STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366097	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Nursing & Rehab C	723 South Shoop Avenue Wauseon, OH 43567

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, staff interview, and review of facility policy, the facility failed to timely notify the physician and resident representative of a change in condition. This affected one (#16) of three resident's reviewed for change in condition. The facility census was 64.Findings include:Record review for Resident #16 revealed an admission date of 02/19/24. Diagnoses included Parkinson's disease and dementia.Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, revealed Resident #16 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14. Review of a physician order dated 06/27/25 revealed Resident #16 was ordered ropinrole HCl (used to treat Parkinson's symptoms) oral tablet 0.5 milligrams (mg) three times daily. Review of the June 2025 Medication Administration Record (MAR) revealed on 06/27/25, the order for ropinrole 0.5 mg three times daily was entered as 5 mg four times daily. Further review of the MAR revealed Resident #16 was administered ropinrole 5 mg on 06/27/25 at 4:00 P.M. and 9:00 P.M.; 06/28/25 at 6:00 A.M., 11:00 A.M., 4:00 P.M., and 11:00 P.M.; and 06/29/25 at 6:00 A.M. On 06/29/25, the order for ropinrole was updated to 0.5 mg three times daily. Review of the nursing progress notes revealed on 06/28/25, Resident #16 experienced hypertension, headache, hallucinations, and increased anxiety. On 06/29/25, Resident #16 experienced dizziness. Further review of Resident #16's medical record revealed no evidence the resident's physician or family were notified of the medication error until 06/30/25. Interview on 12/09/25 at 2:22 P.M. with the Director of Nursing (DON) confirmed Resident #16's ropinrole order was entered incorrectly and the resident was administered the wrong dosage. Additionally, the DON confirmed the resident experienced symptoms during the time she was administered the incorrect dosage of ropinrole. While the medication error was discovered on 06/29/25, the DON verified the physician and Resident #16's family were not notified until 06/30/25.Review of the facility policy titled, Change of Status Notification, undated, revealed the facility would notify the attending physician and the resident's advocate of any significant change in the resident's medical condition immediately.This deficiency represents noncompliance investigated under Complaint Number 2564492.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of staff witness statements, review of facility submitted Self-Reported Incidents (SRIs), and review of facility policy, the facility failed to report allegations of abuse to the state survey agency (SSA). This affected one (#57) of three residents reviewed for abuse. The facility census was 64.Findings include:Review of the medical record revealed Resident #57 was admitted on [DATE]. Diagnoses included unspecified dementia, moderate with agitation; major depressive disorder, recurrent; Alzheimer's disease; and Type II diabetes mellitus without complications. Review of the Minimum Data Set (MDS) assessment, dated 11/23/25, revealed the resident was moderately cognitive impaired. The resident had physical, verbal, rejection of care, wandering, and other behaviors and was (staff) dependent for toileting, lower body dressing, and personal hygiene. Review of the care plan, dated 09/17/25, revealed Resident #57 had a behavior problem due to accusing others, expressing frustration/anger at others, screaming at others, threatening others, disruptive sounds, repetitive motions, agitated, anxious/restless, and verbalizing persistent beliefs that were not true. Review of a nursing progress note, dated 11/08/25, revealed Resident #57 was yelling and making false accusations about staff throughout the day. Specifically, that staff were hitting her in the stomach, kicking her in the head, and punching her in the face. Additionally, the resident stated she was going to throw herself on the floor and attempted to do so several times, although unsuccessful. Resident #57's family visited and the resident was verbally abusive to them. The physician was notified and orders were received for a urinalysis, blood work, and a one-time dose of Ativan (antianxiety). Review of a nursing progress note, dated 11/09/25, revealed Resident #57 continued the same behaviors as the day prior. The resident was yelling, making false accusations of being abused by staff, and threatening to throw herself on the floor. As needed medication was provided but was not effective. Review of Registered Nurse (RN) #223's witness statement, undated, revealed Certified Nursing Assistant (CNA) #313 reported that she was walking down a hall when she heard feet hustling, she turned around and began to walk back when she observed RN #265 hustling away and Resident #57 yell out in pain. CNA #313 stated she heard a smack noise. After that, RN #265 came up behind her and asked what the resident