STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366410	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Commons	12469 Five Point Road 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, resident interview, staff interview, medical record review, review of Resident Council meeting minutes, and review of facility policy, the facility failed to ensure residents who were dependent for care received showers as scheduled. This affected three (#1, #25, and #31) of three residents reviewed for showers. The facility census was 54.Findings include:1. Review of Resident #1's medical record revealed an admission date of 07/23/25. Diagnoses included atrial fibrillation, weakness, and parkinsonism (causes movement problems such as tremors, stiffness and slow movements and balance issues).Review of the Minimum Data Set (MDS) assessment, dated 10/28/25, revealed Resident #1 was cognitively intact and required maximal (staff) assistance with activities of daily living (ADLs).Review of the care plan, revised on 08/12/25, revealed Resident #1 had and ADL self-care performance deficit related to parkinsonism. Interventions included providing a sponge bath when a full bath or shower could not be tolerated, and the resident required maximum (staff) assistance for shower/bath.Review of Resident #1's bathing documentation for November 2025 revealed the resident was scheduled to receive a bed bath every Tuesday and Friday on day shift. Further review of the documentation revealed Resident #1 received a bed bath on 11/04/25 and 11/18/25 (two of eight opportunities). Additional review revealed no evidence Resident #1 was provided a bed bath on any other days in November 2025. Observation on 11/25/25 at 8:30 A.M. of Resident #1 revealed the resident had long fingernails with dirt under them. Resident #1 had dry skin on his head and face.Interview on 11/25/25 at approximately 8:35 A.M. with Resident #1, with a family member present, revealed his last bed bath was about one week ago, when his family member provided him one. Resident #1 stated he could not recall the last time that staff washed his entire body. Resident #1's family member stated the resident would go weeks without a bed bath and the concerns had been expressed to the Administrator and the Director of Nursing (DON) on multiple occasions, without resolution.Interview on 12/01/25 at 1:50 P.M. with the Director of Nursing (DON) verified that Residents #1 did not receive showers as scheduled. The DON further confirmed issues with showers had been brought to her and the Administrator's attention and education had been given to staff; however, no evidence was provided related to the education or any corrective action taken by the facility.2. Review of the medical record for Resident #25 revealed an admission date of 05/01/25. Diagnoses included dementia, muscle weakness, and depression.Review of the quarterly MDS assessment, dated 11/05/25, revealed Resident #25 was cognitively impaired. Resident #25 was assessed to require substantial (staff) assistance for toileting, bathing, and personal hygiene.Review of the care plan, dated 05/01/25, revealed Resident #25 had an ADL self-care performance deficit related to activity intolerance, dementia, fatigue, and impaired balance.Review of the shower documentation for November 2025 revealed Resident #25 was scheduled for showers on Monday and Thursdays. Further review revealed no evidence Resident #25 received showers on 11/10/25, 11/13/25 or 11/24/25.Observation on 11/25/25 at 10:30 A.M. revealed Resident #25 was sitting in the common area with food visible on his shirt and face. Interview on 12/01/25 at 1:50 P.M. with the DON verified that Resident #25 did not receive showers as scheduled. The DON further confirmed issues with showers had been brought to her and the Administrator's attention and education had been given to staff; however, no evidence was provided related to the education or any corrective action taken by the facility.3. Review of the medical record for Resident #31 revealed an admission date of 01/13/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke), retention of urine, and anxiety.Review of the quarterly MDS assessment, dated 11/21/25, revealed Resident #31 was cognitively intact. Resident #31 was assessed to be (staff) dependent for ADLs.Review of the care plan dated 01/15/25 revealed Resident #31 had an ADL self-care performance deficit related to hemiplegia, limited mobility, pain, and stroke.Review of Resident #31's shower documentation for November 2025 revealed he was scheduled for showers on Wednesdays and Saturdays on first shift. Further review revealed Resident #31 received a shower on 11/15/25, 11/19/25, and 11/29/25 (three of eight opportunities). There was no evidence Resident #31 was provided any additional showers during the month of November 2025.Observation on 11/25/25 at 9:55 A.M. revealed Resident #31 was sitting in his wheelchair in the common area. Resident #31 had hair that appeared unkept and white flakes were observed on his shirt. Interview on 12/01/25 at 1:00 P.M. with Resident #31's family member revealed the resident went seven to eight days without having a shower on multiple occasions. The family member stated they would have to provide the resident a shower themselves, including transferring the resident. The family member stated the most recent shower they provided was on

