

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  05/08/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</b></p> <p>Based on medical record review, hospital discharge document review, resident interview, and staff interview, the facility failed to ensure resident blood glucose levels were monitored as ordered by the physician. This affected one (#141) of four residents reviewed as new admissions to the facility in a census of 39.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #141 admitted to the facility on [DATE] with the diagnoses including acute kidney failure, chronic kidney disease stage five (5), myocardial infarction, type II diabetes mellitus, hypertension, vitreous hemorrhage right eye, glaucoma, and anemia.</p> <p>Review of an admission assessment dated [DATE] assessed Resident #141 as alert and able to make needs known, received hemodialysis, and had small amount of edema in the legs.</p> <p>Review of Resident #141's hospital discharge community referral form (CRF) dated 05/03/25 revealed the discharge physician orders included the use of a glucometer and glucose blood test strips, and glucose blood test strips were directed to be used three times daily and as needed to monitor the resident's blood sugar levels.</p> <p>Review of a nursing plan of care dated 05/04/25 revealed it was developed to address Resident #141's diagnosis of diabetes mellitus. Interventions included for diabetes medication to be provided as ordered by physician, monitor and document for side effects and effectiveness, and monitor blood sugars as ordered by physician.</p> <p>Review of the medical record lacked documented evidence indicating Resident #141 blood sugar had been obtained or monitored.</p> <p>On 05/07/25 at 8:27 A.M., interview with Resident #141 stated he had a history of monitoring his blood sugar daily and administering insulin according to the a sliding scale based on the blood sugar result (level).</p> <p>Interview with Licensed Practical Nurse (LPN) #456 on 05/07/25 at 8:31 A.M., during review of Resident #141's medical record, verified no evidence of daily blood glucose monitoring or related insulin coverage was documented in the medical record. At 8:40 A.M., LPN #456 obtained a blood sugar from Resident #141 with a level of 166 milligrams per deciliter (mg/dL) obtained.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/07/25 at 9:06 A.M., interview with the Director of Nursing (DON), during medical record review, confirmed Resident #141 had a diagnosis of type II diabetes mellitus with a history of blood sugar monitoring and related insulin administration. The DON verified physician orders for daily blood sugar monitoring was listed on the resident's hospital discharge CRF; however, no daily blood glucose monitoring had occurred since admission on 05/03/25.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>51529</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to potential hazards were secured in a safe manner. This had the potential to affected six (#1, #6, #7, #19, #27, and #34) of six residents who the facility identified as cognitively impaired and independently ambulatory. The facility census was 39.</p> <p>Findings include:</p> <p>Observation on 05/05/25 at 9:16 A.M. of the pantry located at the nurse's station revealed one sharp kitchen knife with a blade approximately four inches long, and one sharp kitchen knife with a blade approximately eight inches long located in the left-most drawer. Further observation revealed the door to the pantry was not locked.</p> <p>Interview on 05/05/25 at 9:32 A.M. with Certified Nurse Aide (CNA) #423 confirmed the pantry at the nurse's station was unlocked and there were two sharp kitchen knives in the left-most drawer.</p> <p>Interview on 05/06/25 at 10:33 A.M. with the Administrator revealed the door to the pantry at the nurse's station should be locked to prevent unauthorized access.</p> <p>Review of an undated facility policy titled, Safe and Homelike Environment, revealed the facility would provide a safe environment for residents.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529</b></p> <p>Based on observation, medical record review, staff interview, review of an equipment manual, and review of a facility policy, the facility failed to initiate orders and plans of care to ensure bilevel positive airway pressure (BiPAP) therapy was correctly utilized and staff responded timely to BiPAP machine alarms. This affected one (#14) of two residents reviewed for respiratory care. The facility census was 39.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, heart disease, lymphocytic leukemia of B-cell type, depression, anxiety, mild intermittent asthma, chronic obstructive pulmonary disease, and obstructive sleep apnea.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] for Resident #14 revealed she was cognitively intact and experienced shortness of breath with exertion and when lying flat.