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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Commons	12469 Five Point Road Perrysburg, OH 43551

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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 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, record review, and policy review, the facility failed to ensure residents received feeding assistance in a dignified manner. This affected one (#56) of three residents reviewed for feeding assistance. The facility census was 51.Findings include:Review of the medical record for Resident #56 revealed an admission date of 09/27/24 with diagnoses of Alzheimer's disease, stroke, anorexia, dysphagia, and dementia with agitation.Review of the quarterly Minimum Data Set assessment, dated 01/01/26, revealed Resident #56 had severely impaired cognition and required supervision/touching assistance for eating.Review of the care plan initiated 02/22/24, and revised 08/28/25, revealed Resident #56 had an activity of daily life self-care performance deficit related to dementia. Interventions stated the resident requires maximum assistance and may need to be fed by staff. Observation on 03/25/26 at 7:22 A.M. revealed Certified Nursing Assistant (CNA) #300 taking Resident #56's breakfast tray into the room and walking out to continue to pass other resident's trays.Observation on 03/25/26 at 7:37 A.M. revealed Resident #56 sitting up in bed with CNA #300 sitting next to Resident #56's bed. Resident #56's overbed table was in front of CNA #300 and CNA #300 was wearing an earbud in her left ear, visible from the doorway, and was holding her cell phone up while watching a video. CNA #300 was not actively feeding Resident #56. Concurrent interview with CNA #300 confirmed she was watching social media on her personal phone. Continued observation revealed CNA #300 asked Resident #56 if she would like eggs. Resident #56 nodded and opened her mouth. CNA #300 fed Resident #56 a bite of yogurt. Concurrent interview with CNA #300 confirmed she offered eggs and provided yogurt. Further observation revealed Resident #56's eyes were closed periodically during the meal and CNA #300 would lift a bite of food to Resident #56's mouth and hold it there without notifying Resident #56 she was providing another bite of food. Alternatively, Resident #56 would open her mouth, possibly in anticipation of a bite of food, and CNA #300 would spend time cleaning off the spoon and attempting to load the spoon with a new bite of food without verbalizing what was happening or about to happen for Resident #56. Interview on 03/25/26 at 8:02 A.M. with the Interim Director of Nursing (IDON) confirmed staff should not watch their cell phones while providing resident care. Review of the policy, Meal Supervision and Assistance, reviewed 02/18/26, revealed the facility would provide a relaxing, enjoyable environment during mealtime.This was an incidental finding identified during the Complaint Survey completed 03/26/26.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of a personnel file, review of camera footage, policy review, and review of Self-Reported Incident #272120 the facility failed to ensure residents were free from verbal abuse. This affected two (#11 and #65) of four residents reviewed for abuse. The facility census was 51.Findings include:1. Review of Resident #11's medical record revealed an admission date of 09/17/24. Diagnoses included Alzheimer's, congestive heart failure, anxiety, and seizures. Review of Resident #11's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had a cognitive deficit. The resident was dependent on staff for all care. Review of Resident #11's most recent care plan revealed she had pain related to osteoarthritis in multiple sites. The resident had an activity of daily living care performance deficit related to confusion, dementia, and limited mobility. Interventions included two staff members to reposition and turn in bed, and the resident required a mechanical lift with two staff members for transfers. Review of Resident #11's room revealed the family had a camera installed to ensure proper care. In addition, the family provided a personal care companion to stay with the resident several hours a day. Review of a video tape provided by Resident #11's family revealed on 03/15/25 at Licensed Practical Nurse (LPN) #219 was assisting Certified Nursing Assistant (CNA) #312 with care. On Video #1 at 0:16 seconds LPN #219 was providing incontinence care and in a loud voice told Resident #11 to stop squeezing her butt cheeks. At 0:24 seconds LPN #219 yelled Daughter, you need to tell her to stop squeezing her butt cheeks. During incontinence care LPN #219 was viewed throwing