

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 08/21/2025
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.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the facility failed to ensure that residents were served together during dining in the memory care unit. This had the potential to affect all 24 residents who reside on the memory care unit. Additionally the facility failed to ensure a female resident was free from long facial hair. This affected one (#27) of one resident reviewed for facial hair. The facility census was 96. Findings include: 1. Observation on 08/18/25 at 8:58 A.M. of breakfast trays being delivered to the dining room on the memory care unit revealed the staff began delivering trays to the tables. Staff removed the plates and drinks from the trays and placed them in front of the residents. Staff did not serve the residents by tables. One table with two residents sitting at the table had one resident that was served at 9:00 A.M. while the other resident was served at 9:14 A.M. The staff were observed serving tables at random from the cart. Observation of another two top table revealed one resident was served at 9:04 A.M. and the other resident was served at 9:08 A.M. Four other tables were observed with only one resident eating and the other resident was waiting to be served. The average wait time of residents watching the other residents eat was between four to eight minutes. Interview on 08/18/25 at 9:07 A.M. with Resident #41 revealed he would like to eat at the same time as his friend. Resident #41 stated he had been in the dining room since 6:30 A.M. Interview on 08/18/25 at 9:15 A.M. with Certified Nursing Assistant (CNA #446) revealed the trays do not come out in sequence of the tables. CNA #446 verified the tables were not served together and the residents were watching the other resident at the table eating. CNA #446 stated they serve the trays as they come off the cart. Observation on 08/19/25 at 8:50 A.M. of breakfast trays being delivered to the dining room on the memory care unit revealed the trays were on a open cart. Staff were observed to start passing trays at 8:54 A.M. 16 residents were observed in the dining room at 8:57 A.M. Two more residents arrived at 8:58 A.M. One big table observed in the dining room had seven residents sitting at the table. One resident at the big table was observed to be served their meal at 9:04 A.M. Staff were observed serving other tables while the six other residents at the big table were without breakfast. The second resident at the big table was served at 9:09 A.M. Observation of another two top table revealed one resident served at 9:06 A.M. and the other resident was served at 9:13 A.M. The big table was observed with five out of seven residents not served at 9:12 A.M. Four staff members were observed passing trays. The last resident at the big table was served at 9:20 A.M. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/19/25 at 8:08 A.M. with CNA #446 revealed almost all the residents from the unit come to the dining room for meals. CNA #446 stated they did not have any residents that consistently eat in their room. Interview on 08/19/25 at 10:00 A.M. with CNA #446 it was verified the residents sitting together at the dining tables were not served together this morning. CNA #446 stated they did try to serve the residents together, but the meal trays were not delivered to the unit on the cart that way and it made it more difficult to do. Observation on 08/20/25 at 8:51 A.M. revealed 17 residents were in the dining room on the memory care unit. Staff were observed not passing trays by table. At 8:51 A.M. the big table with seven residents had three residents out of seven residents who had been served their meal. One resident at a two top table was observed with a meal at 8:52 A.M. and the second resident was served at 8:58 A.M. Two more residents were observed entering the dining room bringing the total to 19 residents in the dining room. Two staff members were observed passing the trays in the dining room. At 9:06 A.M. four residents at the big table were waiting on breakfast. At 9:10 A.M. two residents at the big table still were waiting on food. The last resident at the big table was served at 9:15 A.M. Interview on 08/20/25 at 9:19 A.M. with CNA #446 it was verified the residents in the dining room were not served by tables again this morning. Observation on 08/20/25 at 12:24 P.M. of lunch on the memory care unit revealed the first meal trays were delivered already. 