Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366022	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at Perrysburg	250 Manor Drive Perrysburg, OH 43551

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a comprehensive care plan was timely completed. This affected one (#100) of three residents reviewed for care planning. The facility census was 99. Findings include Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic kidney disease, vascular dementia, and atrial fibrillation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. The resident was always incontinent of bowel and bladder. Review of the comprehensive care plan dated 10/01/24 and last revised on 10/12/24 revealed there was no care plan in place for incontinence care. Review of the continence task documentation from 09/30/24 through 10/22/24 revealed the resident was always incontinent of bowel and bladder. Interview on 10/22/24 at 7:23 A.M., Licensed Practical Nurse (LPN) #423 revealed Resident #100 was incontinent of bowel and bladder. LPN #423 revealed the resident was unaware of when she was incontinent. Interview on 10/23/24 at 2:48 P.M., MDS Coordinator #367 verified there was no incontinence care plan included in the comprehensive care plan for Resident #100. MDS Coordinator #367 revealed Resident #100's comprehensive care plan needed to be finished. MDS Coordinator #367 verified the comprehensive care plan should be completed within seven days of the comprehensive assessment. Review of the policy, Comprehensive Care Plan, last revised 11/2016 revealed the comprehensive care plan would include services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. A comprehensive care plan must be developed within seven days after the completion of the comprehensive assessment.

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 35033

Based on review of the medical record, staff interview, and policy review, the facility failed to ensure medications were administered per physician orders. Additionally, the facility failed to maintain controlled substance drug records. This affected four (#118. #24, #117, #84) of seven residents reviewed for medication administration. The facility census was 99.

Findings include

1. Review of the medical record for Resident #118 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included Alzheimer's disease with late onset, chronic obstructive pulmonary disease, dementia, chronic kidney disease, hypertension, and chronic diastolic heart failure.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment.

Review of the physician orders dated 06/18/24 revealed the resident was ordered Ceftriaxone sodium injection solution reconstituted one gram, inject one gram intramuscularly one time only for infection for one day. There was no type of infection documented for indication of use.

Review of the medication administration record for 06/18/24 revealed the resident was administered the incorrect antibiotic. The resident was administered cefazolin sodium injection solution reconstituted one gram.

Review of a medication incident report dated 06/18/24 at 12:45 P.M. revealed Registered Nurse (RN) #341 administered the antibiotic cefazolin instead of the antibiotic ceftriaxone. RN #341 had signed out the incorrect medication out of the contingency supply. The resident had no allergies to the medication and no adverse effects were observed. The five medication rights was reviewed with the nurse.

Review of a nurse's note dated 06/18/24 at 4:20 P.M. revealed cefazolin one gram for injection given instead of ceftriaxone one gram for injection. The nurse practitioner was notified. Will continue to monitor the resident.

Interview on 10/24/24 at 7:35 A.M., the Director of Nursing (DON) revealed the newer nurse had pulled the wrong medication and was educated. The DON revealed the physician was contacted. The DON verified there was no documentation for the indication of use for the medication and the nurse was educated to include the type of infection in the order.

2. Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, lymphedema, heart failure, atrial fibrillation, and hypertension.

Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders dated 08/31/24 revealed an order for oxycodone-acetaminophen 10/325 milligrams (mg) by mouth every four hours as needed for pain. Review of the controlled substance scheduled drug record revealed 17 doses of the oxycodone acetaminophen were pulled from the medication cards for one dose on 09/10/24, two doses on 09/11/24, one dose on 09/12/24, one dose on 09/21/24, two doses on 09/22/24, one dose on 09/24/24, two doses on 09/26/24, one dose on 09/28/24, one dose on 09/29/24, one dose on 09/30/24, two dose on 10/01/24, one dose on 10/02/24 and one dose on 10/09/24. Review of the medication administration records from 09/01/24 through 10/09/24 revealed the 17 doses pulled from the medication card were not documented as administered on the medication administration record. Interview on 10/22/24 at 3:46 P.M. RN #399 revealed controlled substances should be signed out in the narcotic book when pulled and then documented on the medication administration record when administered. Interview on 10/22/24 at 3:53 P.M., Licensed Practical Nurse (LPN) #351 revealed controlled substances should be signed out in the narcotic book then signed out on the medication administration record. Interview on 10/23/24 at 11:40 A.M., the DON verified 17 doses of oxycodone/acetaminophen 10/325 mg were pulled from the medication card and were not documented as administered in the medication administration record. 3. Review of the medical record for Resident #84 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, osteoarthritis, and chronic kidney disease. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of the physician orders dated 06/21/24 revealed orders for oxycodone oral capsule five milligrams (mg) by mouth every six hours as needed for a pain level of eight to ten on a zero to ten scale. Review of the controlled substance scheduled drug record revealed oxycodone was removed from the medication card for one dose each on 09/17/24, 09/19/24, 09/23/24, 09/28/24, 10/16/24 and two doses on 09/26/24. Review of the medication administration record revealed the medication pulled on 09/17/24, 09/19/24, 09/23/24, 09/28/24, 10/16/24 and 09/26/24 were not documented as administered on the medication administration record. Interview on 10/23/24 at 11:50 A.M., the DON verified seven doses of oxycodone were pulled from Resident #84's medication card and never documented as administered in the medication administration record. 4. Review of the medical record revealed Resident #117 had an admitted [DATE] and a discharge date of [DATE]. Diagnoses include down syndrome, hydrocephalus, Barrett's esophagus, and scoliosis. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the five-day MDS assessment dated [DATE] revealed the resident had impaired cognition. Review of the physician orders dated 07/12/24 revealed an order for morphine sulfate 20 mg/milliliter (ml), give 0.3 ml by mouth every one hour as needed for shortness of breath/pain. Review of the medication administration record dated 07/01/24 through 07/17/24 revealed the resident was administered the morphine sulfate once on 07/13/24, three times on 07/14/24, three times on 07/15/24, six times on 07/16/24, and three times on 07/17/24. Review of the medical record revealed there was no controlled substance scheduled drug record for removal of the 16 doses of morphine sulfate. Interview on 10/23/24 at 1:49 P.M., the DON verified the facility was unable to locate the controlled substance record for morphine sulfate administered on 07/13/24 through 07/17/24 for Resident #117. Review of the policy, Medication Administration General Guidelines, revised 03/20/18, revealed medication were administered in accordance with written orders of the attending physician. Review of policy, Order Procedure and Accountability for Controlled Medications, last revised 11/30/18, revealed when a controlled medication dose was removed from control inventory, the licensed nurse immediately documents the date and time of removal for administration, amount to be removed for administration, signature of the nurse removing the medication dose on the proof-of-use sheet (Scheduled Drug Record Form). Administration of the dose is also documented on the medication administration record or the electronic medication record after the medication was administered. This deficiency represents non-compliance investigated under Complaint Number OH00158689 and Complaint Number OH00157665.