

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2025
NAME OF PROVIDER OR SUPPLIER Avalon by Otterbein at Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 - 3533 Rivers Edge 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of the refrigerator temperature logs, staff interview, and review of facility policy, the facility failed to ensure the medication refrigerator temperature was monitored to ensure safe storage of medications. This had the potential to affect all residents at the facility. The facility census was 58. Findings include: Review of the medication refrigerator temperature logs for January 2025 through August 2025 revealed no evidence the facility monitored the temperature on nine days in January 2025, 13 days in February 2025, 18 days in March 2025, 15 days in April 2025, 26 days in May 2025, 14 days in June 2025, and 26 days in July 2025. Interview on 08/13/25 at 8:15 A.M. with Assistant Director of Nursing (ADON) #604 confirmed the facility did not have evidence the medication refrigerator temperatures were monitored as identified above, and it should have been monitored daily. ADON #604 stated the medication refrigerator could, at any time, contain medications for any resident in the facility. Review of facility policy dated 07/09/21 and titled Medication Storage revealed refrigerated medications would be stored at 36 to 46 degrees Fahrenheit (F).		

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure insulin was administered per physician orders. This affected four (#13, #20, #08, #19) of four residents reviewed for insulin administration. The facility census was 58. Findings include: 1. Review of Resident #13's medical record revealed an admission date of 04/02/25. Diagnoses included dementia, Type I diabetes mellitus, osteoarthritis, hyperlipidemia, depression, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 07/09/25, revealed Resident #13 was moderately cognitively impaired, received insulin injections on seven of seven days of the look back period and exhibited no rejection of care. Review of the care plan, dated 04/02/25, revealed Resident #13 had diabetes, with an outcome goal to be free of signs and symptoms of hyperglycemia (high blood sugar). Interventions included to administer medications as ordered. Review of the physician orders revealed Resident #13 had an order dated 04/03/25 for Lantus (a slow acting insulin), inject 15 units subcutaneously (under the skin) one time a day in the morning. The order was discontinued on 06/17/25. Further review revealed an order dated 06/18/25 for Lantus, inject 25 units subcutaneously in the morning. The order was discontinued on 07/24/25. Additionally, Resident #13 had an order dated 07/29/25 for Lantus, inject 25 units subcutaneously twice a day, one time in the morning and one time at bedtime. Lastly, none of the three Lantus orders included parameters to withhold Lantus administration. Review of the Medication Administration Record (MAR) from 06/01/25 through 08/11/25 revealed Resident #13 was not administered her bedtime dose of Lantus due to her blood sugar (BS) being outside of order parameters on 06/03/25, 06/07/25, 06/08/25, 06/14/25, 06/17/25, 06/19/25, 06/21/25, 06/22/25, 06/25/25, 06/26/25, 07/01/25, 07/03/25, 07/05/25 in the morning, 07/05/25 at bedtime, 07/06/25 at bedtime, 07/08/25 at bedtime, 07/09/25 at bedtime, 07/17/25, 07/23/25, 07/24/25, 07/29/25, 07/31/25, 08/01/25, 08/02/25, 08/03/25, 08/06/25, 08/07/25, and 08/11/25. Additionally, Resident #13's Lantus was not administered for the morning doses on 07/05/25, 07/26/25, 07/30/25, and 08/10/25, with the documented reason being her BS was outside of order parameters. Interview on 08/14/25 at 3:12 P.M. with the Director of Nursing (DON) verified Lantus was not administer to Resident #13 on the above dates and further confirmed the physician orders did not include any parameters to withhold the administration of Lantus. The DON stated there was no reason Lantus was withheld. 2. Review of the medical record for Resident #20 revealed she was admitted on [DATE] with diagnoses that included Type two diabetes mellitus, hypertension, and stage four chronic kidney disease. Review of a physician order dated 04/16/25 revealed Resident #20 was ordered 30 units of Insulin Glargine (long-acting insulin) each evening, with no parameter exclusions included in the order. Further review revealed an order dated 04/17/25 for 35 units of Insulin Glargine each morning, with no parameter exclusions included in the order. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR from 06/01/25 through 08/14/25 revealed for Resident #20 was not administered Insulin Glargine due to outside of parameters for administration on the mornings of 06/04/25, 06/05/25, 06/10/25, 06/14/25, 06/15/25, 06/16/25, 06/17/25, 06/19/25, 06/24/25, 06/30/25, 07/01/25, 07/03/25, 07/04/25, 07/06/25, 07/10/25, 07/11/25, 07/18/25, 07/21/25, 07/22/25, 07/23/25, 07/24/25, 07/26/25, 07/28/25, 07/29/25, 08/02/25, 08/03/25, 08/04/25, 08/05/25, 08/06/25, 08/07/25, 08/08/25, 08/11/25, 08/13/25 and 08/14/25. Additionally, Insulin Glargine was also held for the reason outside of parameters for administration on the evening of 07/28/25. Interview on 08/14/25 at 3:12 P.M. with the DON verified Resident #20's medication was documented as not administered on the above dates due to being outside of parameters . Further interview with the DON verified Resident #20's Insulin Glargine orders did not have parameters for administration and it should have been administered as ordered. 3. Review of the medical record for Resident #8 revealed and admission date of 01/06/21. Diagnoses included Type two diabetes mellitus, hypertension, and dementia. Review of the physician order dated 03/07/25 revealed Resident #8 was ordered 18 units of Lantus twice daily. The order did not include parameters for withholding the medication. Review of the MAR from 06/01/25 through 08/14/25 revealed Resident #8's Lantus was held for the reason outside of parameters for administration on the mornings of 06/19/25, 06/26/25, 07/10/25, 07/23/25, and 08/02/25. Further review revealed Lantus was also held for the reason outside of parameters for administration on the evening of 06/29/25. Interview on 08/14/25 at 3:12 P.M. with the DON confirmed Resident #8's Lantus was held on the above dates with the reason being documented as outside of parameters for administration. Further interview with the DON verified Resident #8's Lantus order did not include parameters for administration and should not have been held. 4. Review of Resident #19's medical record revealed an admission date of 07/18/25. Diagnoses included cellulitis of the lower limbs, back pain, and Type II diabetes. Review of Resident #19's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of eight, indicating Resident #19 was moderately cognitively impaired and received insulin injections. Review of Resident #19's care plan, revised 07/30/25, revealed supports and interventions for anticoagulant therapy, self-care deficit, impaired cognitive function, mood problem, risk for falls, and diabetes. Interventions for diabetes was to administer her medications as ordered. Review of Resident #19's physician orders revealed an order dated 07/18/25 for Insulin Glargine 100 units per milliliter (ml). Inject 10 units at bedtime for high glucose. Further review of the order revealed no parameters for withholding the medication. Review of Resident #19's MAR revealed on 07/28/25, Resident #19's Insulin Glargine was not administered at bedtime. The reason code indicated this was due to Resident #19 being out of parameters. Interview on 08/14/25 at 3:25 P.M. with the DON verified Resident #19's Insulin Glargine had been held on 07/28/25 and long-acting insulin should never be held unless ordered by the physician. Review of the facility policy titled, Medication Administration Policy, revised 07/09/21, revealed medications would be administered as prescribed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility policy the facility failed to ensure foods were properly stored and kitchens were maintained in a safe and sanitary manner. This affected 35 residents who resided in House 1 (#1, #3, #6, #7, #8, 10, #17, #27, #31, #35, #50 #58), House 2 (#4, #11, #14, #22, #25, #29, #36, #38, #42, #44, #53, #57) and House 5 (#2, #5, #12, #15, #40, #54, #61, #66, #67, #68, #69) who were identified by the facility as receiving food from the kitchen. The facility census was 58. Findings include: Observation on 08/11/25 at 8:34 A.M. of the kitchen in House 2 found the reach in freezer to have a frozen brown substance approximately two inches in length hanging between the bars of shelf. The freezer also had dust build-up along the bottom grating and debris and food build up in the bottom. A partially used bottle of Worcestershire sauce, with an opened date of 05/21/25 and and labeled refrigerate after opening, was stored on the dry storage shelf. Additionally, an open container of sanitization wipes was being stored in a lower cupboard next to an open bottle of vanilla. Interview on 08/11/25 at 8:42 A.M. with Admissions Staff (AS) #656 verified the reach in freezer had food and dust build-up, a frozen brown substance hanging on the shelf, the Worcestershire sauce was open on the dry storage shelf, and the open cleaning supplies were improperly stored next to food items. Observation on 08/11/25 at 8:49 A.M. of the kitchen of House 1 found a can of dented corn in line for use and an open and unsealed package of pecan cookies and an open and unsealed package of fudge stripe cookies on the shelf of the dry storage area. Interview on 08/11/25 at 8:58 A.M. with Certified Nursing Assistant (CNA) #607 verified the dented can in line for use and the cookies were open and had not been reclosed on the dry storage shelf. Observation on 08/11/25 at 9:08 A.M. of the House 5 kitchen preparation area found an open, partially use 1.5 liter bottle of coffee creamer on the counter. The bottle pump was broken off the top and there was spilled, dried creamer built up covering the majority of the exterior of the bottle. Interview on 08/11/25 at 9:15 A.M. with CNA #628 verified the coffee creamer bottle was broken, spilled, and should have been thrown away. CNA #628 then disposed of the coffee creamer. Review of the facility policy titled, Food Storage Policy and Procedure, revised May 2013 revealed the policy was to assure all food was stored, labeled, and dated to assure stock rotation and prevent food illnesses.