18 residents were observed in the dining room. Observation of the big seven top table revealed all but one resident had been served lunch. The second meal cart was delivered to the dining room at 12:30 P.M. The last resident at the big seven top table was served at 12:32 P.M. Interview on 08/20/25 at 12:42 P.M. with Dietary Supervisor (DS #438) revealed the dietary staff had been putting the trays on the cart according to the type of diet prior to lunch today. DS #438 stated that today at the lunch meal they started splitting the two meal delivery carts and having the first cart have all of the seven top table resident's meals on it and the rest of the meals were delivered on the second cart. 2. Review of the medical record for Resident #27 revealed an admission date of 05/18/23 with diagnoses of Alzheimer's disease and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had intact cognition and required setup or clean-up assistance for personal hygiene. Review of the current care plan, updated 08/03/25, revealed Resident #27 required one staff for setup and assistance with personal hygiene. Review of the electronic medical record (EMR) indicated Resident #27 received a shower on 08/19/25 at 5:30 A.M. Observation and interview on 08/18/25 at 10:13 A.M. revealed Resident #27 sitting in her recliner in her room. Resident #27 had several long chin hairs she was able to pull at with her fingers. Resident #27 stated she did not have the eyesight to remove them herself, but would like them removed. Resident #27 stated she did not ask staff to remove them. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/19/25 at approximately 4:00 P.M. with Certified Nursing Assistant (CNA) #469 and concurrent review of the EMR confirmed Resident #27 received a shower on the morning of 08/19/25. Continued interview and concurrent observation of Resident #27 confirmed her chin hairs remained long and visible. Resident #27 again stated she would like the chin hairs removed as she found them embarrassing. CNA #469 confirmed Resident #27's chin hairs should have been removed during her shower. Review of the policy Quality of Care Policy/Activities of Daily Living, revised 04/2016, revealed the facility would provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the psychotropic education form was completed prior to starting medications. This affected one (#30) of five residents reviewed for psychotropic medications. The facility census was 96. Findings include: Review of the medical record for Resident #30 revealed an admission date of 06/25/25 with diagnoses of insomnia, bipolar disorder, depression, stroke, and dementia. Review of the 5-day MDS assessment dated [DATE] revealed Resident #30 was rarely/never understood. Review of the physician order initiated 06/25/25, discontinued 08/20/25, and re-initiated 08/20/25, revealed Resident #30 received Divalproex Sodium (an anticonvulsant) oral tablet delayed release 250 milligrams (mg), twice daily for bipolar disorder. Review of the physician order initiated 07/24/25, discontinued 08/20/25, and re-initiated 08/20/25, revealed Resident #30 received Sertraline Hydrochloride (HCl) (an antidepressant) oral tablet 50 mg once daily for depression. An additional physician order dated 07/24/25 revealed Resident #30 received Sertraline HCl oral tablet 100 mg once daily for depression. Review of the physician order initiated 07/24/25, discontinued 08/20/25, and re-initiated 08/20/25, revealed Resident #30 received Trazodone HCl (an antidepressant) oral tablet 50 mg once daily for insomnia. Interview on 08/20/25 at 2:50 P.M. with the Director of Nursing (DON) confirmed the facility could not provide any evidence Resident #30 or her representative was provided education and alternatives to psychotropic medications Divalproex Sodium, Sertraline HCl, or Trazodone HCl prior to Resident #30 receiving them.		

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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** Based on record review, interview, and policy review the facility failed to ensure the comprehensive care plan included all resident care areas. This affected two (#77 and #98) of 26 residents reviewed for care plans. The facility census was 96. Findings include: 1. Review of medical record for Resident #77 revealed an admission date of 09/01/25 with diagnoses including but not limited to Alzheimer's disease, dementia, and visual hallucinations. Review of minimum data set (MDS) dated [DATE] revealed the resident had severely impaired cognition. No pressure ulcers during the look back period. Review of current physician orders revealed right lateral foot cleanse with wound wash, pat dry, cover with foam dressing every third day and as needed if soiled. Review of care plan dated 08/01/25 revealed the resident is at risk for skin breakdown related to decreased mobility. Interventions included apply lotion/moisture barrier cream as needed, encourage frequent repositioning, encourage to lay down after meals to offload, offload heels with pillows, and skin assessment as needed. Further review of care plan revealed no care plan for the actual skin impairment and interventions. Interview on 08/21/25 at approximately 1:40 P.M. with Regional Clinical Nurse (RCN #550) revealed the resident did not have an actual skin impairment care plan until today. RCN #550 stated they were waiting for wound physician to classify wound before implementing a care plan. 2. Review of medical record for Resident #98 revealed an admission date of 08/01/22 with diagnoses including but not limited to Alzheimer's disease, generalized anxiety disorder, dementia, and post-traumatic stress disorder (PTSD). Review of the quarterly MDS dated [DATE] revealed the resident had severe cognitive impairment. Resident #98 had PTSD. Review of the care plan dated 06/23/25 revealed Resident #98 had no care plan their diagnosis of PTSD. Interview on 08/19/25 at 11:22 A.M. with MDS