was yelling about. A few moments later, CNA #313 had Resident #57 in the bathroom and Resident #57 inquired if she had seen what happened between her and RN #265. Resident #57 reported RN #265 had hit her in the head. In another situation, Resident #57 had accused staff of rape. In yet another situation, RN #223 was sitting next to Resident #57 when she stated, Did you see that? and the resident pointed to RN #265 and stated that he had just come over and kicked her in the foot and now her feet hurt. RN #223 stated she explained to Resident #57 that no one had come over and touched her. The physician and family were notified. Review of CNA #355's witness statement, dated 11/10/25, revealed on 11/09/25, Resident #57 stated the man hit her on the head twice. CNA #313 was in the common area and CNA #355 came from a resident's room. CNA #355 stated she assisted CNA #313 in toileting Resident #57. Resident #57 kept repeating that the man had hit her. CNA #313 reported to CNA #355 that she was in the common area and RN #265 was on the phone while Resident #57 was calling out. From her peripheral view, she reportedly observed RN #265 dart quickly to the day area, heard a smack, and Resident #57 say ouch. CNA #313 reportedly hurried toward the resident and assisted her with toileting. Resident #57 identified RN #265 as the man who hit her. Review of the Certification and Licensure System (CALS) from 11/08/25 through 12/08/25 revealed no evidence the facility submitted an SRI related to the allegation of abuse involving Resident #57 and RN #265. Interview on 12/08/25 at 1:15 P.M. with RN #223 revealed on 11/09/25, CNA #313 requested her to come to the shower room. CNA #313 reported she was walking down the hall and heard Resident #57 yell out. CNA #313 thought she heard a slap and observed RN #265 walk away from Resident #57. Resident #57 reported to CNA #313 that RN #265 had hit her. RN #223 stated Resident #57 was often confused and had accused staff of many things. RN #223 stated she called the Director of Nursing (DON), with no response, and spoke with Assistant Director of Nursing (ADON) #354, who instructed her to call the Administrator. RN #233 called the Administrator to report the allegation. Interview on 12/08/25 at 1:38 P.M. with ADON #354 verified RN #223 reported Resident #57's allegation of abuse. ADON #354 stated he believed the allegation was investigated and unsubstantiated. Interview on 12/08/25 at 1:42 P.M. with the Administrator verified she had received a call from RN #223 stating Resident #57 alleged that RN #265 popped her on the head. The Administrator stated the same day the resident had stated she was getting

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of witness statements, and review of facility policy, the facility failed to investigate allegations of abuse. This affected one (#57) of three residents reviewed for abuse. The facility census was 64.Findings include:Review of the medical record revealed Resident #57 was admitted on [DATE]. Diagnoses included unspecified dementia, moderate with agitation; major depressive disorder, recurrent; Alzheimer's disease; and Type II diabetes mellitus without complications. Review of the Minimum Data Set (MDS) assessment, dated 11/23/25, revealed the resident was moderately cognitive impaired. The resident had physical, verbal, rejection of care, wandering, and other behaviors and was (staff) dependent for toileting, lower body dressing, and personal hygiene. Review of the care plan, dated 09/17/25, revealed Resident #57 had a behavior problem due to accusing others, expressing frustration/anger at others, screaming at others, threatening others, disruptive sounds, repetitive motions, agitated, anxious/restless, and verbalizing persistent beliefs that were not true. Review of a nursing progress note, dated 11/08/25, revealed Resident #57 was yelling and making false accusations about staff throughout the day. Specifically, that staff were hitting her in the stomach, kicking her in the head, and punching her in the face. Additionally, the resident stated she was going to throw herself on the floor and attempted to do so several times, although unsuccessful. Resident #57's family visited and the resident was verbally abusive to them. The physician was notified and orders were received for a urinalysis, blood work, and a one-time dose of Ativan (antianxiety). Review of a nursing progress note, dated 11/09/25, revealed Resident #57 continued the same behaviors as the day prior. The resident was yelling, making false accusations of being abused by staff, and threatening to throw herself on the floor. As needed medication was provided but was not effective. Review of Registered Nurse (RN) #223's witness statement, undated, revealed Certified Nursing Assistant (CNA) #313 reported that she was walking down a hall when she heard feet hustling, she turned around and began to walk back when she observed RN #265 hustling away and Resident #57 yell out in pain. CNA #313 stated she heard a smack noise. After that, RN #265 came up behind