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	04/30/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure residents were treated with dignity. This affected one (Resident #3) of five residents observed during dining. The facility census was 59. Findings include:Review of the medical record for Resident #3 revealed an admission date of 01/11/22 with diagnoses of Alzheimer's disease, dementia, protein-calorie malnutrition, anxiety, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/06/26, revealed Resident #3 was rarely/never understood and was dependent on staff for eating assistance.Observation on 04/27/26 at 12:39 P.M. revealed Certified Nurse Aide (CNA) #137 sitting next to Resident #3 and providing meal assistance in the restorative dining room. Four additional residents (Resident #12, Resident #14, Resident #30, and Resident #31) were also present in the dining room. Additionally, CNA #233 and Registered Nurse #126 were present in the dining room. Further observation on 04/27/26 at 12:43 P.M. revealed CNA #137 talking loudly to her co-workers and referring to the residents as feeders. Concurrent interview with CNA #137 confirmed she called the residents feeders and further stated they receive restorative feeding.Follow-up interview on 04/27/26 at 12:55 P.M. with CNA #137 revealed she heard other staff call the residents feeders and picked up the word from them. CNA #137 stated the assistance with eating should really be called restorative care. Interview on 04/29/26 at approximately 4:20 P.M. with the Administrator verified staff should not refer to residents as feeders.Review of the policy titled, Resident Rights Guidelines, revised 05/11/17, revealed residents have a right to be treated with dignity and respect and be treated fairly, courteously and with respect by all staff.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, medical record review, and policy review, the facility failed to properly store medications. This affected one (#64) of one residents observed for medication storage in residents' rooms. The facility census was 59. Findings include:Review of the medical record revealed Resident #64 was admitted to the facility on [DATE]. Diagnoses included cellulitis of the right lower limb and cellulitis of the left lower limb. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 was cognitively intact and was assessed with no behaviors. Review of the comprehensive care plan dated 04/28/26 revealed Resident #64 received high risk medications related to congestive heart failure, edema, and hypertension. Interventions included administering medications per physician orders. Observation and interview on 04/27/26 at 8:40 A.M. revealed Resident #64 was awake and lying in bed with her bedside table near her. On the bedside table was a medication cup containing seven medications in tablet form. Resident #64 stated she left her morning medications on the table so she could take them with food.Observation and interview on 04/27/26 at 8:45 A.M. with Licensed Practical Nurse (LPN) #242 confirmed Resident #64 should not have medications at bedside. LPN #242 went into Resident #64's room and asked about the medications. Resident #64 again stated she was waiting to take the medications with food. LPN #242 explained to Resident #64 that medications could not be left at bedside and that she would bring them back when breakfast arrived. Resident #64 was in agreeance. LPN #242 stated Resident #64 had the medications in the hatch (meaning in her mouth) prior to her walking out of the room during morning medication administration. Review of the policy titled, Medication Storage, dated 10/01/23 gave no direction regarding medications being left at bedside.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, medical record review, review of a diet guide, and staff interview, the facility failed to follow instructions for the preparation and serving of residents receiving pureed textured food to ensure accurate portion sizes. This had the potential to affect three (#3, #17, and #29) of three residents receiving pureed diets. The facility census was 59. Findings include:Observation on 04/28/26 at 11:31 A.M. revealed [NAME] #128 preparing the lunch meal. [NAME] #128 was observed blending goulash mixture and egg noodles together.Interview on 04/28/26 at 11:31 A.M. with [NAME] #128 verified the goulash mixture and egg noodles were blended together.Observation on 04/28/26 at 12:40 P.M. revealed [NAME] #128 plating one, four-ounce scoop of pureed goulash and egg noodle mixture. Further observation revealed [NAME] #128 plating two, four-ounce scoops of mechanical soft goulash and noodle mixture.Interview on 04/28/26 at 12:45 P.M. with [NAME] #128 verified one, four-ounce scoop of pureed goulash and noodle mixture was added to the plate. [NAME] #128 was questioned as to why the mechanical soft plates received two, four-ounce scoops of goulash and noodle mixture while the puree diet plates received only one four-ounce scoop of goulash and noodle mixture. [NAME] #128 stated the noodles for the pureed are more ground down so the one, four-ounce scoop of pureed was equal to two, four-ounce scoops of mechanical soft.Interview on 04/28/26 at 1:20 P.M. with Dining Services Assistant Director (DSAD) #179, during concurrent review of the facility document titled, Diet Guide Sheet, revealed guidance for the preparation and serving of the pureed meal. DSAD #179 confirmed the goulash mixture and egg noodles were to be blended separately and served separately. Review of the Diet Guide Sheet further revealed residents receiving a pureed diet should have received one, four-ounce scoop of goulash mixture and one, three-ounce scoop of egg noodles. DSAD #179 verified residents with a pureed diet did not receive the correct amount of beef goulash mixture therefore the residents did not receive the correct amount of protein.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, medical record review, and staff interview, the facility failed to ensure food was fed to residents in a sanitary manner. This affected one (#3) of one residents observed receiving meal assistance. The facility identified three (#3, #10, and #17) residents who received meal assistance. The facility census was 59.Findings include:Review of the medical record for Resident #3 revealed an admission date of 01/11/22 with diagnoses of Alzheimer's disease, dementia, protein-calorie malnutrition, anxiety, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/06/26, revealed Resident #3 was rarely/never understood and was dependent on staff for eating assistance.Observation on 04/27/26 at 12:39 P.M. revealed Certified Nurse Aide (CNA) #137 sitting next to Resident #3 and providing meal assistance in the restorative dining room. Continued observation on 04/27/26 at 12:43 P.M. revealed CNA #137 stating Resident #3's soup was very hot. CNA #137 scooped a spoonful of soup and blew on it with her mouth to cool it off before offering the spoon to Resident #3. Resident #3 consumed the spoonful of soup. CNA #137 proceeded to scoop a second spoonful of soup, blow on the soup with her mouth to cool it, and offer it to Resident #3. Follow-up interview on 04/27/26 at 2:05 P.M. with CNA #137 verified the soup was often hot and she had to blow on it to cool it.Interview on 04/30/26 at 9:55 A.M. with Assistant Director of Dining Services #179 confirmed the act of blowing on residents' food was not a hygienic practice and staff should not blow on residents' food.