

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35035</p> <p>Based on observation, review of the facility policy, and staff interview, the facility failed to ensure medications were administered via feeding tube per physician orders. This affected one resident (#15) out of 6 residents reviewed for medications. The census was 95.</p> <p>Findings include:</p> <p>Record review for Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #15 include sick sinus syndrome, traumatic brain injury, dysphagia, and dementia.</p> <p>Review of Resident #15's Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed the resident had impaired cognition and was receiving nutrition through a feeding tube.</p> <p>Review of Resident #15's care plans dated 02/19/25 revealed a focus for alteration in gastro-intestinal status related to Percutaneous Endoscopic Gastronomy (PEG) tube for tube feeding and nothing per mouth due to dysphagia. Interventions include administering medications per order.</p> <p>Further review of the care plans dated 03/16/25 revealed a focus for nutrition and hydration relating to the PEG tube. Interventions include dietician to monitor and make diet changes as needed.</p> <p>Review of Resident #15's physician orders dating from 02/19/25 to 03/26/25 revealed the resident was ordered to receive Clopidogrel 75 milligrams (mg) by mouth, Enalapril Maleate 20 mg by mouth, Ferrous Sulfate 7.4 milliliters (ml) by mouth, Flomax 0.4 mg capsule by mouth, hydrochlorothiazide 12.5 mg by mouth, Vitamin D3 250 micrograms (mcg), Apixaban 5 mg, Metoprolol 25 mg by mouth, and Gabapentin 8 ml by mouth.</p> <p>Further review of Resident #15's physician orders revealed on 03/25/25 at 3:52 P.M. the resident's diet and medication orders were advanced to medications to be crushed in applesauce or pudding, upright for meals, no cream or wheat or coffee. 1500 ml fluid restriction document total intake of eternal.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/25/25 at 9:59 A.M. Licensed Practical Nurse (LPN) #100 was observed preparing medications for Resident #15's morning administration. LPN #100 was observed preparing the Clopidogrel, Enalapril Maleate, Flomax, hydrochlorothiazide, Vitamin D3, Apixaban, and Metoprolol tablets and crushed them and placing the crushed pills in a medication cup, no applesauce or pudding was added. LPN #100 was observed pouring the Gabapentin and Ferrous Sulfate liquids into a medication cup.</p> <p>During the observation LPN #100 entered the resident's room and told Resident #15 she had his medications for his PEG tube. Resident #15 stated he has been eating recently and taking fluids by mouth. LPN #100 stated she knew his tube feedings were discontinued and stated 'I am so glad you can eat and swallow again'. Resident #15 asked about his medications and LPN #100 stated she planned to administer them through his PEG tube.</p> <p>During the observation LPN #100 was observed preparing the tube for the administration. LPN #100 washed her hands, retrieved a large syringe with no plunger, and retrieved a container of water in the bathroom. LPN #100 assessed the tube site by looking at the insertion site. LPN #100 began the administration of the medications by pouring the crushed pills into the tube without adding any water to the medication cup. The surveyor observed the tube becoming clogged with crushed pills. LPN #100 was observed taking the syringe with the crushed medications out of the PEG tube and shaking the pills into the container of water. LPN #100 was observed pouring the container of water into the PEG tube. LPN #100 was observed pouring the fluid medications into the tube and then pouring more of the water with the medications down the tube.</p> <p>Interview during the observation with LPN #100 verified she did not pour water into the crushed pill medication prior to administering them to the PEG tube which caused the tube to clog. LPN #100 stated she also pour the crushed medications into the water container which she intended to flush the tube after medication administration. LPN #100 stated she did review the physician orders prior to the medication administration and thought the resident did not have any tube flushes ordered and was unsure if he had any fluid restrictions.</p> <p>Interview and review of medication orders on 03/26/25 at 2:00 P.M. with the Director of Nursing (DON) verified there was an order on 03/25/26 to change the route of medication administration to oral instead of PEG tube in Resident #15's records. DON stated it was facility procedure to flush water through the PEG tube prior to administering crushed medications, crushed medications were to have water added prior to being poured into the tube, and the nurse should have reviewed the orders for route administration prior to giving the medications via the PEG tube. DON stated she was discussing Resident #15's condition with the primary physician and was awaiting the physician's guidance.