the dirty wash clothes over the bed and onto the bare floor. LPN #219 then said in a loud voice at 2:24 on the video I am not an aide. I'm doing the best I can! Resident #11 was observed grunting, moaning, and crying out. Resident #11 was also swinging her arms around in the air. The resident was non-verbal. At 2:34 on the video the family care giver came over to comfort the resident, speaking to her calmly and holding her hand. Resident #11 then calmed down. Review of Video #2 dated 03/15/25 revealed two CNAs (#311 and #312) were providing care for Resident #11. At 2:03 CNA #311 referred to Resident #11's daughter as the spy stating we have to do care this way because That's how her spy wants it done. At 1:45 in the video CNA #311 informed CNA #312 that Resident #11's daughter was not allowed in the facility and could not even visit Resident #11 on her birthday. This conversation was completed while providing care for Resident #11 and transferring her from the bed to wheelchair via mechanical lift. Review of the videos and interview with the interim Director of Nursing on 03/26/26 at 10:10 A.M. verified the actions and speech of LPN #219 and CNA #311 were unprofessional and abusive. 2. Review of the medical record for Resident #65 revealed an admission date of 07/23/25 and a discharge date of 03/02/26 with diagnoses of atrial fibrillation, obesity, tremor, need for assistance with personal care, and Parkinsonism. Review of the quarterly MDS assessment, dated 01/28/26, revealed Resident #65 had intact cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #65's care plan, initiated 07/29/25, and revised 08/12/25, revealed Resident #65 elected to have video monitoring in his room. Review of the personnel file, on 03/26/26 at approximately 11:45 A.M., for LPN #221 revealed a Corrective Action Report (CAR), signed 01/01/26. Review of the CAR revealed LPN #221 received written counseling for incidents on 12/01/25 and 12/22/25 due to violating rules of conduct and behavior. Further review revealed LPN #221 was observed on 12/01/25 on video shouting at the resident and using foul/cursing language. Further review revealed a family member of submitted a written concern on 12/22/25 regarding LPN #221's behavior toward them. Additional review of the CAR revealed the statement This behavior is disrespectful, abusive and unprofessional. Interview on 03/26/26 at 12:00 P.M. with the Interim Director of Nursing (IDON) and concurrent review of the CAR confirmed the situation met the criteria for a self-reportable incident due to the description of abusive behavior. Interview on 03/26/26 at 12:18 P.M. with Human Resources Director (HRD) #313, and concurrent review of the CAR signed 01/01/26, revealed HRD #313 signed the document along with a former Director of Nursing. HRD #313 stated Resident #65 was the resident affected by the behavior identified in the written counseling for LPN #221. Review of the facility's policy, Abuse, Neglect and Exploitation, approved 05/22/25, defined verbal abuse as the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability. This was an incidental finding identified during the Complaint Survey completed 03/26/26.

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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. Based on record review, personnel file review, staff interview and policy review, the facility failed to report an allegation of verbal abuse to the state agency as required. This affected one (#65) of four residents reviewed for abuse. The facility census was 51.Findings include:Review of the medical record for Resident #65 revealed an admission date of 07/23/25 and a discharge date of 03/02/26 with diagnoses of atrial fibrillation, obesity, tremor, need for assistance with personal care, and Parkinsonism.Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/28/26, revealed Resident #65 had intact cognition. Review of Resident #65's care plan, initiated 07/29/25, and revised 08/12/25, revealed Resident #65 elected to have video monitoring in his room.Review of Resident #65's progress notes, dated 12/01/25 through 12/22/25, revealed no evidence of verbal abuse by staff.Review of the personnel file, on 03/26/26 at approximately 11:45 A.M., for Licensed Practical Nurse (LPN) #221 revealed a Corrective Action Report (CAR), signed 01/01/26. Review of the CAR revealed LPN #221 received written counseling for incidents on 12/01/25 and 12/22/25 violating rules of conduct and behavior. Further review revealed LPN #221 was observed on 12/01/25 on video shouting at the resident and using foul/curing language. Further review revealed a family member of submitted a written concern on 12/22/25 regarding LPN #221's behavior toward them. Additional review