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, resident interview, staff interview, review of the medical record, and review of facility policy, the facility failed to provide timely incontinence care. This affected one (#1) of three residents reviewed for incontinence care. The facility census was 54.Findings include:Review of Resident #1's medical record revealed an admission date of 07/23/25. Diagnoses included atrial fibrillation, weakness, and parkinsonism (causes movement problems such as tremors, stiffness and slow movements and balance issues).Review of the Minimum Data Set (MDS) assessment, dated 10/28/25, revealed Resident #1 was cognitively intact and required maximal (staff) assistance with activities of daily living (ADLs).Review of the care plan, dated 07/23/25, revealed Resident #1 had bowel incontinence related to mobility. Interventions included to assist with toileting as needed.Review of a wound care progress note dated 11/20/25 revealed Resident #1 was seen for an area on his buttocks, with a new diagnosis of irritant dermatitis due to body fluid. Interview on 11/25/25 at 8:30 A.M. with Resident #1 revealed the staff did not provide timely incontinence care and he sat in his own bowel movement for hours. The resident stated he had two areas on his buttocks that were the result of not receiving timely incontinence care.Observation on 12/01/25 at 8:50 A.M. revealed Resident #1's call light was on. Concurrent interview with Resident #1 revealed he pushed his call light at approximately 8:45 A.M. because he had a bowel movement and needed assistance with clean up and changing his brief. Continuous observation revealed at 10:00 A.M., Certified Nursing Assistant (CNA) #100 responded to Resident #1's call light (one hour and 10 minutes after the observation began). CNA #100 was observed to have an ear bud in her left ear and was looking at her cellular (cell) phone. Interview on 12/01/25 at 10:00 A.M. with CNA #100 revealed she was unable to respond to Resident #1's call light timely because she had other residents to take care of. CNA #100 was unable to state what an acceptable call light response time was and stated she would get to them when she could. Continued observation revealed the Director of Nursing (DON) entered the resident's room to assist with incontinence care. Resident #1 was observed to have two scabbed areas on his buttocks.Interview on 12/01/25 at 1:50 P.M. with the DON revealed an acceptable time to wait for assistance after a call light was activated was 10 minutes. The DON confirmed and hour and 10 minutes was not acceptable to wait for care. Further interview with the DON verified Resident #1 had scabbed areas on his buttocks.Review of the facility policy titled, Call Lights: Accessibility and Timely Response, revised 12/01/25, revealed all staff members who see or hear and activated call light were responsible for responding. If the staff member could not provide what the resident desired, the appropriate personnel should be notified.This deficiency represents noncompliance investigated under Master Complaint Number 267960 and Complaint Number 2663701.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure staff were trained on the use of mechanical lifts. This affected one (#25) of three residents reviewed for mechanical lift use. The facility identified 28 residents who were dependent on a mechanical lift for transfers. The facility census was 54.Findings include: Review of the medical record for Resident #25 revealed an admission date of 05/01/25. Diagnoses included dementia, muscle weakness, and depression.Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/05/25, revealed Resident #25 was cognitively impaired and was assessed to require partial assistance from sitting to standing.Review of the care plan dated 05/01/25 revealed Resident #25 had an Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance, dementia, fatigue, and impaired balance. Interventions included maximum assistance of one to two staff to transfer.Observation on 11/25/25 at 9:18 A.M. revealed Certified Nursing Assistant (CNA) #300 attempted to transfer Resident #25 from the bed to the wheelchair to get to the bathroom. CNA #300 attempted to stand Resident #25 by taking both hands and pulling him from sitting to standing. CNA #300 attempted three times to have Resident #25 stand, with Resident #25 sitting back on the bed each time. CNA #300 then obtained a mechanical lift and transferred Resident #25 to the wheelchair and then to the bathroom, without a second staff present during the use of the mechanical lift. Interview on 11/25/25 at 10:32 A.M. with the Administrator revealed two staff should be present to assist with a mechanical lift transfer. The Administrator confirmed the facility did not provide mechanical lift training to CNA #300. Interview on 11/25/25 at 1:04 P.M. with CNA #300 revealed Resident #25 was typically able to stand and pivot into the wheelchair; however, the resident sometimes required more assistance. CNA #300 verified she transferred Resident #25 using a mechanical lift without a second staff and further stated the facility did not provide training on the use of mechanical lifts when hired into the facility. Review of the facility policy titled, Lifting Machine, Using a Mechanical, dated 05/22/25, revealed, at least two nursing assistants were needed to safely move a resident with a mechanical lift. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility.This deficiency represents non-compliance investigated under Complaint Number 2676960.