

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 12/24/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, observation, staff interview and record review, the facility failed to ensure wound treatments were completed as physician ordered. This affected one (#13) of one resident reviewed for wound treatments. The facility census was 106. Findings include: Review of the medical record for Resident #13 revealed an admission date of 09/30/23 with diagnoses including type II diabetes mellitus, non-pressure chronic ulcer of other part of right foot, congestive heart failure, and non-pressure chronic ulcer of right calf. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had intact cognition and had open lesions of the foot, other than ulcers, rashes or cuts. Review of the physician orders dated 12/19/25 revealed Resident #13 had a wound to the right foot with treatment directions to cleanse with normal saline, pat dry, apply calcium alginate with silver, wrap with kerlix then ACE wrap, every day shift for open area. There were treatment directions to cleanse the right toe and right side upper thigh with normal saline, pat dry, apply calcium alginate with silver and wrap with kerlix every day shift for wound. The wound to the right shin had treatment directions to cleanse with normal saline, pat dry, apply alginate with silver and cover with island dressing daily and as needed, every day shift for skin tear. Review on 12/24/25 at 1:25 P.M. of the Treatment Administration Record (TAR) dated December 2025 revealed each of the above noted physician orders was documented on 12/23/25 with HN and staff initials. Each of the above noted physician orders were documented on 12/24/25 with a checkmark with staff initials. Additional review of the Chart Codes on the TAR revealed HN meant Hold/See Nurse Notes. Review of the progress notes for Resident #13, dated 12/23/25, revealed no indication why the wound treatment was not completed. Interview on 12/24/25 at 1:02 P.M. with Resident #13 revealed her wound treatments were not completed since Monday (12/22/25). Resident #13 stated her wound treatments should be completed daily. Interview on 12/24/25 at 1:25 P.M. with Licensed Practical Nurse (LPN) #201, and concurrent review of Resident #13's TAR confirmed LPN #201 charted she completed the wound treatments to Resident #13's right leg on 12/24/25 but had not yet completed them. Observation on 12/24/25 at approximately 1:30 P.M. and concurrent interview with LPN #201 revealed Resident #13's right leg was wrapped in an ace wrap. LPN #201 confirmed Resident #13's ace wrap showed indication of wound seepage around the calf and toes. LPN #201 further confirmed Resident #13's right upper outer calf had exposed open wound areas due to the drooping of the wound covering and ace bandage. Continued observation revealed LPN #201 removed the ace wrap from Resident #13's right leg, exposing gauze from upper right calf to the tips of her toes. At the top of the right foot, written in pen on the gauze, was the date 12/22/25 with staff initials. Continued interview with LPN #201, and concurrent review of Resident #13's December TAR, confirmed the initials on the gauze matched the initials of the nurse who documented treatments were completed on 12/22/25. Additionally, the initials on the TAR for 12/23/25 were a different nurse (LPN #202). Interview on 12/24/25 at 1:42 P.M. with the Director of Nursing (DON) and review of Resident #13's TAR and progress notes confirmed there was no indication in Resident #13's chart to explain why the wound treatment was not completed on 12/23/25. The DON further stated Resident #13's wound treatments should have been completed on 12/23/25, as ordered by the physician. Follow-up interview on 12/24/25 at 2:28 P.M. with the DON revealed she spoke with LPN #202, who charted on Resident #13's chart on 12/23/25. The DON stated LPN #202 confirmed she did not complete Resident #13's wound treatments because she ran out of time on her shift. This was an incidental finding identified during the complaint survey completed 12/24/25.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of meal tickets, staff and resident interviews, and review of Resident Council meeting minutes, the facility failed to ensure residents received menu items as selected at mealtime. This affected two (#11 and #15) of four residents reviewed for accuracy of meal tray food items. The facility census was 106. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 01/09/24 with diagnoses including hemiplegia, type II diabetes mellitus, and overactive bladder. Review of the annual comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition and was able to eat independently. Interview on 12/24/25 at 8:48 A.M. with Resident #11 revealed she generally did not receive the choices she selected on her menus for lunch and dinner. Observation during meal service on 12/24/25 at 12:55 P.M. with Licensed Practical Nurse (LPN) #203, and concurrent interview, confirmed Resident #11 did not receive the vegetable soup she selected on her meal ticket. Further interview with LPN #203 revealed residents complained about not receiving items they select on their meal tickets. Interview on 12/24/25 at 12:59 P.M. with Certified Nursing Assistant (CNA) #101 revealed she was able to provide Resident #11's vegetable soup upon request from the surveyor. 2. Review of the medical record for Resident #15 revealed an admission date of 10/22/25 with diagnoses including hypertensive heart disease, type II diabetes mellitus, and heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition and required setup or clean-up assistance for eating. Observation during meal service on 12/24/25 at 12:05 P.M. revealed Certified Nursing Assistant (CNA) #102 providing Resident #15 her noon meal. Concurrent interview and review of the selective menu for Resident #15 revealed she selected crackers and did not receive them on her tray. CNA #102 was able to provide the crackers from an unused meal tray for a resident who was out of the facility. Interview on 12/24/25 at 12:59 P.M. with CNA #101 confirmed CNAs were responsible for passing out menu tickets for lunch and dinner meals the day before service, and ensuring the meal tickets were completed by residents and returned to the kitchen by 6:00 P.M. Additionally, CNA #101 confirmed residents complained about not receiving the items they requested. CNA #101 further stated she was able to coordinate with her co-workers and the kitchen to obtain the requested items timely during meal service. Review of the Resident Council Food Committee notes, dated 11/03/25, revealed a concern regarding menus not being filled out and residents not getting what they request. This deficiency represents non-compliance investigated under Complaint Number 2664244.</p>		