</p> <p>Interview on 03/26/25 at 4:00 P.M. the DON produced a written signed physician order dated 03/26/25 for Resident #15's medications to be changed back to PEG tube administration.</p> <p>Review of the facility policy titled, 'Medication Administration,' dated 03/20/18 revealed if a resident is tube-fed medications are to be crushed finely and administered as to not clog the tube. Medications are to be administered in accordance with the physician's order. Medications are to be administered without unnecessary interruptions and are to be administered at the time they are prepared.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163556.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35035</p> <p>Based on observation, record review, review of the facility policies, and staff interview, the facility failed to ensure all nursing care was provided in accordance with standards and practices. This affected three residents (#15, #16, and #18) of three residents observed for medication administration. The current census was 95.</p> <p>Findings include:</p> <p>1. Record review for Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #15 include sick sinus syndrome, traumatic brain injury, dysphagia, and dementia.</p> <p>Review of Resident #15's Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had impaired cognition and was receiving nutrition through a feeding tube.</p> <p>Review of Resident #15's care plans dated 02/19/25 revealed a focus for alteration in gastro-intestinal status related to Percutaneous Endoscopic Gastronomy (PEG) tube for tube feeding and nothing per mouth due to dysphagia. Interventions include administering medications per order.</p> <p>Further review of the care plans dated 03/16/25 revealed a focus for nutrition and hydration relating to the PEG tube. Interventions include dietician to monitor and make diet changes as needed.</p> <p>Review of Resident #15's physician prescribed medication orders dating from 02/19/25 to 03/26/25 revealed the resident was ordered to receive Clopidogrel 75 milligrams (mg) by mouth, Enalapril Maleate 20 mg by mouth, Ferrous Sulfate 7.4 milliliters (ml) by mouth, Flomax 0.4 mg capsule by mouth, hydrochlorothiazide 12.5 mg by mouth, Vitamin D3 250 micrograms (mcg), Apixaban 5 mg, Metoprolol 25 mg by mouth, and Gabapentin 8 ml by mouth.</p> <p>Further review of Resident #15's physician orders revealed on 03/25/25 at 3:52 P.M. the resident's diet and medication orders were advanced to medications to be crushed in applesauce or pudding, upright for meals, no cream or wheat or coffee. 1500 ml fluid restriction document total intake of eternal.</p> <p>Observation on 03/25/25 at 9:59 A.M. Licensed Practical Nurse (LPN) #100 was observed preparing medications for Resident #15's morning administration. LPN #100 was observed preparing the Clopidogrel, Enalapril Maleate, Flomax, hydrochlorothiazide, Vitamin D3, Apixaban, and Metoprolol tablets and crushed them and placing the crushed pills in a medication cup, no applesauce or pudding was added. LPN #100 was observed pouring the Gabapentin and Ferrous Sulfate liquids into a medication cup.</p> <p>During the observation LPN #100 entered the resident's room and told Resident #15 she had his medications for his PEG tube. Resident #15 stated he has been eating recently and taking fluids by mouth. LPN #100 stated she knew his tube feedings were discontinued and stated 'I am so glad you can eat and swallow again'. Resident #15 asked about his medications and LPN #100 stated she planned to administer them through his PEG tube.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the observation LPN #100 was observed preparing the tube for the administration. LPN #100 washed her hands, retrieved a large syringe with no plunger, and retrieved a container of water in the bathroom. LPN #100 assessed the tube site by looking at the insertion site. LPN #100 began the administration of the medications by pouring the crushed pills into the tube without adding any water to the medication cup. The surveyor observed the tube becoming clogged with crushed pills. LPN #100 was observed taking the syringe with the crushed medications out of the PEG tube and shaking the pills into the container of water. LPN #100 was observed pouring the container of water into the PEG tube. LPN #100 was observed pouring the fluid medications into the tube and then pouring more of the water with the medications down the tube.