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	01/14/2025

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 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** 49742 Based on review of medical record, staff interview, and review of facility policy, the facility failed to ensure physician ordered medications were available for administration. This affected two residents (#26 and #80) of five (#26, #71, #80, #89, and #93) residents reviewed for accurate medical records. The Facility census was 92. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes mellitus, vascular dementia, hyperlipidemia, hypertension (HTN), symptomatic epilepsy and epileptic syndrome, bipolar disorder, gastroesophageal reflux disease (GERD), and aphasia following cerebral infarction. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating Resident #26 was severely cognitively impaired. Review of the current physician orders for Resident #26 revealed an order dated 09/12/24 for Famotidine (a medication used to treat ulcers of the stomach and intestine and prevent ulcers from coming back after they have healed) oral suspension reconstituted 40 milligrams (mg) per 5 milliliters (ml). The order was to administer 5 ml via PEG (a percutaneous endoscopic gastrostomy (PEG) tube is a tube that is surgically placed into the stomach to allow a person to receive nutrition and medications when they are unable to swallow orally) tube at bedtime for acid reflux. Review of the medication administration record (MAR) for Resident #26 revealed the resident did not receive the ordered 5 ml dose of Famotidine on 12/15/24, 12/19/24, 12/21/24, 12/22/24, and 12/24/24. Review of the MAR for Resident #26 revealed the entry on 12/15/24 stated hold, see nurses note. Review of the nurse progress note dated 12/15/24 for Resident #26 revealed Famotidine 5 ml was on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for Resident #26 revealed the entry on 12/19/24 stated hold/see nurses note. Review of the nurse progress notes for Resident #26 dated 12/19/24 revealed Famotidine 5 ml was documented as not available. Review of the MAR for Resident #26 revealed the entry on 12/21/24 stated hold/see nurses note. Review of the nurse progress notes for Resident #26 dated 12/21/24 revealed Famotidine 5 ml was documented as on order. Review of the MAR for Resident #26 revealed the entry on 12/22/24 stated hold/see nurses note. Review of the nurse progress note for Resident #26 dated 12/22/24 revealed Famotidine 5 ml was documented as not available. Review of the MAR for Resident #26 revealed the entry on 12/24/24 stated hold/see nurses note. Review of the nurse progress notes for Resident #26 dated 12/24/24 revealed Famotidine 5 ml was documented as not available. An interview with the Director of Nursing (DON) verified Resident #26 had not received the physician ordered 5 ml dose of Famotidine on 12/15/24, 12/19/24, 12/21/24, 12/22/24, and 12/24/24 as the medication was not available. 2. Review of the medical record for Resident #80 revealed an admitted [DATE]. Diagnoses included hypothyroidism, diverticulitis of large intestine, hypokalemia, gastroesophageal reflux disease, and hyperlipidemia. Review of the MDS assessment, dated 12/29/24, revealed Resident #80 had a BIMS score of 11, indicating moderate cognitive impairment. Review of the current physician orders for Resident #80 revealed an order for Omeprazole (a medication used to treat certain stomach and esophagus problems, such as acid reflux and ulcers) Delayed Release 20 mg with one capsule to be administered by mouth each morning for acid indigestion related to GERD. Review of the medication administration record revealed Resident #80 had not receive the ordered dose of Omeprazole Delayed Release capsule 20 mg on 12/13/24, 12/16/24, 12/18/24, and 12/19/24. Review of the MAR for Resident #80 revealed the entry on 12/13/24 stated hold/see nurses note. Review of the nurse progress note dated 12/13/24 revealed Omeprazole Delayed Release capsule 20 mg was unavailable. Review of the MAR for Resident #80 revealed the entry on 12/16/24 stated not required. Review of the nurse progress notes for 12/16/24 revealed no documentation to support he documentation contained in the MAR. Review of the MAR for Resident #80 revealed the entry on 12/18/24 stated hold/see nurses note. Review of the nurse progress note dated 12/18/24 revealed Omeprazole Delayed Release capsule 20 mg was out of stock - on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for Resident #80 revealed the entry on 12/19/24 stated hold/see nurses note. Review of the nurse progress notes dated 12/19/24 revealed no note to support the documentation contained in the MAR. An interview with the DON verified Resident #80 had not received the physician ordered doses of the Omeprazole Delayed Release capsule, 20 mg on the dates of 12/13/24, 12/16/24, 12/18/24, and 12/19/24. Concurrent interview with the DON revealed there were no hold parameters outlined by the physician in the Omeprazole Delayed Release capsule order that would constitute the medication to be documented as not required on 12/16/24. Review of the facility policy titled, Medication Administration - General Guidelines, with a revision date of 03/20/18 revealed medications are administered as prescribed in accordance with good nursing practices. This deficiency represents non-compliance investigated under Complaint Number OH00161236.