Coordinator #472 revealed the MDS Nurse typically completes the care plans for the residents. MDS Coordinator #472 stated that the facility is currently training the other nurse managers to complete certain parts of the care plans as well. MDS Coordinator #472 verified Resident #98 did not have a care plan addressing their PTSD and triggers or interventions. Review of policy titled Care Plan Policy dated 05/2025 revealed the facility will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, record review and facility policy review, the facility failed to ensure resident fingernails were cleaned and groomed. This affected one (#68) of three residents reviewed for activities of daily living. The facility census was 96. Findings Include: Review of the medical record for Resident #68 revealed an admission date of 09/20/19 with diagnoses of Alzheimer's disease, chronic obstructive pulmonary disease, and depression. Review of the comprehensive annual Minimum Data Set (MDS) assessment, dated 07/02/25, revealed Resident #68 had intact cognition and was dependent on staff for personal hygiene. Review of the current care plan, updated 07/10/25, revealed Resident #68 required staff participation with personal hygiene. Interview and observation on 08/18/25 at 9:11 A.M. revealed Resident #68 lying in bed. Resident #68 stated his fingernails needed to be trimmed and observation revealed there was debris under his fingernails on both hands. Interview on 08/19/25 at 7:59 A.M. with Certified Nursing Assistant (CNA) #471 revealed she received in report from night shift Resident #68 was showered and dressed during night shift. Continued interview and concurrent observation of Resident #68 revealed his nails were long and there was debris under the nails of the first two fingers of each hand. CNA #471 confirmed nails should be cleaned and trimmed during showers. Review of the policy Quality of Care Policy/Activities of Daily Living, revised 04/2016, revealed the facility would provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to timely ensure a resident's wound was accurately assessed and documented. This affected one (#77) of two residents reviewed for wounds. The facility census was 96. Findings include: Review of medical record for Resident #77 revealed an admission date of 09/01/22 with diagnoses including but not limited to Alzheimer's disease, dementia, and visual hallucinations. Review of minimum data set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. No pressure ulcers were coded on the assessment. Review of current physician orders revealed on order dated 08/01/25 for right lateral foot, cleanse with wound wash, pat dry, cover with foam dressing every third day and as needed if soiled. Review of the form titled Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) shower reviews dated 08/11/25 and 08/04/25 revealed the diagram of the body had no skin alterations marked on the diagram, and the CNA had hand written on the form no new skin issues/area. Review of progress note dated 07/20/25 at 12:48 A.M. revealed Skin issue has not been evaluated, Location: Right lateral fore foot. Issue type documented as other skin issue. Other skin issue description: red blister wound acquired in house. Wound is new. Review of the form titled Nursing Weekly Skin and Body Reviews dated 07/30/25 and 08/10/25 revealed no new areas noted. Review of hospice note dated 07/10/25 revealed no wounds. Review of hospice note dated 07/15/25 revealed wound to right outer pinky toe/foot as dry flat red area measuring 1.5 centimeters (cm) in length by 0.4 cm in width. Review of hospice note dated 07/25/25 revealed no wounds. Review of hospice note dated 08/01/25 revealed a pressure injury to right lateral foot measuring 1.2 cm in width by 1.5 cm in length by 0.02 cm in depth. Review of hospice note dated 08/08/25 revealed pressure injury to right lateral foot measuring 2.9 cm in length by 1.4 cm in width by 0.1 cm in depth. Review of hospice note dated 08/14/25 revealed right lateral foot pressure ulcer was present, however no there was no wound assessment included and it was documented wound care was not completed as it was not due that day. Review of wound evaluation and management summary dated 08/21/25 by wound physician revealed wound one was a non-pressure wound of the right foot with undetermined thickness measuring 0.5 cm length by 0.6 cm width by non-measurable depth. Wound had dried fibrinous exudate (scab) with no signs of infection noted. Second wound was non-pressure wound of the right foot full thickness measuring 1.6 cm length by 1.4 cm width by 0.1 cm depth. Peri wound with erythema, blanchable erythema surrounding wound, no evidence of deep tissue injury to suggest pressure injury at this time. Heavy Serosanguinous drainage. 