</p> <p>Interview during the observation with LPN #100 verified she did not pour water into the crushed pill medication prior to administering them to the PEG tube which cause the tube to clog. LPN #100 stated she also pour the crushed medications into the water container which she intended to flush the tube after medication administration. LPN #100 stated she did review the physician orders prior to the medication administration and thought the resident did not have any tube flushes ordered and was unsure if he had any fluid restrictions.</p> <p>Interview and review of medications orders on 03/26/25 at 2:00 P.M. with the Director of Nursing (DON) verified there was an order on 03/25/26 to change the route of medication administration to oral instead of PEG tube in Resident #15's records. DON stated it was facility procedure to flush water through the PEG tube prior to administering crushed medications, crushed medications were to have water added prior to being poured into the tube, and the nurse should have reviewed the orders for route administration prior to giving the medications via the PEG tube. DON stated she was discussing Resident #15's condition with the primary physician and was awaiting the physician's guidance.</p> <p>Interview on 03/26/25 at 4:00 P.M. the DON produced a written signed physician order dated 03/26/25 for Resident #15's medications to be changed back to PEG tube administration.</p> <p>2. Record review for Resident #16 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #16 include atrial fibrillation, heart failure, depression and anxiety.</p> <p>Review of the comprehensive MDS assessment for Resident #16 revealed the resident had intact cognition.</p> <p>Review of Resident #16's physician prescribed medications dated from 02/16/25 to 03/26/25 revealed the resident was to receive Amiodarone 200 mg, Biotin 1 mg, Cholecalciferol 2000 units, Metoprolol 60 mg, Miralax 17 grams, multi-vitamin tablet, Omeprazole 20 mg, Sertraline 100 mg, Wellbutrin 300 mg, Zinc 50 mg, Colace 100 mg, Eliquis 5 mg, and Gabapentin 300 mg.</p> <p>Observation on 03/26/25 from 9:15 A.M. to 9:30 A.M. LPN #100 was observed at the medication cart preparing Resident #15, Resident #16, and Resident #18's medications at the same time. LPN #100 verified multiple times she prepares more than one resident's medications during her medication pass. LPN #100 was observed reviewing the medication orders for Resident #16 and stated she would administer each resident's medications separately. LPN #100 was observed preparing the Amiodarone, Biotin, Cholecalciferol, Metoprolol, MiraLAX, Multi-Vitamin, Omeprazole, Sertraline, Wellbutrin, Zinc, Colace, Eliquis, and Gabapentin medications for Resident #16.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the same observation, LPN #100 was observed taking two medication cups, one with pills and one with liquids and placing them into the top drawer of the medication cart. LPN #100 stated those medications were for Resident #15 and she would have to prepare them for his tube so she couldn't bring those medications cups into the room. LPN #100 was observed taking three medication cups with pills and one eight ounce cup with MiraLAX 17 grams added to water, one eight ounce cup of water with glycol powder added, one insulin flex-pen and an alcohol swab with a pair of gloves into Resident #16's room. LPN #100 stated she had Resident #18's medications in her left hand and Resident #16's medications in her right hand so she did not confuse them. LPN #100 verified with the surveyor this is her usual procedure for medication administration. LPN #100 was observed giving Resident #16 her medications with the medications for Resident #18 on her left hand.</p> <p>Interview on 03/26/25 at 10:00 A.M. with LPN #100 verified she had taken another resident's medications into Resident #16's rooms during her medication. LPN #100 stated her usual duties were on nightshift and she passes medications as a charge nurse to all residents in the facility during her shifts.</p> <p>3. Record review for Resident #18 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #18 include diabetes type two, chronic obstructive pulmonary disease, and obesity.</p> <p>Review of Resident #18's comprehensive MDS assessment dated [DATE] revealed the resident had intact cognition and was receiving insulin injections.</p> <p>Review of Resident #18's care plans dated 09/21/23 revealed a focus for diabetes mellitus. Interventions include checking blood glucose per physician order and to administer medications per order.</p> <p>Review of Resident #18's physician ordered medications dating from 09/30/23 to 03/25/25 revealed the resident was ordered to receive Amiodarone 200 mg, Bumetanide 2 mg, Cholecalciferol 1000 units, Ferrous Sulfate 325 mg, folic acid 1 mg, Januvia 100 mg, Jardiance 10 mg, Lisinopril 5 mg, oyster shell vitamin D 1 tab, glycol powder 17 grams, Trintellix 10 mg, Docusate 100 mg, Eliquis 5 mg, magnesium oxide 400 mg, Insulin Aspart Flex-Pen insulin on a sliding scale, and Metoprolol 100 mg.