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure advanced directives were clearly and accurately documented in the medical record. This affected one (#22) of 18 residents reviewed for code status. The facility census was 58. Findings include: Review of Resident #22's medical record revealed an admission date of [DATE]. Diagnoses included Alzheimer 's disease, hypertension, obstructive sleep apnea, hyperlipidemia, and heart failure. Review of the current physician orders revealed Resident #22 had a code status (advanced directive) order of Do Not Resuscitate - Comfort Care (DNRCC - do not provide cardiopulmonary resuscitation [CPR] in the event of cardiac or respiratory arrest). Further review of Resident #22's medical record revealed no evidence of a physician signed DNRCC advanced directive. Review of the care plan revealed Resident #22 had a focus area identifying his code status as full code (provide all possible life-saving measures in the event of a medical emergency). Interview on [DATE] at 10:55 A.M. with Assistant Director of Nursing (ADON) #604 confirmed Resident #22 had a physician order for a DNRCC code status, there was no physician signed DNRCC advanced directive, and the resident's care plan indicated the resident was a full code status. ADON #604 stated she was unable to determine the resident's correct code status. Review of the facility policy titled, Advance Directives Policy, dated [DATE], revealed the facility would, upon admission to the facility, identify if a resident would like a Do Not Resuscitate (DNR) code status ordered.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident interview, and staff interview, the facility failed to ensure the facility was maintained in good repair. This affected two (#9 and #16) of five residents reviewed for physical environment. The facility census was 58. Findings include: 1. Observation on 08/11/25 at 10:22 A.M. of Resident #9's room revealed the door to the bathroom was split at the top and bottom at the hinges. Additionally, there was an approximately two inch hole with an about two foot long scrape along the wall leading from the entry door to the bedroom area with exposed drywall. Interview on 08/11/25 at 10:29 A.M. with Resident #9 confirmed the bathroom door was broken. Resident #9 stated she was not sure how long it had been in that condition and added that it did not look safe the way it was broken. Resident #9 was also unsure of how long the hole and scrape had been along the wall, stating she did not recall it ever not being there. Observation on 08/13/25 at 7:43 A.M. of Resident #9's room found the door continued to be broken and splitting at the hinges, and the hole and exposed drywall continued to be along the entry way wall. Coinciding interview with Maintenance Director (MD) #657 verified the door was broken at the hinges and the wall was in need of repair. MD #657 stated the door was a high priority and would be repaired today. 2. Observation on 08/11/25 at 11:12 A.M. of Resident #16 found her in bed with her bed in the low position. The wall behind the bed was observed to have large gouges with exposed drywall. Resident #16 was not able to be interviewed. Observation on 08/13/25 at 7:47 A.M. of Resident #16's room revealed the bed continued to be in the low position and the wall behind the bed continued to have large gouges with the drywall exposed. Coinciding interview with MD #657 verified the wall behind Resident #16's bed was in need of repair.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on open and closed medical record review, staff interview, and review of the facility policy, the facility failed to ensure transfer and/or discharge notices were provided to residents, resident representatives, receiving facilities, and the Ombudsman. This affected two (#63 and #3) of three residents reviewed for transfer and discharge. The facility census was 58. Findings include: 1. Review of Resident #63's closed medical record revealed an admission date of 04/07/25. Diagnoses included open wound on the left hip post-surgery, anxiety, heart disease, and hernia. The resident discharged to the hospital on [DATE]. Review of the Minimum Data Set (MDS) assessment, dated 04/14/25, revealed Resident #63 had intact cognition and was continent of bowel and bladder. Review of a nursing progress note dated 05/13/25 revealed Resident #63 was discharged to the hospital for a rectal prolapse. Further review of Resident #63's medical record, including notification communication documentation and discharge summaries, revealed no evidence the facility sent transfer/discharge there was no documentation in the records the receiving facility received a discharge summary and resident or family representative was notified of the transfer to the hospital prior to discharge. Additional there was no documentation of notification to the Ombudsman office noted in the records. Interview on 08/13/25 at 2:30 P.M. with the Director of Nursing, (DON) verified there was no documentation of a discharge/transfer summary sent to the receiving facility, provided to the resident or resident representative, or Ombudsman notification of Resident #63's transfer/discharge to the hospital. 