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. Based on family, provider, and staff interview, medical record review, and policy review, the facility failed to ensure transportation to medical appointments. This affected one (#31) of three residents reviewed for outside medical appointments. The facility census was 54. Findings include:Review of the medical record for Resident #31 revealed an admission date of 01/13/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, retention of urine, and anxiety.Review of the quarterly Minimum Date Set (MDS) assessment, dated 11/21/25, revealed Resident #31 had intact cognition. Resident #31 was (staff) dependent for activities of daily living (ADLs). Review of the Nurse Practitioner (NP) progress note date 05/05/25 revealed Resident #31 was seen for a follow-up evaluation of diabetes with neuropathy (damage to nerves outside the brain that causes pain, tingling and numbness in hands and feet), and left hemiparesis. Further review revealed Resident #31 had left shoulder pain likely due to osteoarthritis and stiffness. The NP referred Resident #31 to Physical Medicine and Rehabilitation (PMR) for evaluation and possible Botox injections.Review of the nurse progress note dated 10/31/25 revealed transportation arrived to the facility at 8:30 A.M. to take Resident #31 to his PMR appointment, however the driver stated that the van could not accommodate Resident #31's wheelchair. The appointment had to be rescheduled.Interview on 12/01/25 at 1:00 P.M. with Resident #31's family member revealed the resident was referred to PMR for Botox injections due to pain from contractions. Since that referral, Resident #31 had missed three appointments due to transportation not showing up or not having the right van for transportation.Interview on 12/01/25 at 2:00 P. M. with PMR Staff #700 revealed Resident #31 was referred for Botox injections due to pain. An initial appointment was scheduled for 07/03/25. The facility cancelled the appointment on 07/03/25 and rescheduled for 07/23/25. The facility cancelled the appointment on 07/23/25 and rescheduled it to 07/24/25. Resident #31 was scheduled for a follow-up appointment on 08/13/25 and the appointment was cancelled and rescheduled for 09/03/25. Lastly, PMR #700 stated a 10/31/25 follow-up appointment was cancelled and rescheduled by the facility.Interview on 12/01/25 at 3:00 P.M. with the Director of Nursing (DON) revealed Resident #31 had an appointment at PMR on the facility calendar for 07/03/25 and 08/13/25, with no documentation as to why Resident #31 missed the appointments. The DON verified the appointment on 07/23/25 was cancelled because the facility arranged transportation did not show and the appointment on 10/31/25 had to be rescheduled because the facility arranged transportation did not bring a vehicle that could accommodate the resident's wheelchair. Review of the facility policy titled, Provision of Physician Ordered Services, dated 10/24/25, revealed in instances where consultations were not able to be performed on-site, the facility would work with the resident and their family to secure appropriate transportation arrangements for appointments.This deficiency represents non-compliance investigated under Complaint Number 2663701.

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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, review of the dietary spreadsheets (DS), medical record review, and staff interview, the facility failed to ensure correct portion sizes for meals. This affected one (#3) of three residents reviewed for portion sizes. The facility census was 54.Findings include:Review of the medical record for Resident #3 revealed an admission date of 09/17/25. Diagnoses included Alzheimer's disease, chronic kidney disease, and epilepsy.Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/21/25, revealed Resident #3 had severe cognitive impairment.Review of the care plan dated 09/18/24 revealed Resident #3 had nutritional problems or a potential nutritional problem related to Alzheimer's and received a mechanically altered diet related to dysphagia. Interventions included providing diet as ordered, and monitoring intakes. Review of the DS for 11/25/25 revealed the lunch meal for a pureed diet was six ounces of pureed baked potato soup, six ounces of pureed [NAME] Marzetti (pasta dish), four ounces of pureed home fried potatoes, four ounces of pureed seasoned broccoli, and four ounces of sherbert ice cream.Observation on 11/25/25 at 12:00 P.M. of the lunch meal service revealed Dietary Aide (DA) #201 served a pre-plated pureed meal to Resident #25. Further observations revealed the portion sizes appeared small. Upon Surveyor request, DA #201 measured the meal served to Resident #25, with the [NAME] Marzetti being less than two ounces and the pureed vegetable being less than two ounces. Continued observation with DA #201 revealed the serving utensils used to serve the pureed meal included a four ounce scoop for the [NAME] Marzetti (six ounces was identified on the DS), a three ounce scoop for the soup (six ounces was identified on the DS) , a two ounce scoop for the broccoli (four ounces was on the DS), and a spoon with no serving size was utilized for the potatoes (four ounces was identified on the DS).Interview with DA #201 on 11/25/25 at 12:05 P.M. confirmed Resident #25's meal was less than two ounces of [NAME] Marzetti and less than two ounces of the vegetable. DA #201 further confirmed the serving utensils used for lunch were randomly selected and DA #201 eyed the portions. DA #201 was unaware of what the serving sizes were to be for lunch.Interview on 11/25/25 at 1:58 P.M. with Dietary Manager (DM) #200 confirmed staff should use color coded serving utensils with specific serving sizes and follow the DS.This deficiency represents non-compliance investigated under Master Complaint Number 2676960 and Complaint Number 2663701.