</p> <p>Review of Resident #18's Medication Administration Record (MAR) dated 03/2025 revealed LPN #100 documented the resident's blood glucose was 216 for the Insulin Aspart medication on 03/26/25 morning dose.</p> <p>Observation on 03/26/25 from 9:15 A.M. to 9:30 A.M. of LPN #100 revealed the nurse was observed preparing Resident #18's medications in a medication cup. The nurse prepared the Amiodarone, Bumetanide, Cholecalciferol, Ferrous sulfate, folic acid, Januvia, Jardiance, Lisinopril, oyster shell, Trintellix, Docusate, Eliquis, magnesium oxide, and Metoprolol pills into the cup and pouring the glycol powder into the 8-ounce water cup. LPN #100 stated Resident #18 had continuous blood glucose monitor and the resident will monitor the current blood glucose, and the nurse will know how much insulin to give her per the scale.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further observations revealed after LPN #100 entered Resident #16's room and administered the resident's medications she held Resident #18's medications in her left hand. LPN #100 was observed entering Resident #18's room and giving her the eight ounce cup and the medication cup with pills. LPN #100 asked the resident what her blood glucose was, and the resident took her phone and showed her blood glucose reading was 228. LPN #100 was observed washing her hands in the bathroom, applying gloves, swabbing the resident upper right bicep area, taking the insulin Flex-pen and drawing up 2 units, pushing the plunger, and then drawing up 4 units. LPN #100 stated the resident's sliding scale required 4 units for a blood glucose of 228. LPN #100 was observed placing the Flex-pen on Resident #18's upper bicep and pushing the plunger quickly and removing the pen from the resident. The surveyor asked if the nurse had held the pen and stated the injection went quickly. LPN #100 stated that's how she always gives injections, 'I'm very fast'.</p> <p>Interview on 03/26/25 at 2:00 P.M. with the DON and Regional Director of Nursing (RDON) revealed it was the facility's practice to only prepare one resident's medications at a time, to not enter a room with another resident's medications, and to hold the Flex-pen injections for insulin for a full 10 seconds per manufacturer's guidelines. DON verified LPN #100's medication administrations observed were not facility practice.</p> <p>Interview on 03/26/25 at 4:00 P.M. the DON verified LPN #100 documented in Resident #18's MAR dated 03/26/25 for the morning dose of the Insulin Aspart the resident's blood glucose as being 216, not 228 per the observation. The DON verified LPN #100 was a charge nurse for nightshift and the nurse administers medications to all of the residents in the facility.</p> <p>Review of the facility's policy titled, 'Insulin Pen Administration,' dated 08/31/16 revealed after the dose of the insulin is dialed into the pen the nurse shall leave the needle in the skin and hold for a count of at least 10 seconds.</p> <p>Review of the facility policy titled, 'Medication Administration,' dated 03/20/18 revealed if a resident is tube-fed medications are to be crushed finely and administered as to not clog the tube. Medications are to be administered in accordance with the physician's order. Medications are to be administered without unnecessary interruptions and are to be administered at the time they are prepared.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163556.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35035</p> <p>Based on observation, review of the facility policies, staff interview, and review of medical records, the facility failed to ensure a medication error rate lower than 5%. The error rate on 03/26/24 was 19%, this affected three residents (#15, #17, and #18) of three residents observed for medication administration. The current census is 95.</p> <p>Findings include:</p> <p>Observation on 03/26/25 from 9:15 A.M. to 10:01 A.M. of Licensed Practical Nurse (LPN) #100 administering medications to the residents on the B-hall revealed there to be 11 medication errors noted during 3 medication administrations for Resident #15, Resident #17, and Resident #18. LPN #100 was observed administering 57 medications to four residents during the observation.</p> <p>1. Review of Resident #15's care plans dated 02/19/25 revealed a focus for alteration in gastro-intestinal status related to Percutaneous Endoscopic Gastronomy tube, (PEG) for tube feeding and nothing per mouth due to dysphagia. Interventions include administering medications per order.