2. Review of the medical record for Resident #3 revealed she was admitted to the facility on [DATE] with diagnoses that included hypertension, atrial fibrillation, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and history of COVID-19. Resident #3 was transferred to an acute care facility on 05/06/25. Further review of Resident #3's medical record revealed no evidence a report or transfer notification was given to the receiving acute care facility, and there was no evidence the Ombudsman was notified of the transfer. Interview on 08/14/25 at 12:00 P.M. with the DON verified there was no evidence report was given to the receiving acute care facility, and there was no evidence the Ombudsman was notified of the transfer. Further interview confirmed the receiving acute care facility should have been given report by the nurse on duty and the Ombudsman should have been notified of the transfer. Review of facility policy titled, Discharge/Transfer Policy and Procedure, dated 03/07/25, revealed the facility would provide notice to the resident's representative and the Ombudsman. Additionally, the policy indicated the facility would convey the following information to the receiving provider: contact information of the primary care provider, resident representative information, advance directives, all special instructions for ongoing care, comprehensive care plan information, and all other necessary information to ensure a safe and effective care transition.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure comprehensive care plans were developed to include dental care needs. This affected one (#19) of three residents reviewed for ancillary services. The facility census was 58. Findings include: Review of Resident #19's medical record revealed an admission date of 07/18/25. Diagnoses included cellulitis of the lower limbs, back pain, osteoporosis, spinal stenosis, heart failure, chronic obstructive pulmonary disease (COPD), Type II diabetes, and glaucoma. Review of Resident #19's Minimum Data Set (MDS) assessment, dated 07/23/25, revealed a Brief Interview for Mental Status (BIMS) score of eight, indicating the resident was moderately cognitively impaired. Resident #19 required moderate assistance with toilet use, bathing, parts of dressing, and transfers. Resident #19 displayed no behaviors at the time of the review. The assessment noted Resident #19 had no mouth or facial pain, discomfort or difficulty chewing at the time of the review. Review of Resident #19's care plan, revised 07/30/25, revealed supports and interventions for self-care deficit, diabetes, actual skin breakdown, risk for decline in cognition, impaired cognitive function, mood problem, risk for falls, possible nutritional risk and had a swallowing problem. No supports or interventions for dental concerns were found. Further review of Resident #19's medical record revealed the resident was seen on 02/15/25 by the dentist. It was recommended Resident #19 have five teeth extracted. Contact information was provided for three provider options for completing the extractions. Resident #19's had five teeth extracted on 04/09/25. The resident had a follow up dental visit on 04/23/25 and additional extractions were completed 07/23/25. Interview on 08/11/25 at 4:06 P.M. with Resident #19 revealed she was alert and aware. Resident #19 reported her teeth were terrible and had been bad for a long time. Resident #19 reported she had to go to the hospital to have her teeth taken care of. She reported they were bothering her again and she was having trouble eating. Interview on 08/13/25 at 8:10 A.M. with Licensed Practical Nurse (LPN) #609 verified Resident #19 had oral surgery to remove a lot of her teeth. LPN #609 was not aware of Resident #19 having any additional pain but was aware her teeth had been an ongoing concern. Interview on 08/14/25 at 11:31 A.M. with the Director of Nursing (DON) verified Resident #19 had dental care needs and there were no care plan supports or interventions for dental care. Review of the facility policy titled, Comprehensive Care Planning Procedure, revised 11/13/17, revealed a comprehensive person-centered plan of care was developed for each resident within 21 days of admission and updated on a quarterly basis and with any significant change in resident status.