100 percent granulation tissue. Review of previous wound documentation provided by the facility revealed only one wound was observed and documented for Resident #77. Observation on 08/20/25 at 11:36 A.M. of Resident #77's wound to the right lateral foot revealed there are two wounds. The wound located on the lateral side of the right foot midline is about the size of a dime and is beefy red with no drainage or odor. The second area is located on the lateral side of the foot just below the pinky toe and extends down to approximately mid ball of the foot. The wound presents as an open area, beefy red approximately 0.3 cm in width by four to five cm in length. No drainage or odor is noted. Wound edges and peri wound were intact. Interview on 08/20/25 at 2:26 P.M. with Regional Clinical Nurse (RCN #550) stated she would try to locate wound documentation that contained measurements and description of Resident #77's wound/wounds. RCN #550 verified the resident was not seeing the facility wound physician. Interview on 08/20/25 at approximately 4:00 P.M. with RCN #550 revealed the facility was unable to locate any wound documentation from 06/27/25 through 07/15/25 with wound description and measurements for Resident #77. RCN #550 verified the facility had no wound documentation with wound description and measurements from 07/15/25 through 08/01/25. RCN #550 verified no wound documentation with description and measurements could be located from 08/08/25 through present date. Interview on 08/21/25 at 11:03 A.M. with RCN #550 revealed Resident #77 was seen by the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound physician inhouse and they classified the wound as trauma due to the wounds being blanchable in the surrounding tissue of both wounds. RCN #550 stated she would inform hospice that the wounds are not pressure. Review of policy titled Pressure Ulcer Policy dated 04/2016 revealed should a pressure area present either upon admission or in house, the wound will be monitored at least weekly and should have documentation including: location and staging, size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth, and the presence, location and extent of any undermining or tunneling/sinus tract, drainage, the amount and characteristics, pain if present and characteristics, and wound bed and surrounding tissue.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy, the facility failed to ensure interventions to prevent skin breakdown were implemented as ordered by the physician. This affected one of two residents (#2) reviewed for pressure ulcer care prevention and treatment. The facility census of 96. Findings include: Resident #2 admitted to the facility on [DATE] with the diagnoses including, end stage renal disease, asthma, chronic kidney disease, congestive heart failure, urinary tract infection, chronic pain syndrome, anemia, lymphedema, dependence on renal dialysis, neuromuscular dysfunction of bladder, hypertension, anxiety disorder, and bipolar disorder. According to the most current minimum data set assessment dated [DATE] Resident #2 had intact cognition, no recorded behaviors, impaired range of motion to bilateral lower extremities, was dependent on staff for the provision of activities of daily living, and at risk for pressure ulcer development with a current stage II and stage IV pressure ulcer. On 02/27/24 a physician order was implemented for heel offloading/suspension boots at all times. On 01/18/25 a nursing plan of care was developed to address Resident #2's risk for skin breakdown related to impaired mobility cognition, and moisture. Interventions included the application of a low air loss air mattress, keep right heel off bed float both as tolerated, float right calf as able, observe skin for redness or open areas, notify the nurse, and offloading boots as tolerated. According to wound physician specialist (WPS) #1 evaluation and documentation dated 07/10/25 Resident #2 was evaluated for a stage II pressure ulcer to the right heel, stage IV full thickness pressure ulcer to the right buttock and two non-pressure wounds to the left thigh and buttock. WPS #1 noted the right heel wound as healed at the time of the evaluation on 07/10/25. Physician orders directed the continued implementation of pressure off-loading boots, floating heels in bed, with a preventative treatment of skin prep each shift to the right heel. On 08/14/25 WPS #1 assessed the resident and interventions were to continued as recommended on the 07/10/25 visit. On 08/16/25 Resident #2 was assessed at moderate risk of developing a pressure ulcer with a score of 14. Observations on 08/19/25 at 6:25 A.M., 10:24 A.M., 12:08 P.M., 3:03 P.M., 08/20/25 at 2:26 P.M., and on 08/21/25 at 6:27 A.M. noted Resident #2 in bed with heels resting on the mattress surface without pressure off-loading boots in use. On 08/21/2025 at 6:27 A.M. observation noted Resident #2 in bed awake and alert, resting on back with head of bed elevated. Resident #2 stated the pressure relief boots were not applied during the night and nursing staff did not offer the application. At 6:30 A.M. interview with Certified Nurse Aide (CNA) #457 during observation of Resident #2's heels verified the pressure relief boots were not offered or applied during the night. Observation of bilateral heels concurrently noted the bilateral heels with reddened skin. On 08/21/25 at 6:34 A.M. interview with Registered Nurse (RN) #466 verified the pressure relief boots had not been applied during the night. In addition RN #466 confirmed the boots were documented as applied in the medical record in spite of not being utilized. No documentation contained in the medical record documented an occurrence when Resident #2 refused the application of the heel offloading/suspension boots or heel elevation. Review of the Treatment Administration Record between 08/01/25 and 08/20/25 documented the heel offloading/suspension boots applied during the 7:00 A.M.