</p> <p>Further review of the care plans dated 03/16/25 revealed a focus for nutrition and hydration relating to the PEG tube. Interventions include dietician to monitor and make diet changes as needed.</p> <p>Further review of Resident #15's physician orders revealed on 03/25/25 at 3:52 P.M. the resident's diet and medication orders were advanced to medications to be crushed in applesauce or pudding, upright for meals, no cream or wheat or coffee. 1500 ml fluid restriction document total intake of eternal.</p> <p>Review of Resident #15's physician prescribed medication orders dating from 02/19/25 to 03/26/25 revealed the resident was ordered to receive Clopidogrel 75 milligrams (mg) by mouth, Enalapril Maleate 20 mg by mouth, Ferrous Sulfate 7.4 milliliters (ml) by mouth, Flomax 0.4 mg capsule by mouth, hydrochlorothiazide 12.5 mg by mouth, Vitamin D3 250 micrograms (mcg), Apixaban 5 mg, Metoprolol 25 mg by mouth, and Gabapentin 8 ml by mouth.</p> <p>Observation on 03/25/25 at 9:59 A.M. Licensed Practical Nurse (LPN) #100 was observed preparing medications for Resident #15's morning administration. LPN #100 was observed preparing the Clopidogrel, Enalapril Maleate, Flomax, hydrochlorothiazide, Vitamin D3, Apixaban, and Metoprolol tablets and crushed them and placing the crushed pills in a medication cup. LPN #100 was observed pouring the Gabapentin and Ferrous Sulfate liquids into a medication cup.</p> <p>During the observation LPN #100 entered the resident's room and told Resident #15 she had his medications for his PEG tube. Resident #15 stated he has been eating recently and taking fluids by mouth. LPN #100 stated she knew his tube feedings were discontinued and stated 'I am so glad you can eat and swallow again'. Resident #15 asked about his medications and LPN #100 stated she planned to administer them through his PEG tube.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the observation LPN #100 was observed preparing the tube for the administration. LPN #100 washed her hands, retrieved a large syringe with no plunger, retrieved a container of water in the bathroom. LPN #100 assessed the tube site by looking at the insertion site. LPN #100 began the administration of the medications by pouring the crushed pills into the tube without adding any water to the medication cup. The surveyor observed the tube becoming clogged with crushed pills. LPN #100 was observed taking the syringe with the crushed medications out of the PEG tube and shaking the pills into the container of water. LPN #100 was observed pouring the container of water into the PEG tube. LPN #100 was observed pouring the fluid medications into the tube and then pouring more of the water with the medications down the tube.</p> <p>Interview during the observation with LPN #100 verified she did not pour water into the crushed pill medication prior to administering them to the PEG tube which cause the tube to clog. LPN #100 stated she also pour the crushed medications into the water container which she intended to flush the tube after medication administration. LPN #100 stated she did review the physician orders prior to the medication administration and thought the resident did not have any tube flushes ordered and was unsure if he had any fluid restrictions.</p> <p>Interview and review of medications orders on 03/26/25 at 2:00 P.M. with the Director of Nursing (DON) verified there was an order on 03/25/26 to change the route of medication administration to oral instead of PEG tube in Resident #15's records. DON stated it was facility procedure to flush water through the PEG tube prior to administering crushed medications, crushed medications were to have water added prior to being poured into the tube, and the nurse should have reviewed the orders for route administration prior to giving the medications via the PEG tube. DON stated she was discussing Resident #15's condition with the primary physician and was awaiting the physician's guidance.</p> <p>Interview on 03/26/25 at 4:00 P.M. the DON produced a written signed physician order dated 03/26/25 for Resident #15's medications to be changed back to PEG tube administration.</p> <p>2. Record review for Resident #17 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #17 include chronic obstructive pulmonary disease, heart disease, and atrial fibrillation.</p> <p>Review of Resident #17's comprehensive MDS assessment dated [DATE] revealed the resident had intact cognition and received supplemental oxygen.</p> <p>Review of Resident #17's care plans dated 06/07/24 revealed a focus for oxygen therapy. Interventions include give medications per order and observe for side effects and effectiveness.