revealed Resident #19 had a potential nutritional problem related to DM, HTN, and PCM. Intervention included to obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated. In addition, on 07/17/24, a nursing plan of care was revised to address Resident #19's risk for skin breakdown related to risk of malnutrition. Intervention included to obtain blood work such as complete blood count with differential (CBC with Diff), as ordered by the physician. Review of the laboratory blood test results revealed out of eight opportunities, the labs were obtained four times on 06/07/24, 06/28/24, 07/03/24, 07/15/24. The medical record was silent to lab testing being obtained on 05/29/24, 06/12/24, 06/19/24, and 07/10/24. There was no documentation Resident #19 refused lab blood testing on 05/29/24, 06/12/24, 06/19/24, and 07/10/24. On 07/17/24 at 11:55 A.M., an interview with the Director of Nursing (DON) verified Resident #19 had labs obtains four of the eight opportunities. The DON verified the were no labs drawn on 05/29/24, 06/12/24, 06/19/24, and 07/10/24. 44454 2. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE]. Diagnoses included depression, type II diabetes mellitus, muscle weakness, hyperlipidemia, encephalopathy, hypertension, and chronic kidney disease with heart failure. Review of the plan of care dated 05/11/21 revealed Resident #25 was at risk for hypoglycemic and/or hyperglycemic episodes. Interventions included labs as ordered. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's physician orders dated 06/06/24 revealed an order for complete blood count including differential/platelet, hemoglobin A1c, comprehensive metabolic panel, fasting lipid panel now and every six months, and fasting glucose now and every year. Review of the medical record revealed there was no evidence the laboratory testing was ever completed from 06/06/24 to 07/17/24 for Resident #25 An interview on 07/18/24 at 7:59 A.M. with the Director of Nursing verified Resident #25 did not have the laboratory testing completed as physician ordered. 3. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included hypertension, chronic obstructive pulmonary disease, encephalopathy, chronic pain, heart failure, schizoaffective disorder, and anxiety disorder. Review of the plan of care revised 07/07/24 revealed Resident #42 was at risk for malnutrition. Interventions included obtaining and monitoring laboratory/diagnostic work as ordered. Review of Resident #42's physician orders dated 02/01/24 revealed there were orders for valproic acid level for checking therapeutic level, comprehensive metabolic panel medication that may affect liver and platelet, and for complete blood count including differential and platelets. Review of the medical record revealed there was no evidence the laboratory testing was ever completed from 02/01/24 to 07/17/24. An interview on 07/18/24 at 7:59 A.M. with the Director of Nursing verified Resident #42 did not have the laboratory testing completed. Interview on 07/18/24 at 9:29 A.M. with Clinical [NAME] President #300 revealed the laboratory that the facility contracts with to obtain resident labs does not keep a record of refusals and if the facility does not have laboratory results, the ordered laboratory tests have not been obtained as ordered. Review of the facility's prevention and screening clinical protocol revised March 2018 revealed the physician will order lab screening tests that are relevant to monitoring the individuals treatment regimen or identifying modifiable risk and complications.

Printed: 09/27/2024
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 07/18/2024
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44454 Based on observation, resident and staff interview, and review of the facility policy, the facility failed to maintain the resident's environment in a clean and sanitary manner. This affected one (#21) of eight residents reviewed for environment. The facility census was 51. Findings include: Observation and interview on 07/15/24 at 10:10 A.M. revealed Resident #21 was sitting up in a wheelchair located in their room. The wall located behind the headboard of the resident's bed had large gauges, including some that were beyond the layers of the drywall. The same wall and near the light switch was visibly dirty with darkened marks and a dried red substance. The privacy curtain hanging in the room was visibly dirty with numerous black marks and a dried brown substance on it. The bottom of the bathroom door (on the side facing the resident's room) was scraped, as well as the lower part of the wall to the left of the bathroom door. Water was steadily flowing from the sink located in the resident's bathroom, even though the faucet handles were turned to the off position. Resident #21 stated the sink had been running constantly for about two months and the resident had been asking for it to be fixed. The resident reported the noise bothered them and that it could be heard in the room at times. An interview and observation on 07/17/24 at 1:38 P.M. with the Maintenance Director #500 verified the sink in Resident #21's bathroom had water running from it and could not be turned off without the entire faucet being replaced. Maintenance Director #500 also verified the damage to the wall behind the bed. An interview and observation on 07/17/24 beginning at 1:58 P.M. with Floor Technician #389 verified the dirty curtain, dirty wall, and scraped wall and door. Review of the facility's undated policy titled Safe and Homelike Environment revealed the facility would provide a safe, clean, comfortable and homelike environment.