-7:00 P.M. and 7:00 P.M.-7:00 A.M. shifts as indicated. Review of Pressure Ulcer Policy dated revised 04/2016. All residents will be assessed or pressure ulcer risk on admission, monitored weekly, and reviewed quarterly and as needed. Appropriate preventative interventions will be implemented.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and policy review, the facility failed to ensure post-fall assessments were completed, including neurological assessments. This affected two (#30 and #78) of four residents reviewed for falls. Additionally, the facility failed to ensure fall prevention measures were in place for one (#12) of four residents reviewed for falls. The facility census was 96. Findings Include: 1. Review of the medical record for Former Resident #53 revealed an admission date of 05/19/25 with diagnoses of type 1 diabetes mellitus, kidney transplant failure, and dependence on renal dialysis. Resident #53 discharged home with family on 08/08/25. Review of the 5-day Minimum Data Set (MDS) assessment, dated 07/31/25, revealed Resident #53 had intact cognition, had an impairment on one side of her lower extremity, and required partial/moderate assistance for toileting, bathing, dressing, bed mobility, sit-to-standing, and transfers. Further review revealed Resident #53 had one fall without injury since admission. Review of the incident log dated 05/18/25 through 08/18/25 revealed Resident #53 fell on [DATE], 06/25/25, and 07/30/25. Review of the facility investigations for the falls dated 06/22/25, 06/25/25, and 07/30/25 revealed the falls were unwitnessed. Resident #53 was assessed to have no injuries as a result of the falls. Further review of the record revealed no neurological assessments were completed after the falls on 06/22/25, 06/25/25 and 07/30/25. Additionally, the facility failed to complete post-fall assessments after the fall on 07/30/25. 2. Review of the medical record for Resident #68 revealed an admission date of 09/20/19 with diagnoses of Alzheimer's disease, chronic obstructive pulmonary disease, and depression. Review of the comprehensive annual MDS assessment, dated 07/02/25, revealed Resident #68 had intact cognition and required staff assistance for transfers. Further review revealed Resident #68 had one fall without injury since the previous assessment. Review of the incident log dated 05/18/25 through 08/18/25 revealed Resident #68 fell on [DATE] and 07/31/25. Review of the facility investigations for the falls dated 06/09/25 and 07/31/25 revealed the falls were unwitnessed. Resident #68 was assessed to have no injuries as a result of the falls. Further review of the record revealed no neurological assessments were completed after the falls on 06/09/25 and 07/31/25. Additionally, the facility failed to complete post-fall assessments after the fall on 07/31/25. Interview on 08/21/25 at 11:23 A.M. with Regional Director of Clinical Services (RDCS) #550 confirmed the facility protocol was to complete neurological assessments after unwitnessed falls. Interview on 08/21/25 at 1:52 P.M. with RDCS #550 confirmed no neurological assessments were completed after Resident #53's falls on 06/22/25, 06/25/25, and 07/30/25. Further, RDCS #550 confirmed no neurological assessments were completed for Resident #68's falls on 06/09/25 and 07/31/25. Interview on 08/21/25 at 2:42 P.M. with the Director of Nursing (DON) (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Manor at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Manor Drive Perrysburg, OH 43551	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed no post-fall assessments were completed for Resident #53's fall on 07/30/25 or for Resident #68's fall on 07/31/25. Review of the policy, "Head Injury Routine," revised 03/2001, revealed no guidance regarding performing neurological assessments after an unwitnessed fall. Review of the policy, "Fall Reduction Policy," revised 04/2016, revealed when a resident experienced a fall, follow-up documentation will be done each shift for a minimum of three days or longer if needed. This deficiency represents non-compliance investigated under Complaint Number 2579614. 3. Review of medical record for Resident #12 revealed an admission date of 02/28/25 with diagnoses including but not limited to Alzheimer's disease, dementia with mood disturbance, hallucinations, major depressive disorder, and hypertension. Review of care plan dated 06/25/25 revealed the resident is at risk for falls related to potential adverse effects from prescribed medications and diagnosis of Alzheimer's/dementia negatively impacting safety awareness. Interventions included encourage non-skid footwear, encourage to use walker, keep bed in lowest position, keep call light in reach, keep frequently used items in reach, encourage resident to wear non-skid socks at all times when shoes are not on, and keep room free from clutter. Review of fall investigation dated 04/16/25 at 3:15 A.M. revealed the staff heard the