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, family interview, and staff interview the facility failed to provide translation assistance or devices to aide in communication with residents. This affected one (#67) of three residents reviewed for communication. The facility census was 58. Findings include: Record review for Resident #67 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #67 included cholangitis, peripheral vascular disease, diabetes Type II, disease of the pancreas, pressure ulcer of sacrum stage two, and heart failure. Resident #67's Minimum Data Set (MDS) comprehensive admission assessment was in progress. Review of Resident #67's baseline care plan, dated 08/08/25, revealed a focus area for communication. Identified interventions included to provide a translator for communication and the translators would be the resident's family. Observation on 08/13/25 at 11:00 A.M. of Resident #67 revealed the resident was laying in her bed resting. No translation equipment or communication boards were observed in the room at the time of the observation. Observation on 08/13/25 at 2:30 P.M. of Resident #67 revealed the resident was sitting up in her wheelchair with her daughter in the room visiting. No communication boards or translation equipment was observed in the room. Interview on 08/13/25 at 2:30 P.M. with Resident #67's daughter revealed the resident only spoke Spanish. The daughter stated she and her brother were in the facility most of the day and sometimes at night and could provide translation to staff for Resident #67. The daughter stated there were times during the day and throughout the evening that family were not available to visit and provide translation services. Resident #67's daughter stated she was unaware of any translation interventions provided by the facility for the staff to be able to communicate with the resident when family were unavailable. Interview on 08/14/25 at 8:33 A.M. with Certified Nursing Assistant (CNA) #673 revealed she spoke a little Spanish and was able to communicate with Resident #67 on a very basic level. CNA #673 stated Resident #67 was able to say yes and no to some simple questions, but the aide was unaware of how much English the resident comprehended. CNA #673 stated she could use a translation application on her personal cell phone but she was uncertain of the accuracy of the translation. CNA #673 verified the facility did not provide any communication devices or other services to aide in communicating with Resident #67. Observation on 08/14/25 at 9:00 A.M. of wound and incontinence care for Resident #67, provided by CNA #619 and Licensed Practical Nurse (LPN) #631, revealed the staff spoke English throughout care and the resident did not respond to any of the questions asked. Concurrent interview with CNA #619 and LPN #631 verified the facility did not provide any translation services or communication devices to aid in communication with Resident #67.		

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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. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure used needles were properly disposed of. This affected one (#27) of one resident observed for insulin administration. The facility census was 58. Findings include: Observation on 08/13/25 at 7:55 A.M. of medication administration with Licensed Practical Nurse (LPN) #611 revealed LPN #611 prepared and administered insulin glargine and insulin aspart to Resident #27, as ordered. At the completion of administration, LPN #611 removed the needles from the insulin pens and disposed of them in Resident #27's bathroom trash can. Interview on 08/13/25 at 8:08 A.M. with LPN #611 confirmed she disposed of two insulin pen needles in Resident #27's bathroom trash can. Interview on 08/13/25 at 8:15 A.M. with Assistant Director of Nursing (ADON) #604 verified that insulin pen needles should be disposed of in a sharps container (one-way puncture resistant container) after use. Review of undated facility policy titled, Syringe and Needle Disposal, revealed needles would be placed in a one-way puncture resistant container immediately after use.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure nutritional needs were assessed and interventions were implemented timely for residents identified with nutritional problems. This affected one (#48) of four residents reviewed for nutrition. The facility census was 58. Findings include: Review of the medical record for Resident #48 revealed the resident was admitted on [DATE]. The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Diagnoses included parkinsonism, myasthenia gravis, multi-system degeneration of the autonomic nervous system, dystonia, dysphagia, and need for assistance with personal care. Review of the Minimum Data Set (MDS) assessment, dated 07/16/25, revealed Resident #48 was moderately cognitively impaired and had no significant weight loss. Review of the care plan, dated 07/17/25, revealed Resident #48 was at risk for altered nutritional