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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** 49742 Based on review of facility medical record, review, staff interview, and review of facility policy, the facility failed to ensure that residents were free of significant mediation errors. This affected three residents (#26, #89, and #93) of five residents (#26, #71, #80, #89, and #93) reviewed for accurate medical records. The Facility census was 92. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes mellitus, vascular dementia, hyperlipidemia, hypertension (HTN), symptomatic epilepsy and epileptic syndrome, bipolar disorder, gastroesophageal reflux disease (GERD), and aphasia following cerebral infarction. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating Resident #26 was severely cognitively impaired. Further review of the current physician orders for Resident #26 revealed a physician order written on 11/07/23 for Novolog insulin, 100 units per milliliter (u/ml) to be injected subcutaneously (under the skin) per a sliding scale every eight hours related to diabetes mellitus. Review of the medication administration record for Resident #26 revealed the resident did not receive the ordered sliding scale dose of Novolog on 12/02/24 at 10:00 P.M., on 12/03/24 at 6:00 A.M., and on 01/05/25 at 6:00 A.M. An interview with the DON verified Resident #26 did not receive the ordered sliding scale dose of Novolog on 12/02/24 at 10:00 P.M., on 12/03/24 at 6:00 A.M., and on 01/05/25 at 6:00 A.M. 2. Review of the medical record for Resident #89 revealed an admitted [DATE]. Diagnoses included of aphasia (inability to speak) following cerebral infarction (stroke), and type II diabetes mellitus. Review of the Medicare Five Day MDS assessment for Resident #89, dated 01/08/25 revealed a BIMS score of 00, indicating Resident #89 was severely cognitively impaired. Review of the current physician orders for Resident #89 revealed an order for 25 units of Lantus insulin 100 mg/ml to be injected subcutaneously two times a day for diabetes mellitus. Review of the medication administration record for Resident #89 revealed the resident had not received the ordered afternoon dose of 25 units of Lantus insulin, scheduled on 01/05/25 at 4:00 P.M. An interview with the DON verified Resident #89 had not receive the ordered afternoon dose of 25 units of Lantus on 01/05/25 at 4:00 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #93 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, morbid obesity, major depressive disorder, and hypertension. Review of the most recent quarterly MDS assessment for Resident #93, dated 10/18/24, revealed a BIMS score of 15, indicating Resident #93 had intact cognition. Review of the current physician orders for resident #93 revealed an order for 25 units of Insulin Glargine Solution 100 mg per ml to be injected subcutaneously twice a day for diabetes mellitus. Review of the MAR for Resident #93 revealed the resident had not receive the ordered morning dose of 25 units of Insulin Glargine on 12/22/24. An interview with the Director of Nursing on 01/05/25 at 4:00 P.M. verified Resident #93 had not received the ordered morning dose of 25 units of Insulin Glargine on 12/22/24. Review of the facility policy titled, Medication Administration - General Guidelines, with a revision date of 03/20/18 revealed medications are administered as prescribed in accordance with good nursing practices. This deficiency represents non-compliance investigated under Complaint Number OH00161236.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure gloves were worn while administering subcutaneous insulin. This affected one resident (#71) of five (#26, #71, #80, #89, and #93) reviewed for medication administration. The facility identified 24 residents (#3, #4, #7, #8, #9, #10, #17, #26, #28, #29, #32, #39, #42, #50, #61, #65, #67, #69, #70, #71, #73, #79, #89, and #93) who were prescribed insulin. The facility census was 92. Findings include: Review of the medical record for Resident #71 revealed an admitted [DATE] with diagnoses of hemiplegia and hemiparesis, and type two diabetes mellitus, type II. Review of the current physician orders for Resident #71 revealed an order, dated 05/03/22, for 16 units of Lantus SoloStar Solution Pen-injector 100 unit per milliliter (ml) to be administered subcutaneously (injected under the skin) (SQ) one time a day for diabetes mellitus, type II. Observation of medication administration to Resident #71 on 01/14/25 at 7:40 A.M. revealed Registered Nurse (RN) #147 did not wear gloves while administering 16 units of Lantus SoloStar Solution Pen-injector 100 unit per ml to Resident #71. Interview on 01/14/25 at 7:42 A.M. with RN #147 verified gloves were not worn when 16 units of Lantus SoloStar Solution Pen-injector 100 unit per ml was administered to Resident #71. Review of the facility policy titled, Gloves, with a revision date of 08/09/16, revealed all personnel must wear gloves while performing a task that involves the potential exposure to blood or body fluids. Gloves shall be worn when working with sharp items.