resident calling out for help. Resident #12 was observed sitting on the floor with back leaning against the bed with legs extended out in front of her. No non-skid footwear was on. The resident stated she slid off of the bed. Resident #12 was assessed with no injuries noted. New intervention was to encourage staff to apply non-skid socks at all times when shoes were not on. Review of fall investigation dated 07/12/25 at 10:35 P.M. revealed the resident was lying on her back on the bathroom floor with legs extended out in front of her with knees slightly flexed. The resident did not have her walker with her. Resident #12 was reoriented to walker and use for safety. Resident did not have shoes on. Non-skid socks were put on her feet and the resident was assessed with no injuries noted. New intervention was to place a reminder sign to use her walker. Interview on 08/20/25 at 2:36 P.M. with Regional Clinical Nurse (RCN #550) verified the resident did not have non-skid socks on when she had the fall on 07/12/25 which was the intervention put into place for the fall on 04/16/25. RCN #550 verified there was no documentation to support whether the resident was compliant with keeping the non-skid socks on.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, staff interview, and record review, the facility failed to ensure nutrition supplements were provided as ordered. This affected one (#50) of five residents reviewed for nutrition. The facility census was 96. Findings Include: Review of the medical record for Resident #50 revealed an admission date of 09/27/24 with diagnoses of Parkinson's disease, type II diabetes mellitus, unspecified psychosis, and adult failure to thrive. Resident #50 was under the care of hospice. Review of the significant change comprehensive minimum data set (MDS) assessment, dated 07/21/25, revealed Resident #50 was rarely/never understood and was dependent for all activities of daily life. Review of the physician order dated 01/17/25 revealed Resident #50 received a nutrition supplement (Magic Cup) twice daily with meals. Interview on 08/21/25 at 10:08 A.M. with Dietetic Technician, Registered (DTR) #551 confirmed Resident #50 received Magic Cup twice daily to supplement her calorie intake. Interview on 08/21/25 at 12:05 P.M. with Certified Nursing Assistant (CNA) #451, and concurrent observation of Resident #50's noon meal tray revealed no nutrition supplement was on the tray. Further interview with CNA #451 and observation of Resident #50's meal ticket revealed Resident #50 should have received a Magic Cup on her noon meal tray. Interview on 08/21/25 at 12:35 P.M. with Dietary Manager (DM) #438 confirmed the facility had Magic Cup in stock and DM #438 confirmed Resident #50 was supposed to receive the nutrition supplement on her lunch and dinner trays.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, record review and policy review, the facility failed to ensure proper equipment for residents with a tracheostomy were available at bedside. This affected one (#7) of one resident reviewed for a tracheostomy. Resident #7 was the only resident in the facility with a tracheostomy. The facility census was 96. Findings Include: Review of the medical record for Resident #7 revealed an admission date of 03/15/25 with respiratory failure and tracheostomy status. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/05/25, revealed Resident #7 had intact cognition and had a tracheostomy. Review of the care plan initiated 03/15/25 for Resident #7 revealed to keep an extra tracheostomy tube and obturator (a curved rod designed to help the tracheostomy tube fit into the trachea) at bedside. Review of the current physician order initiated 03/18/25 revealed Resident #7 had an order to change tracheostomy tube with size 5.5 and style 41c65 Name of Tracheostomy Shiley every day shift every 90 day(s) for tracheostomy maintenance with Pulmonologist present. Review of the current physician order initiated 07/08/25 revealed Resident #7 had an order for tracheostomy type/size: 4UN65H #4 Shiley flex cuffless every shift for monitoring. Interview on 08/18/25 at 12:27 P.M. with Licensed Practical Nurse (LPN) #455, and concurrent observation of emergency tracheostomy and respiratory supplies in Resident #7's room, revealed a re-sealable bag with a single size 5.5 inner cannula tracheostomy tube and a single size #7 cuffless tracheostomy outer cannula. Further interview and concurrent review of the physician orders revealed LPN #455 could not determine if the size #7 cuffless tracheostomy outer cannula was equivalent to the physician order for a #4 cuffless tracheostomy tube. Continued observation and interview at that time revealed LPN #455 could find no other outer tracheostomy tubes amongst the care supplies stored on Resident #7's counter. Follow-up interview on 08/18/25 at 12:48 P.M. with LPN #455 revealed LPN #455 spoke with respiratory services and determined the #7 cuffless trach was a size 7 millimeter (mm) and Resident #7 required a #4, which was a size 6.5 millimeter. Follow-up interview on 08/18/25 at 1:13 P.M. with LPN #455 confirmed the tracheostomy outer canula #7 was too big for Resident #7 and was not appropriate. LPN #455 further confirmed she found the correct tracheostomy outer cannula size 6.5 mm in a box in Resident #7's room under other supplies. Review of the policy, Tracheostomy Tube Guide, revised 05/01/24, revealed all residents with a tracheostomy should have a spare tracheostomy or at minimum an obturator at bedside in case of accidental decannulation or airway obstruction.