</p> <p>Review of Resident #17's physician ordered medications dating from 06/2024 to 03/25/25 revealed the resident was ordered to receive Ipratropium-Albuterol inhalation solution 0.6-2.5 mg in 3 ml of solution, inhale every six hours for chronic obstructive pulmonary disease.</p> <p>Review of Resident #17's Medication Administration Record (MAR) dated 03/2025 revealed LPN #100 had documented the resident received the Ipratropium-Albuterol inhalation treatment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/26/25 at 9:50 A.M. LPN #100 was observed pouring the Ipratropium-Albuterol solution into Resident #17's nebulizer and placing the breathing mask back into the nebulizer holder. LPN #100 did not turn on the machine. LPN #100 did not as Resident #17 if she wanted to wait for her nebulizer treatment. LPN #100 administered the resident's pills and left the room. LPN #100 verified she did not observe Resident #17 start her nebulizer inhalation treatment.</p> <p>Interview on 03/26/25 at 2:00 P.M. with the DON revealed it was facility practice to observe the start of each nebulizer treatment prior to leaving the resident's room. DON verified LPN #100 had documented the resident received the treatment in the record.</p> <p>3. Review of Resident #18's care plans dated 09/21/23 revealed a focus for diabetes mellitus. Interventions include checking blood glucose per physician order and to administer medications per order.</p> <p>Review of Resident #18's physician ordered medications dating from 09/30/23 to 03/25/25 revealed the resident was ordered to receive Amiodarone 200 mg, Bumetanide 2 mg, Cholecalciferol 1000 units, Ferrous Sulfate 325 mg, folic acid 1 mg, Januvia 100 mg, Jardiance 10 mg, Lisinopril 5 mg, oyster shell vitamin D 1 tab, glycol powder 17 grams, Trintellix 10 mg, Docusate 100 mg, Eliquis 5 mg, magnesium oxide 400 mg, Insulin Aspart Flex-Pen insulin on a sliding scale, and Metoprolol 100 mg.</p> <p>Review of Resident #18's Medication Administration Record (MAR) dated 03/2025 revealed LPN #100 documented the resident's blood glucose was 216 for the Insulin Aspart medication on 03/26/25 morning dose.</p> <p>Observation on 03/26/25 from 9:15 A.M. to 9:30 A.M. of LPN #100 the nurse was observed preparing Resident #18's medications in a medication cup. The nurse prepared the Amiodarone, Bumetanide, Cholecalciferol, Ferrous sulfate, folic acid, Januvia, Jardiance, Lisinopril, oyster shell, Trintellix, Docusate, Eliquis, magnesium oxide, and Metoprolol pills into the cup and pouring the glycol powder into the 8-ounce water cup. LPN #100 stated Resident #18 had continuous blood glucose monitor and the resident will monitor the current blood glucose, and the nurse will know how much insulin to give her per the scale.</p> <p>Further observations revealed after LPN #100 entered Resident #16's room and administered the resident's medications she held Resident #18's medications in her left hand. LPN #100 was observed entering Resident #18's room and giving her the 8-ounce cup and the medication cup with pills. LPN #100 asked the resident what her blood glucose was, and the resident took her phone and showed her blood glucose reading was 228. LPN #100 was observed washing her hands in the bathroom, applying gloves, swabbing the resident upper right bicep area, taking the insulin Flex-pen and drawing up 2 units, pushing the plunger, and then drawing up 4 units. LPN #100 stated the resident's sliding scale required 4 units for a blood glucose of 228. LPN #100 was observed placing the Flex-pen on Resident #18's upper bicep and pushing the plunger quickly and removing the pen from the resident. The surveyor asked if the nurse had held the pen and stated the injection went quickly. LPN #100 stated that's how she always gives injections, 'I'm very fast'.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/25 at 2:00 P.M. with the DON and Regional Director of Nursing, (RDON) revealed it was the facility's practice to only prepare one resident's medications at a time, to not enter a room with another resident's medications, and to hold the Flex-pen injections for insulin for a full 10 seconds per manufacturer's guidelines. DON verified LPN #100's medication administrations observed were not facility practice.</p> <p>Interview on 03/26/25 at 4:00 P.M. the DON verified LPN #100 documented in Resident #18's MAR dated 03/26/25 for the morning dose of the Insulin Aspart the resident's blood glucose as being 216, not 228 per the observation. The DON verified LPN #100 was a charge nurse for nightshift and the nurse administers medications to all of the residents in the facility.</p> <p>Review of the facility's policy titled, 'Insulin Pen Administration,' dated 08/31/16 revealed after the dose of the insulin is dialed into the pen the nurse shall leave the needle in the skin and hold for a count of at least 10 seconds.