of the CAR revealed the statement This behavior is disrespectful, abusive and unprofessional.Interview on 03/26/26 at 12:00 P.M. with the Interim Director of Nursing (IDON) and concurrent review of the CAR confirmed the situation met the criteria for a self-reportable incident due to the description of abusive behavior. Interview on 03/26/26 at 12:13 P.M. with the Administrator, and concurrent review of the CAR signed 01/01/26, revealed she could not determine which resident was involved in the incident.Interview on 03/26/26 at 12:18 P.M. with Human Resources Director (HRD) #313, and concurrent review of the CAR signed 01/01/26, revealed HRD #313 signed the document along with a former Director of Nursing. HRD #313 stated Resident #65 was the resident affected by the behavior identified in the written counseling for LPN #221.Follow-up interview on 03/26/26 at 2:36 P.M. with the Administrator confirmed the facility did not report the incident to the state agency.Review of the facility's policy, Abuse, Neglect and Exploitation, approved 05/22/25, defined verbal abuse as the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability. Further review revealed the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.This was an incidental finding identified during the Complaint Survey completed 03/26/26.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, personnel file review, staff interview and policy review, the facility failed to investigate an allegation of verbal abuse. This affected one (#65) of four residents reviewed for abuse. The facility census was 51.Findings include:Review of the medical record for Resident #65 revealed an admission date of 07/23/25 and a discharge date of 03/02/26 with diagnoses of atrial fibrillation, obesity, tremor, need for assistance with personal care, and Parkinsonism.Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/28/26, revealed Resident #65 had intact cognition. Review of Resident #65's care plan, initiated 07/29/25, and revised 08/12/25, revealed Resident #65 elected to have video monitoring in his room.Review of Resident #65's progress notes, dated 12/01/25 through 12/22/25, revealed no evidence of verbal abuse by staff.Review of the personnel file, on 03/26/26 at approximately 11:45 A.M., for Licensed Practical Nurse (LPN) #221 revealed a Corrective Action Report (CAR), signed 01/01/26. Review of the CAR revealed LPN #221 received written counseling for incidents on 12/01/25 and 12/22/25 violating rules of conduct and behavior. Further review revealed LPN #221 was observed on 12/01/25 on video shouting at the resident and using foul/curing language. Further review revealed a family member of submitted a written concern on 12/22/25 regarding LPN #221's behavior toward them. Additional review of the CAR revealed the statement This behavior is disrespectful, abusive and unprofessional.Interview on 03/26/26 at 12:00 P.M. with the Interim Director of Nursing (IDON) and concurrent review of the CAR confirmed the situation met the criteria for a self-reportable incident due to the description of abusive behavior. Interview on 03/26/26 at 12:13 P.M. with the Administrator, and concurrent review of the CAR signed 01/01/26, revealed she could not determine which resident was involved in the incident.Interview on 03/26/26 at 12:18 P.M. with Human Resources Director (HRD) #313, and concurrent review of the CAR signed 01/01/26, revealed HRD #313 signed the document along with a former Director of Nursing. HRD #313 stated Resident #65 was the resident affected by the behavior identified in the written counseling for LPN #221.Follow-up interview on 03/26/26 at 2:36 P.M. with the Administrator confirmed the facility could not provide evidence of an investigation into the incidents affecting Resident #65 and Resident #65's family member on 12/01/25 and 12/22/25, respectively. Review of the facility's policy, Abuse, Neglect and Exploitation, approved 05/22/25, defined verbal abuse as the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability. Further review revealed an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.This was an incidental finding identified during the Complaint Survey completed 03/26/26.