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure pre and post dialysis assessments were completed. This affected one (#54) of one resident reviewed for dialysis. The facility census was 96. Findings include: Review of the medical record for Resident #54 revealed an admission date of 07/05/25 with diagnoses including but not limited to Alzheimer's disease, major depressive disorder, generalized anxiety disorder, schizoaffective disorder depressive type, end stage renal disease, and vascular dementia. Review of minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact. Resident #54 received dialysis. Review of current physician orders revealed the resident had dialysis on Monday, Wednesday, and Friday. Further review of the electronic medical records revealed no dialysis assessments. Interview on 08/20/25 at 11:26 A.M. with Regional Clinical Nurse (RCN #550) revealed the facility did not do the post dialysis assessments when the residents return from dialysis. RCN #550 stated there were pre and post dialysis assessments in the electronic medical record system the facility used however the staff were not completing that. RCN #550 stated the facility was doing a pre assessment and sending that with the resident to the dialysis center for them to fill out their portion and send the form back with the resident. Interview on 08/20/25 at approximately 3:15 P.M. with RCN #550 verified the facility could not produce pre and post dialysis assessments. Review of policy titled Dialysis Care Policy dated 02/2018 revealed the manor will provide ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, physician interview, staff interview, and review of Medscape website the facility failed to ensure residents were not given unnecessary medications. This affected one (#10) of six residents reviewed for unnecessary medications. The facility census was 96. Findings include: Review of medical record for Resident #10 revealed an admission date of 09/08/20 with diagnoses including Alzheimer's disease with late onset, epilepsy, major depressive disorder severe with psychotic features, dementia with psychotic disturbance, delusional disorders, generalized anxiety disorder, other schizoaffective disorders, and subdural hematoma. Review of minimum data set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. Review of current physician orders revealed Lovenox (blood thinner) injection prefilled syringe kit 40 milligrams (mg)/0.4 milliliters (ml) daily for prevention of blood clot request clarification with Neurosurgery follow up on 06/23/25 (started on 06/11/25 and continued until 08/21/25). Plavix (platelet inhibitor) 75 mg give one tablet daily for blood clot prevention started on 06/10/25 with no stop date indicated. Review of hospital discharge orders dated 06/09/25 revealed Lovenox 30 mg/0.3 mls twice daily with no stop date. Note to change the Lovenox to 40 mg/0.4 mls daily until follow up then request clarification on aspirin, Plavix, and Lovenox (blood thinners). Review of Nurse Practitioner (NP) note dated 06/10/25 revealed the resident had been discharged on Lovenox for deep vein thrombosis (DVT) prophylaxis. Plan to continue Lovenox daily until activity is back to baseline and until follow up with neurosurgery as scheduled 06/23/25. Review of NP note dated 06/17/25 revealed no mention of Lovenox. Plavix remains on hold until follow up with neurosurgery. Review of Neurology follow up note dated 06/23/25 revealed continue medications for Lovenox 30 mg/0.3 mls twice daily and Plavix 75 mg daily. The duration of Lovenox was not addressed. Review of NP note dated 07/01/25 revealed no mention of Lovenox. Plavix remains on hold until follow up with neurosurgery. Review of Neurology follow up note dated 07/08/25 revealed continue medications for Lovenox 30 mg/0.3 mls twice daily. Progress note revealed CT scan improvement. Okay to resume Plavix. Repeat CT of head in one to two weeks after restarting Plavix. Follow up in three to four weeks. The duration of Lovenox was not addressed. Review of progress notes from 06/11/25 through 08/20/25 revealed no record of the facility asking for clarification of Lovenox order. Review of health status note dated 08/20/25 at 5:10 P.M. revealed the writer attempted several times to call neurology Certified Nurse Practitioner (CNP) office to talk to one personnel stated that the CNP was busy with a patient and obtained the facility phone number for a return call. No return call received as of this time. Interview on 08/21/25 at 1:15 P.M. with CNP #600 via phone revealed the neurology office did not manage Lovenox. CNP #600 stated the resident was residing in a facility and her attending physician or cardiologist would or should monitor that. CNP #600 stated the facility had contacted her earlier today and she did state that the resident would not need to take Lovenox now that her Plavix had been