</p> <p>Observation on 05/06/25 at 7:17 A.M. in Resident #14's room revealed the resident was resting in bed with her eyes closed under a blanket with her BiPAP machine on and alarming.</p> <p>Interview on 05/06/25 at 7:30 A.M. with Licensed Practical Nurse (LPN) #420 at the nurse's station confirmed the BiPAP machine alarm coming from Resident #14's room was not audible at the nurse's station and LPN #420 did not know how long the BiPAP machine had been alarming.</p> <p>Observation on 05/06/25 at 8:19 A.M. in the doorway to Resident #14's room revealed the resident was resting with her eyes closed under a blanker in bed and her BiPAP machine was alarming.</p> <p>Interview on 05/06/25 at 8:20 A.M. with Registered Nurse (RN) #457 at the nurse's station confirmed the BiPAP machine alarm coming from Resident #14's room was not audible at the nurse's station.</p> <p>Interview on 05/06/25 at 12:39 P.M. with the Administrator confirmed there were no orders nor care plans for Resident #14's oxygen or BiPAP machine.</p> <p>Review of Resident #14's physician orders for oxygen and BiPAP machine revealed these orders were not entered until 05/06/25.</p> <p>Observation on 05/07/25 at 7:10 A.M. in Resident #14's room revealed she was resting in bed with her eyes closed wearing pajamas and her BiPAP machine was not running.</p> <p>Observation on 05/07/25 at 7:23 A.M. in Resident #14's room with Certified Nurse Aide (CNA) #423 revealed the resident stated she did not know why her BiPAP machine was not on.</p> <p>Interview on 05/07/25 at 9:45 A.M. with LPN #456 revealed she was not aware Resident #14's BiPAP machine was not running. Additionally, LPN #456 indicated she had not been informed of any issues or refusal of care regarding Resident #14's BiPAP machine.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the manual for Resident #14's BiPAP machine indicated alarms must be responded to, and corrective actions implemented, promptly.</p> <p>Review of an undated facility policy titled, Noninvasive Ventilation, indicated noninvasive ventilation would be provided per physician orders. Procedures included the facility would obtain physician orders for use and settings, the facility would follow manufacturers instructions regarding proper use of the machine, and there would be documentation regarding the use of the machine.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>15816</p> <p>Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure medications were provided as ordered by the physician and without error. This result in nine (9) medication errors out of 25 medications being administered for an error rate of 36 percent (%). This affected two (#24 and #141) of three residents observed for medication administration in a facility census of 39.</p> <p>Findings include:</p> <p>1. Review of Resident #24's medical record noted physician orders including the narcotic pain medication oxycodone five (5) milligrams (mg) two times daily for pain, scheduled for 9:00 A.M. and 9:00 P.M. and ordered on 02/27/25; the anti-anxiety medication Ativan 0.25 mg every morning and at bedtime, scheduled for 7:00 A.M. and 7:00 P.M. and ordered on 04/07/25; the blood pressure and heart failure medication Coreg 6.25 mg every morning and at bedtime, scheduled for 7:00 A.M. and 7:00 P.M. and ordered on 05/07/24; the nerve pain medication gabapentin 600 mg three times daily, scheduled for 7:00 A.M., 2:00 P.M., 7:00 P.M. and ordered on 04/21/25; and glargine insulin with instructions to inject 30 units subcutaneously every morning and at bedtime for diabetes, scheduled for 7:00 A.M. and 7:00 P.M. and ordered on 01/16/25.</p> <p>Observation and interview on 05/06/25 at 8:21 A.M. noted Licensed Practical Nurse (LPN) #420 obtaining and preparing Resident #24 medications for administration. These medications included, Ativan 0.25 mg, Coreg 6.25 mg, gabapentin 600 mg, and glargine insulin 30 units via insulin syringe. LPN #420 stated Resident #24 was to receive oxycodone 5 mg for pain; however, the medication was not available. Further observation revealed at 8:34 P.M., LPN #420 provided the medications to Resident #24.</p> <p>On 05/06/25 at 8:38 A.M., interview with LPN #420 verified medications were not administered within the prescribed timeframes for Resident #24 and oxycodone 5 mg was omitted.</p> <p>2. Review of the medical record for Resident #141 revealed physician orders including Coreg 25 mg two times a day, scheduled for 8:00 A.M. and 4:00 P.M. and ordered on 05/04/25; the anti-hypertensive medication clonidine 0.2 mg three times daily, scheduled for 7:00 A.M., 2:00 P.M., and 7:00 P.M. and ordered on 05/04/25; erythromycin ophthalmic ointment 5 milligrams per gram (mg/gm) with instructions to instill 1.25 centimeters in the left eye four times a day for keratitis (inflammation of the cornea) of the left eye, scheduled four times daily at 7:00 A.M., 11:00 A.M., 3:00 P.M., and 7:00 P.M. and ordered on 05/04/25; and prednisolone acetic ophthalmic suspension 1% with instructions to instill one drop in the left eye four times daily for neurotropic keratitis of the left eye at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. and ordered on 05/04/25.