STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366406	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakes of Monclova Health Campus The	6935 Monclova Road Maumee, OH 43537

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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 and policy review, the facility failed to ensure the medical record was complete and accurate when addressing elevated blood sugars. This affected one (#13) of three discharged medical records reviewed for accuracy. The facility census was 54.Findings include:Review of the medical record for Resident #13 revealed an admission date of 07/23/25 and a discharge home on [DATE]. Diagnoses included type one diabetes mellitus and intestinal obstruction. Review of the admission Minimum Data Set (MDS) assessment, dated 07/28/25, revealed Resident #13 had intact cognition and received insulin. Review of the care plan dated 07/28/25 revealed Resident #13 was at risk for hypo/hyperglycemia (low or high blood sugars) due to diabetes mellitus. Interventions included providing medication per orders and monitoring blood sugars per physician order. Review of the physician order initiated 08/05/25 revealed Resident #13 received Novolog mix 70-30 FlexPen U-100 (insulin aspart) insulin pen; 100 units per milliliter (unit/mL) (70-30); nine (9) units, subcutaneous once daily between 3:00 P.M. and 5:00 P.M. Review of the physician order initiated 08/05/25, and discontinued 08/14/25, revealed Resident #13 received Novolog Mix 70-30 FlexPen U-100 (insulin aspart) insulin pen; 100 unit/mL (70-30); eight (8) units, subcutaneous with meals, twice daily, between 6:00 A.M. and 9:00 A.M. and between 11:00 A.M. and 1:00 P.M. Review of the physician order initiated 08/08/25, and discontinued 08/14/25, revealed Resident #13 received insulin glargine 100 unit/mL, five (5) units, injectable, once daily between 6:00 P.M. and 10:00 P.M. Review of a progress note dated 08/13/25 at 9:15 P.M. revealed Resident #13 was slumped over his tray table. His blood sugar was checked with a fingerstick and the results were 568 milligrams per deciliter (mg/dL). The on-call practitioner was notified and provided an order to administer 10 units of Novolog and recheck in one hour. Novolog was given. Review of a progress note dated 08/13/25 at 10:30 P.M. revealed Resident #13's blood sugar was rechecked with a fingerstick with results of 565 mg/dL. The on-call practitioner provided an order for 10 additional units of Novolog. Novolog was given. Review of progress note dated 08/14/25 at 12:37 A.M. revealed Resident #13 had a blood sugar of 481 mg/dL and the on-call practitioner provided a new order for 10 units of Novolog and recheck the blood sugar in one hour. If results were less than 350 mg/dL, leave until the morning. Novolog was given. Review of the interdisciplinary progress note dated 08/14/25 at 9:47 A.M. revealed Resident #13 had an episode of hyperglycemia and new orders were obtained for a one time dose of 10 units of insulin and to recheck blood sugar in one hour. Interview on 09/08/25 at 2:43 P.M. with the Director of Nursing (DON) confirmed Resident #13's progress notes indicated he received three separate doses of 10 units of Novolog insulin. The DON confirmed the nurse should have entered a physician order for the three insulin orders. The DON further confirmed no orders for the insulin doses given on 08/13/25 at 9:15 P.M., 08/13/25 at 10:30 P.M., and 08/14/25 at 12:37 A.M. were entered in Resident #13's physician orders. Additionally, the DON confirmed no follow-up blood sugar was documented as ordered by the physician in the progress note dated 08/14/25 at 12:37 A.M. Interview on 09/08/25 at 3:28 P.M. with Licensed Practical Nurse (LPN) #201, with the DON present, revealed LPN #201 worked the shift on 08/14/25 from 12:00 A.M. until 6:00 A.M. and provided care for Resident #13. LPN #201 stated she checked Resident #13's blood sugar an hour after he received the 12:37 A.M. dose of 10 units of insulin and recalled his blood sugar was 254 mg/dL. LPN #201 confirmed she did not document Resident #13's blood sugar in the electronic medical record. Continued interview with the DON regarding the interdisciplinary team (IDT) progress note documented on 08/14/25 at 9:47 A.M. revealed she became aware of Resident #13's hyperglycemic episode and insulin treatment by reading Resident #13's progress notes; however, the DON confirmed she only read the note dated 08/14/25 at 12:37 A.M. and did not identify Resident #13 received 30 units of insulin for hyperglycemia overnight from 08/13/25 to 08/14/25. Review of the policy titled, Guidelines for Late Entry and Corrections to Medical Record, reviewed 12/17/24, revealed each entry to the medical record shall include the date, time, and signature of the staff member recording the data. Every effort should be made to record the information or event as soon as it is available or occurred. Review of the policy titled, Guidelines for Telephone Orders, reviewed 12/17/24, revealed campuses with electronic medical records shall enter the orders directly into the electronic system which automatically transmits to pharmacy. Additionally, telephone orders shall be countersigned by the physician within 14 days or as applicable by state law of receiving the verbal order. This deficiency represents non-compliance investigated under Complaint Number 2597107.