status and needed nutritional supplements. Interventions included providing and serving the diet as ordered, honoring food preferences, and providing and serving supplements as ordered. Review of a Nutritional Screen, dated 07/22/25, revealed Resident #48 had no significant weight loss. The assessment noted the resident struggled to gain weight and was underweight. Further review revealed Resident #48 was placed on a weight gain program and received three nutritional supplements daily and an eight-ounce (oz) milkshake in the afternoon. Review of the physician orders for July 2025 and August 2025 revealed Resident #48's diet and nutritional supplement orders were discontinued on 07/25/25. Further review revealed a regular diet and nutritional supplements were not ordered until 08/12/25 (15 days after the resident's readmission to the facility). Review of Resident #48's weights, located in the medical record, revealed on 07/02/25, the resident weighed 97.4 pounds (lbs.) and on 08/01/25, the resident weighed 88.2 lbs., indicating a 9.45% weight loss in one month. Further review of Resident #48's medical record revealed no evidence the resident was assessed by the Registered Dietitian (RD) for her nutritional needs following her readmission to the facility on [DATE]. Interview on 08/13/2025 at 8:30 A.M. with Licensed Practical Nurse (LPN) #613 revealed that Resident #48 had a decreased appetite and recently only ate small salads provided by her husband. LPN #613 further stated Resident #48 was previously on health shakes (nutritional supplement) for weight loss. Interview on 08/13/25 at 1:27 P.M. with RD #684 verified Resident #48's nutritional needs were not addressed when she readmitted to the facility on [DATE] and the resident was not assessed until 08/12/25, when a regular diet and nutritional supplements were ordered. RD #684 stated Resident #48 was reweighed and her current weight was 95.8 lbs., which was a 1.6% weight loss from her weight on 07/02/25. RD #684 stated the weight obtained on 08/01/25 of 88.2 lbs. was likely an error.		

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Form Approved OMB
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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, medical record review, staff interview, and review of the facility policy, the facility failed to ensure active physician orders for the administration of oxygen therapy and further failed to ensure oxygen tubing was dated. This affected three (#1, #3, and #10) of three residents reviewed for oxygen use. The facility census was 58. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 04/15/25. Diagnoses included chronic obstructive pulmonary disease (COPD) and a history of COVID-19. Review of the Minimum Data Set (MDS) assessment, accepted date of 08/14/25, revealed Resident #1 was cognitively intact and received oxygen therapy. Observations on 08/12/25 at 8:25 A.M. and at 4:45 P.M. revealed Resident #1 had a nasal cannula on, delivering oxygen at three liters per minute (lpm). Further observations revealed the oxygen tubing was not dated. Interview on 08/12/25 at approximately 5:10 P.M. with Assistant Director of Nursing (ADON) #604 verified Resident #1's oxygen tubing was not dated and it should have been. 2. Review of the medical record for Resident #3 revealed an admission date of 02/03/24. Diagnoses included COPD, chronic respiratory failure with hypoxia (low oxygen levels), and a history of COVID-19. Review of the MDS assessment, dated of 07/09/25, revealed Resident #3 was cognitively intact and did not receive oxygen therapy. Review of the current physician orders revealed Resident #3 had no orders for the use of oxygen therapy. Observation on 08/12/25 at 7:35 A.M. revealed Resident #3 had a nasal cannula on, delivering oxygen at four lpm. Further observation revealed the oxygen tubing was not dated. Interview on 08/12/25 at approximately 5:10 P.M. with ADON #604 verified there were no active physician orders for the administration of oxygen therapy for Resident #3 and further confirmed the oxygen tubing was not dated. ADON #604 verified there should be active physician orders for oxygen administration and oxygen tubing should be dated. 3. Review of the medical record for Resident #10 revealed an admission date of 05/16/25. Diagnoses included COPD. Review of the current physician orders revealed Resident #10 had no orders for the use of oxygen therapy. Observation on 08/11/25 at 2:35 P.M. revealed Resident #10 had a nasal cannula on, delivering oxygen at two lpm. Further observation revealed the oxygen tubing was not dated. Interview on 08/12/25 at approximately 5:10 P.M. with ADON #604 verified there were no active physician orders for the administration of oxygen therapy for Resident #10 and further confirmed the oxygen tubing was not dated. ADON #604 verified there should be active physician orders for oxygen administration and oxygen tubing should be dated. Review of facility policy titled, Medication Administration Policy, dated 07/09/21, revealed medications would be administered as prescribed by persons lawfully authorized to do so.