</p> <p>Review of the facility policy titled, 'Medication Administration,' dated 03/20/18 revealed if a resident is tube-fed medications are to be crushed finely and administered as to not clog the tube. Medications are to be administered in accordance with the physician's order. Medications are to be administered without unnecessary interruptions and are to be administered at the time they are prepared.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163556.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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> 35035</p> <p>Based on observation, record review, review of the facility policies, and staff interview, the facility staff failed to properly administer insulin medications per the manufacturer's guidelines. This affected one resident (#18) out of five residents observed receiving medications. The current census was 95.</p> <p>Findings include:</p> <p>Record review for Resident #18 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #18 include diabetes type two, chronic obstructive pulmonary disease, and obesity.</p> <p>Review of Resident #18's comprehensive MDS assessment dated [DATE] revealed the resident had intact cognition and was receiving insulin injections.</p> <p>Review of Resident #18's care plans dated 09/21/23 revealed a focus for diabetes mellitus. Interventions include checking blood glucose per physician order and to administer medications per order.</p> <p>Review of Resident #18's physician ordered medications dating from 09/30/23 to 03/25/25 revealed the resident was ordered to receive Amiodarone 200 mg, Bumetanide 2 mg, Cholecalciferol 1000 units, Ferrous Sulfate 325 mg, folic acid 1 mg, Januvia 100 mg, Jardiance 10 mg, Lisinopril 5 mg, oyster shell vitamin D 1 tab, glycol powder 17 grams, Trintellix 10 mg, Docusate 100 mg, Eliquis 5 mg, magnesium oxide 400 mg, Insulin Aspart Flex-Pen insulin on a sliding scale, and Metoprolol 100 mg.</p> <p>Review of Resident #18's Medication Administration Record (MAR) dated 03/2025 revealed LPN #100 documented the resident's blood glucose was 216 for the Insulin Aspart medication on 03/26/25 morning dose.</p> <p>Observation on 03/26/25 from 9:15 A.M. to 9:30 A.M. of LPN #100 the nurse was observed preparing Resident #18's medications in a medication cup. The nurse prepared the Amiodarone, Bumetanide, Cholecalciferol, Ferrous sulfate, folic acid, Januvia, Jardiance, Lisinopril, oyster shell, Trintellix, Docusate, Eliquis, magnesium oxide, and Metoprolol pills into the cup and pouring the glycol powder into the 8-ounce water cup. LPN #100 stated Resident #18 had continuous blood glucose monitor and the resident will monitor the current blood glucose, and the nurse will know how much insulin to give her per the scale.</p> <p>Further observations revealed LPN #100 was observed entering Resident #18's room and giving her the 8-ounce cup and the medication cup with pills. LPN #100 asked the resident what her blood glucose was, and the resident took her phone and showed her blood glucose reading was 228. LPN #100 was observed washing her hands in the bathroom, applying gloves, swabbing with alcohol the resident upper right bicep area, taking the insulin Flex-pen and drawing up 2 units, pushing the plunger, and then drawing up 4 units. LPN #100 stated the resident's sliding scale required 4 units for a blood glucose of 228. LPN #100 was observed placing the Flex-pen on Resident #18's upper bicep and pushing the plunger quickly and immediately removing the pen from the resident. The surveyor asked if the nurse had held the pen long enough and stated the injection went quickly. LPN #100 stated that's how she always gives injections, 'I'm very fast'.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/25 at 2:00 P.M. with the Director of Nursing, (DON), and Regional Director of Nursing, (RDON) revealed it was the facility's practice to hold the Flex-pen injections for insulin for a full 10 seconds per manufacturer's guidelines. DON verified LPN #100's medication administrations observed were not facility practice.</p> <p>Interview on 03/26/25 at 4:00 P.M. the DON verified LPN #100 documented in Resident #18's MAR dated 03/26/25 for the morning dose of the Insulin Aspart the resident's blood glucose as being 216, not 228 per the observation. The DON verified LPN #100 was a charge nurse for nightshift and the nurse administers medications to all of the residents in the facility.</p> <p>Review of the facility's policy titled, 'Insulin Pen Administration', dated 08/31/16 revealed after the dose of the insulin is dialed into the pen the nurse shall leave the needle in the skin and hold for a count of at least 10 seconds.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163556</p>		