</p> <p>Observation on 05/06/25 at 9:22 A.M. noted LPN #420 gathered Resident #141's medications for administration from the medication cart. The medications included prednisolone acetic ophthalmic suspension 1%, erythromycin ophthalmic ointment 5 mg/gm, Coreg 25 mg, and clonidine 0.2 mg. Continued observation revealed at 9:25 A.M., LPN #420 administered the Coreg 25 mg and clonidine 0.2 mg to Resident #141 with a cup of water. At 9:27 A.M., LPN #420 administered prednisolone acetic ophthalmic suspension 1% one drop into the resident's left eye and at 9:44 A.M., LPN #420 returned to Resident #141, and placed erythromycin ophthalmic ointment 5 mg/gm to the left eye.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 9:48 A.M. with LPN #420 verified Resident #141's medications were administered outside prescribed time frames per the physician orders.</p> <p>Review of facility administering medications policy, revised December 2012, revealed 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 (1) hour of their prescribed time, unless otherwise specified.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</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, the facility failed to ensure medications were administered as ordered by the physician, and within prescribed time frames, to prevent significant medication errors. This affected three (#16, #24, and #141) for four residents reviewed for the administration of medications in a facility census of 39.</p> <p>Findings include:</p> <p>1. Review of Resident #24's medical record noted physician orders including the narcotic pain medication oxycodone five (5) milligrams (mg) two times daily for pain, scheduled for 9:00 A.M. and 9:00 P.M. and ordered on 02/27/25; the anti-anxiety medication Ativan 0.25 mg every morning and at bedtime, scheduled for 7:00 A.M. and 7:00 P.M. and ordered on 04/07/25; the blood pressure and heart failure medication Coreg 6.25 mg every morning and at bedtime, scheduled for 7:00 A.M. and 7:00 P.M. and ordered on 05/07/24; the nerve pain medication gabapentin 600 mg three times daily, scheduled for 7:00 A.M., 2:00 P.M., 7:00 P.M. and ordered on 04/21/25; and glargine insulin with instructions to inject 30 units subcutaneously every morning and at bedtime for diabetes, scheduled for 7:00 A.M. and 7:00 P.M. and ordered on 01/16/25.</p> <p>Observation and interview on 05/06/25 at 8:21 A.M. noted Licensed Practical Nurse (LPN) #420 obtaining and preparing Resident #24 medications for administration. These medications included, Ativan 0.25 mg, Coreg 6.25 mg, gabapentin 600 mg, and glargine insulin 30 units via insulin syringe. LPN #420 stated Resident #24 was to receive oxycodone 5 mg for pain; however, the medication was not available. Further observation revealed at 8:34 P.M., LPN #420 provided the medications to Resident #24.</p> <p>On 05/06/25 at 8:38 A.M., interview with LPN #420 verified medications were not administered within the prescribed timeframes for Resident #24 and oxycodone 5 mg was omitted.</p> <p>2. Review of the medical record for Resident #141 revealed physician orders including Coreg 25 mg two times a day, scheduled for 8:00 A.M. and 4:00 P.M. and ordered on 05/04/25; the anti-hypertensive medication clonidine 0.2 mg three times daily, scheduled for 7:00 A.M., 2:00 P.M., and 7:00 P.M. and ordered on 05/04/25; erythromycin ophthalmic ointment 5 milligrams per gram (mg/gm) with instructions to instill 1.25 centimeters in the left eye four times a day for keratitis (inflammation of the cornea) of the left eye, scheduled four times daily at 7:00 A.M., 11:00 A.M., 3:00 P.M., and 7:00 P.M. and ordered on 05/04/25; and prednisolone acetic ophthalmic suspension 1% with instructions to instill one drop in the left eye four times daily for neurotropic keratitis of the left eye at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. and ordered on 05/04/25.</p> <p>Observation on 05/06/25 at 9:22 A.M. noted LPN #420 gathered Resident #141's medications for administration from the medication cart. The medications included prednisolone acetic ophthalmic suspension 1%, erythromycin ophthalmic ointment 5 mg/gm, Coreg 25 mg, and clonidine 0.2 mg. Continued observation revealed at 9:25 A.M., LPN #420 administered the Coreg 25 mg and clonidine 0.2 mg to Resident #141 with a cup of water. At 9:27 A.M., LPN #420 administered prednisolone acetic ophthalmic suspension 1% one drop into the resident's left eye and at 9:44 A.M., LPN #420 returned to Resident #141, and placed erythromycin ophthalmic ointment 5 mg/gm to the left eye.