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the pharmacy Monthly Medication Reviews (MMR), review of the pharmacy recommendations, staff interview and review of facility policy, the facility failed to ensure pharmacy recommendations were addressed by the physician in a timely manner. This affected two (#4 and #48) of five residents reviewed for unnecessary medications. The facility census was 58. Findings include: 1. Record review for Resident #4 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #4 included Parkinson's disease, diabetes Type two, heart disease, and brief psychotic disorder. Review of Resident #4's Minimum Data Set, (MDS), dated [DATE], revealed the resident had mildly impaired cognition. Review of the pharmacy MMRs revealed the pharmacist reviewed Resident #4's medications on 01/18/25, 02/08/25, and 03/09/25, and made recommendations to the physician. Further review of Resident #4's medical record and the pharmacy recommendations revealed no evidence of what the pharmacist's recommendations were on 01/18/25, 02/08/25, or 03/09/25 or that the physician reviewed and addressed the recommendations. Interview on 08/18/25 at 9:30 A.M. with the Director of Nursing, (DON), verified there was no documentation of the pharmacist's recommendations for 01/18/25, 02/08/25 or 03/09/25 or the physician's response to the recommendations. 2. Review of the medical record for Resident #48 revealed and admission date of 08/18/23. Diagnoses included parkinsonism, myasthenia gravis, multi-system degeneration of the autonomic nervous system, dystonia, and dysphagia. Review of the pharmacy recommendation dated 06/18/25 revealed the pharmacist recommended Resident #48's blood pressure (BP) readings be recorded on the Medication Administration Record (MAR) for the administration of midodrine (medication used to increase BP) and to have parameters for the medication to be held for a systolic (top number in BP) greater than 130 milliliters of mercury (mmHg). Further review revealed no physician response to the recommendation. A note on the document stated done and was signed by the DON on 07/29/25, 41 days after the recommendations was received. Review of a second pharmacy recommendation dated 06/18/25 revealed the pharmacist recommended midodrine not be given at bedtime, with the last dose being given four hours before bedtime and no later than 6:00 P.M. to prevent supine hypertension. Further review revealed no physician response to the recommendation. A note on the documented indicated the medication was changed to twice daily and was signed by the DON on 07/29/25, 41 days after the recommendation was received. Review of the progress notes from 06/18/25 through 07/29/25 revealed no evidence the physician was updated or provided verbal orders related to the pharmacy recommendations dated 06/18/25. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/13/25 at 2:30 P.M. with the DON confirmed the pharmacy recommendations dated 06/18/25 were dated as completed on 07/29/25 and signed by her. Further interview with the DON revealed she was unable to state the timeframe for the physician's response to a pharmacy recommendation. A follow-up interview on 08/13/25 at 3:50 P.M. with the DON revealed the physician gave the pharmacy recommendations dated 06/18/25 for Resident #48 to her to complete. Review of the facility policy titled, Medication Regimen Review Policy, dated 11/13/17, revealed the pharmacist must report any irregularities to the attending physician and the physician's must act upon in a manner that meets the needs of the resident.		

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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 manufacturer instructions, the facility failed to ensure insulin pens were disinfected prior to attaching the needle. This affected one (#27) of one resident reviewed for insulin administration. The facility census was 58. Findings include: Observation on 08/13/25 at 7:55 A.M. revealed Licensed Practical Nurse (LPN) #611 prepared Insulin Glargine and insulin aspart for administration to Resident #27. LPN #611 attached a needle to each insulin pen, without disinfecting the rubber stoppers of the insulin pen tips prior to attaching the needed, and proceeded to administer the medications as ordered. Interview on 08/13/25 at 8:08 A.M. with LPN #611 confirmed she did not disinfect the rubber stoppers of the insulin pen tips prior to attaching the needles. Interview on 08/13/25 at 8:15 A.M. with Assistant Director of Nursing (ADON) #604 revealed the rubber stoppers of insulin pen tips should have been disinfected prior to attaching the needles. Review of the manufacturer instructions for the insulin aspart pen delivery system revealed the first step when preparing an insulin pen for administration was to disinfect the rubber stopper of the pen tip with alcohol prior to attaching the needle to the pen.		