restarted. Interview on 08/21/25 at 1:30 P.M. with the Director of Nursing (DON) revealed that she verified the physician visit dated 06/10/25 stated the resident had been discharged on Lovenox for DVT prophylaxis and the plan was to continue Lovenox daily until activity was back to baseline and until follow up with neurosurgery on 06/23/25. DON verified that in subsequent visits on 06/17/25 and 07/01/25 there was no mention of the plan for Lovenox. DON verified no documentation was present to determine if the staff had contacted the physician or CNP #600 for clarification on the stop date for Lovenox. Review of the Medscape Lovenox dosage and indication revealed for DVT prophylaxis for medical patients with restricted mobility: Duration of administration is six to 11 days; up to 14 days has been administered in clinical trials.		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review, staff interview and policy review, the facility failed to ensure nutrition assessments were completed timely. This affected one (#50) of five residents reviewed for nutrition. The facility census was 96. Findings Include: Review of the medical record for Resident #50 revealed an admission date of 09/27/24 with diagnoses of Parkinson's disease, type II diabetes mellitus, unspecified psychosis, and adult failure to thrive. Review of the significant change comprehensive minimum data set (MDS) assessment, dated 07/21/25, revealed Resident #50 was rarely/never understood and was dependent for all activities of daily life. Review of the physician order dated 07/15/25 revealed Resident #50 was admitted to hospice. Review of the medical record revealed a quarterly nutrition progress note was completed on 04/29/25. Further review revealed no more recent quarterly or annual nutrition assessment was completed. Additionally, no comprehensive nutrition assessment was completed after Resident #50 had a significant change and was admitted to hospice on 07/15/25. Interview on 08/21/25 at 10:08 A.M. with Dietetic Technician, Registered (DTR) #551 confirmed a comprehensive nutrition assessment should be completed when residents were admitted to hospice. DTR #551 further confirmed no comprehensive nutrition assessment was completed for Resident #50 since she was admitted to hospice on 07/15/25. Review of the policy, Nutritional Assessment, reviewed 01/2018, revealed resident reviews were to be completed yearly and as significant changes occur.		

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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. Based on observation, staff interview, and review of facility policy, the facility failed to ensure enhanced barrier precautions were practiced during tracheostomy care. This affected one resident (#7) observed for tracheostomy care. The facility identified only one resident with a tracheostomy in the facility. The facility census was 96. Findings Include: Review of the medical record for Resident #7 revealed an admission date of 03/15/25 with respiratory failure, tracheostomy status, and history of methicillin resistant staphylococcus aureus (MRSA) (a drug resistant bacteria) infection. Review of the current physician orders for August 2025 for Resident #7 revealed she did not have an order for Enhanced Barrier Precautions (EBP) (precautions used to prevent infections for residents with areas of enhanced portals of entry such as tracheostomy or wounds). Review of the care plan initiated in March 2025 for Resident #7 revealed she was care planned for EBP due to have a tracheostomy and gastric feeding tube with a goal of understanding that staff will wear personal protective equipment (PPE) when providing care during high contact resident care activities. Observation on 08/19/2025 at 8:33 A.M. of Resident #7 revealed she had an EBP sign above her bed in her room and there was personal protective equipment available for use in her room. Observation on 08/21/25 at 7:00 A.M. of tracheostomy care for Resident #7 provided by Registered Nurse (RN) # 490 revealed RN #490 did not don (put on) a gown when she provided tracheostomy care for Resident #7. Interview on 08/21/25 at 7:15 A.M. with RN #490 verified Residents #7 was on EBP and verified that during tracheostomy care she did not wear gown when providing care during a high contact resident care activity. RN #490 verified PPE was available in the room for use. Review of the EBP signage posted in Resident #7's room revealed EBP everyone must wear gown and gloves for the following high-contact resident care activities include device care or use: central line, urinary catheter, feeding tube, and tracheostomy. Review of the facility policy titled, Standard Precautions, dated 08/22, revealed it is the intent of this facility to used Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for residents to prevent transmission of Multi-drug Resistant Organism (MDRO) in our care community. The facility will use EBP to prevent transmission of MDRO from an infected or colonized resident through an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. High contact resident care activities include but are not limited to device care or use such as feeding tube, tracheostomy/ventilator, central line, and/or urinary catheter.		