her and asked what the resident was yelling about. A few moments later, CNA #313 had Resident #57 in the bathroom and Resident #57 inquired if she had seen what happened between her and RN #265. Resident #57 reported RN #265 had hit her in the head. In another situation, Resident #57 had accused staff of rape. In yet another situation, RN #223 was sitting next to Resident #57 when she stated, Did you see that? and the resident pointed to RN #265 and stated that he had just come over and kicked her in the foot and now her feet hurt. RN #223 stated she explained to Resident #57 that no one had come over and touched her. The physician and family were notified. Review of RN #265's witness statement, undated, revealed on the night of 11/09/25, he had been on the phone with the pharmacy at the nurses' station. Resident #57 was in her wheelchair in the common area. Resident #57 started to exit her wheelchair and RN #265 dropped the phone and ran to the resident who was nearly halfway out of the chair, leaning over the left side. RN #265 secured the resident and placed her back in the wheelchair. RN #265 asked Resident #57 what she needed and if he could help her. The resident's response was that she did not need anything and she was going home. RN #265 stated he explained she was a resident of the facility and it was her home. At this time, an aide came to the lounge to assist, and the resident was placed in the recliner. RN #265 returned to the nurses' station to resume the phone call. Review of CNA #355's witness statement, dated 11/10/25, revealed on 11/09/25, Resident #57 stated the man hit her on the head twice. CNA #313 was in the common area and CNA #355 came from a resident's room. CNA #355 stated she assisted CNA #313 in toileting Resident #57. Resident #57 kept repeating that the man had hit her. CNA #313 reported to CNA #355 that she was in the common area and RN #265 was on the phone while Resident #57 was calling out. From her peripheral view, she reportedly observed RN #265 dart quickly to the day area, heard a smack, and Resident #57 say ouch. CNA #313 reportedly hurried toward the resident and assisted her with toileting. Resident #57 identified RN #265 as the man who hit her. Interview on 12/08/25 at 1:15 P.M. with RN #223 revealed on 11/09/25, CNA #313 requested her to come to the shower room. CNA #313 reported she was walking down the hall and heard Resident #57 yell out. CNA #313 thought she heard a slap and observed RN #265 walk away from Resident #57. Resident #57 reported to CNA #313 that RN #265 had hit her. RN #223 stated Resident #57 was often confused and had accused staff of many things. RN #223 stated she called the Director of Nursing (DON), with no response, and spoke with Assistant Director of Nursing (ADON) #354, who instructed her to call the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review and staff interview, the facility failed to ensure residents were free from significant medication errors. This affected one (#16) of three residents reviewed for medication errors. The facility census was 64.Findings include:Record review for Resident #16 revealed an admission date of 02/19/24. Diagnoses included Parkinson's disease and dementia.Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, revealed Resident #16 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14. Review of a physician order dated 06/27/25 revealed Resident #16 was ordered ropinrole HCl (used to treat Parkinson's symptoms) oral tablet 0.5 milligrams (mg) three times daily.Review of a nursing nursing note dated 06/27/25 revealed an order was received for ropinrole HCl oral table 0.5 milligrams (mg) three times a day.Review of the June 2025 Medication Administration Record (MAR) revealed on 06/27/25, the order for ropinrole 0.5 mg three times daily was entered into the electronic medical record (EMR) as five mg four times daily. Further review of the MAR revealed Resident #16 was administered ropinrole five mg on 06/27/25 at 4:00 P.M. and 9:00 P.M.; 06/28/25 at 6:00 A.M., 11:00 A.M., 4:00 P.M., and 11:00 P.M.; and 06/29/25 at 6:00 A.M. On 06/29/25, the order for ropinrole was updated to 0. 5 mg three times daily. Review of the nursing progress notes revealed on 06/28/25, Resident #16 experienced hypertension, headache, hallucinations, and increased anxiety. On 06/29/25, Resident #16 experienced dizziness. Interview on 12/09/25 at 2:22 P.M. with the Director of Nursing (DON) verified Resident #16's ropinrole order was entered into the EMR incorrectly and the medication was subsequently administered at the wrong dosage. Interview on 12/10/25 at 9:37 A.M. with Licensed Practical Nurse (LPN) #206 verified she incorrectly entered Resident #16's ropinrole order on 06/27/25. LPN #206 stated there was no warning sign indicating the order was incorrect when she placed the order. While LPN #206 acknowledged she erroneously entered the order, she did not understand why the pharmacy or manager did not notice her mistake. This was an incidental finding identified during the complaint investigation.