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 9:48 A.M. with LPN #420 verified Resident #141's medications were administered outside prescribed time frames per the physician orders.</p> <p>51513</p> <p>3. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including unspecified focal traumatic brain injury without loss of consciousness, unspecified glaucoma, and legal blindness.</p> <p>Review of Resident #16's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact and had severely impaired vision.</p> <p>Review of Resident #16's physician's orders revealed an order dated 10/23/24 to administer the medication used to lower intraocular pressure Rocklatan ophthalmic solution one drop in both eyes at bedtime. Further review revealed an additional physician's order dated 01/23/25 for Resident #16 to receive the pain and anti-inflammatory medication ketorolac tromethamine ophthalmic solution with instructions to instill one drop in both eyes every morning and at bedtime.</p> <p>Review of Resident #16's medication administration record (MAR) for February and March 2025 revealed Rocklatan ophthalmic solution was not administered on 02/09/25, 03/12/25, 03/14/25, 03/16/25, 03/17/25, 03/18/25, 03/27/25, and 03/31/25 as prescribed. Further review revealed ketorolac tromethamine ophthalmic solution was not administered on 03/01/25 at bedtime, 03/02/25 in the morning, 03/03/25 at bedtime, 03/04/25 in the morning and at bedtime, 03/16/25 at bedtime, and 03/17/25 at bedtime as prescribed.</p> <p>Review of the progress notes for February and March 2025 revealed nurses entries indicating Resident #16's Rocklatan ophthalmic solution was on order on 02/09/25, 03/13/25, 03/15/25, 03/16/25, 03/17/25, and 03/31/25.</p> <p>Review of the progress notes for March 2025 revealed nurses entries indicating Resident #16's ketorolac tromethamine ophthalmic solution was on order on 03/02/25, 03/03/25, 03/04/25, and 03/17/25. The medication was unavailable on 03/01/25 and 03/04/25 per entries on those dates. On 03/05/25 an entry revealed late administration due to not being able to locate eye drops.</p> <p>Interview on 05/07/25 at 3:10 P.M. with Registered Nurse (RN) #457 confirmed there was no documentation in Resident #16's medical record to verify the resident received Rocklatan ophthalmic solution and ketorolac tromethamine ophthalmic solution on the aforementioned dates in February and March 2025.</p> <p>Review of facility administering medications policy, revised December 2012, revealed 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 (1) hour of their prescribed time, unless otherwise specified.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51529</p> <p>Based on observation, staff interview, and review of a facility policy, the facility failed to store and label food and drink items in a manner to prevent spoilage and failed to maintain the floor in the nursing unit pantry in a sanitary manner. This had the potential to affect all 39 residents who receive food from the facility. The facility census was 39.</p> <p>Findings include:</p> <p>Observation on [DATE] at 9:16 A.M. in the pantry located at the nurse's station revealed one opened and undated 0.42 ounce packet of thickened tea with a use by date of [DATE]. Further observation of the pantry revealed two single serve bowls covered with plastic lids containing dried cereal that was multicolored and round with no date or label, one plastic mug with a lid that had condensation and no label or date, one 16.9-ounce clear plastic bottle labeled water that was opened and three-quarters full with no date, one opened can of kiwi guava flavored energy drink with no date, and one uncovered gray metal travel mug with a red straw half-full of liquid with no date. Continued observation of the pantry revealed the floor behind the trash can had one empty single-serve container of cranberry juice, two balled up paper towels, and a sticky dried red substance on the floor.</p> <p>Interview on [DATE] at 9:32 A.M. with Certified Nurse Aide (CNA) #423 confirmed the aforementioned observations in the pantry located at the nurse's station of opened, undated, unlabeled, and expired food and drink items, and the observation of the used paper towels and the sticky dried red substance on the floor.</p> <p>Observation on [DATE] at 10:33 A.M. in the pantry located at the nurse's station revealed the floor had not been cleaned. Concurrent interview with the Administrator confirmed the floor behind the trash can in the pantry had one empty single-serve container of cranberry juice, two balled up paper towels, and a sticky dried red substance on the floor.</p> <p>Review of an undated facility policy titled, Food Storage, revealed food would be stored in a clean and sanitary manner to minimize contamination. The policy also indicated the food storage areas would be clean. Further review of the policy indicated food not stored in the original container would be labeled and dated.</p>		