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete non-pharmacological interventions prior to administering as needed psychotropic medications to residents. This affected three (#11, #30, and #60) of four residents reviewed for psychotropic medications. The facility census was 51.Findings include:1. Review of Resident #30's medical record revealed an admission date of 12/08/25. Diagnoses included hip fracture, dementia, anxiety, and bipolar. Review of Resident #30's medical record revealed a physician's order dated 02/11/26 for non-pharmacological interventions to be documented for monitoring as needed. Non pharmacological interventions included relaxation, quiet room, massage, food, fluids, music, repositioning, involve in activity, medication for pain, other to be documented in the progress nursing notes. Review of Resident #30's medical record revealed a physician's order dated 03/10/26 for Ativan 0.5 milligrams (mg) to be administered every four hours as needed for anxiety for 14 days. Review of Resident #30 Medication Administration Record (MAR) revealed the Ativan 0.5 mg was administered on 03/18/26 at 9:21 P.M., 03/19/26 at 2:50 P.M., 03/20/26 at 2:50 P.M., 03/21/26 at 12:40 A.M. and 1:41 P.M. and on 03/22/26 at 12:40 P.M. Review of Resident #30's MAR and nursing progress notes revealed the medical record was absent of non-pharmacological interventions prior to the administration of the as needed Ativan on 03/18/26, 03/19/26, 03/20/26, 03/21/26, and 03/22/26. 2. Review of Resident #11's medical record revealed an admission date of 09/17/24. Diagnoses included Alzheimer's disease and anxiety. Review of Resident #11's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident utilized anti-anxiety medications. Review of Resident #11's current physician orders revealed an order dated 09/17/24 for non-pharmacological interventions including relaxation, quiet room, massage, food, fluids, music, toileting, repositioning, involve in activity, medication for pain, other to be documented in the progress nursing notes as needed for monitoring and an order dated 11/20/25 for Ativan 0.5 mg tablets, give 0.25 mg by mouth every four hours as needed for anxiety. Review of Resident #11's MAR dated December 2025 revealed on 12/10/25 at 3:28 A.M. and on 12/12/25 at 3:28 A.M. and 11:25 P.M. the resident was medicated with as needed Ativan. Review of the Resident #11's MAR and nursing progress notes dated 12/10/25 through 12/12/25 were absent of non-pharmacological interventions prior to the administration of the as needed Ativan. 3. Review of Resident #60's medical record revealed an admission date of 03/13/26. Diagnoses included dementia, hypertension, and incontinence. Review of Resident #60's MDS and care plan revealed the documents were in progress. Review of Resident #60's current physician orders revealed an order dated 03/17/26 for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions to be completed which included relaxation, quiet room, massage, food, fluids, music, toileting, repositioning, involve in activity, medication for pain, other to be documented in the progress nursing notes. Further review of the physician orders revealed orders dated 03/23/26 for Ativan oral tablet 0.5 mg to be administered by mouth one time a day for anxiety and give 0.5 mg by mouth every four hours as needed for anxiety for 14 days. Review of Resident #60's nursing progress notes and the MAR revealed as needed Ativan was administered on 03/15/26 at 7:33 P.M. with no alternate non-pharmacological interventions documented prior to the Ativan administration. Interview with the Interim Director of Nursing (IDON) on 03/25/26 at 1:22 P.M. verified the staff failed to complete or document the resident's non-pharmacological interventions prior to the administration of Ativan. The IDON revealed the facility had no specific policy related to completing non-pharmacological interventions prior to administering psychotropic medications, adding but physician orders must be followed. This deficiency represents non-compliance investigated under Complaint Number 2727791.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, staff interview, and facility policy review, the facility failed to ensure discontinued narcotics were properly disposed of in a timely manner. This affected eight (#28, #30, #38, #62, #63, #65, #70, and #71) of eight residents reviewed for narcotic medications and who had the narcotic medication discontinued. The facility census was 51.Findings include:1. Review of Resident #71's medical record revealed an admission date of [DATE]. The resident expired on [DATE].Review of Resident #71's medical record revealed a physician's order dated [DATE] for Tramadol oral tablet 50 milligrams (mg) to be administered by mouth twice daily for pain.Observation of the 100-hall medication cart on [DATE] at 7:02 A.M. with Licensed Practical Nurse (LPN) #251 verified 15 Tramadol tablets remained in the medication cart for Resident #71. LPN #251 verified Resident #71 had passed away in the facility on [DATE].2. Review of Resident #28's medical record revealed an admission date of [DATE]. Diagnoses included end stage renal disease, congestive heart failure, malignant neoplasm of the kidney, prostate, and retroperitoneum. Resident #28 was discharged from the facility on [DATE].Review of Resident #28's physician order dated [DATE] revealed an order for Tramadol hydrochloride (HCL) tablet 50 mg to be administered by mouth every 12 hours for pain between seven and 10. The medication was discontinued on [DATE].Observation on [DATE] at 7:10 A.M. of the 300 hall medication cart with LPN #251 revealed there were 22 tablets of the 50 mg Tramadol HCL tablets in the locked drawer of the medication cart belonging to Resident #28.3. Review of Resident #38's medical record revealed an admission date of [DATE]. Diagnoses included anxiety, hemiplegia, hemiparesis, and adjustment disorder.Review of Resident #38's medical record revealed an order dated [DATE] for oxycodone-acetaminophen (narcotic pain reliever) oral tablet 10-325 mg to be administered by mouth four times a day for pain while awake.Review of Resident #38's medical record revealed the oxycodone-acetaminophen was discontinued on [DATE].Observation of the 300-hall medication cart on [DATE] at 7:10 A.M. with LPN #251 revealed 22 tablets of Resident #38's discontinued oxycodone-acetaminophen were stored in the locked narcotic drawer of the medication cart.4. Review of Resident #62's medical record revealed an admission date of [DATE]. Diagnoses included dementia, schizophrenia, atrial fibrillation, and congestive heart failure. The resident was transferred out of the facility on [DATE] and did not return.Review of Resident #62's medical record revealed a physician's order dated [DATE] for Tramadol 50 mg, the medication was discontinued on [DATE].Observation of the 300 hall medication cart on [DATE] at 7:10 A.M. with LPN #251 revealed 23 tablets of Tramadol 50 mg remained in the cart belonging to Resident #62.5. Review of Resident #30's medical record revealed an admission date of [DATE]. Diagnoses included hip fracture, dementia, anxiety, bipolar, and diabetes mellitus. The resident expired in the facility on [DATE].Observation of the 300 hall medication cart on [DATE] at 7:10 A.M. with LPN #251 revealed Resident #30 still had 29 tablets of Tramadol (opioid pain medication) 50 mg, 31 tablets of Lorazepam (antianxiety) 0.5 mg, and a full unopened bottle of liquid Morphine Sulfate (opioid analgesic) was in the locked narcotic drawer.Interview with LPN #251 on [DATE] at 7:12 A.M. verified Residents #28 and #62 had been discharged from the facility, Resident #30 passed away, and the discontinued medication for Resident #30 remained in the medication cart as the nurses were waiting for nursing management to remove the resident's narcotics from the medication cart.6. Review of the medical record for Resident #70 revealed an admission date of [DATE] with diagnoses of thoracic vertebra fracture, quadriplegia, contracture, and stiffness of left shoulder. Resident #70 was discharged to an assisted living facility on [DATE].Review of the physician order initiated [DATE] and discontinued [DATE] revealed Resident #70 was prescribed oxycodone-acetaminophen, 5-325 mg tablet with directions to give one tablet by mouth every four (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours as needed for pain.Observation of the 200 hall medication cart with LPN #229 on [DATE] at 7:25 A.M. revealed there were 20 oxycodone-acetaminophen 5-325 mg tablets belonging to Resident #70 in the narcotic drawer of the medication cart. 7. Review of the medical record for Resident #63 revealed an admission date of [DATE] with diagnoses of Alzheimer's disease, dementia, chronic kidney disease, and peripheral vascular disease. Resident #63 expired under hospice care on [DATE].Review of the physician order initiated [DATE] revealed Resident #63 was prescribed morphine sulfate (concentrate) oral solution 20 mg per milliliter (mg/ml). The medication was to be administered 0.25 ml by mouth every four hours as needed for pain/shortness of breath regarding end of life symptoms.Review of the physician order initiated [DATE] and discontinued [DATE] revealed Resident #63 was prescribed Ativan (lorazepam) oral tablet 0.5 mg, one tablet was to be administered by mouth every four hours as needed for shortness of breath/anxiety/agitation. The medication was ordered for 14 days.Observation on [DATE] at 7:25 A.M. with LPN #229 of the 200 hall medication cart revealed 28 Lorazepam 0.5 mg tablets and an unopened bottle of liquid morphine sulfate was stored in the 200 hall medication cart belonging to Resident #63.8. Review of the medical record for Resident #65 revealed an admission date of [DATE] with diagnoses including migraine, osteoarthritis, heart disease, and Parkinsonism. Resident #65 discharged to another long-term care facility on [DATE].Review of the physician order initiated [DATE] revealed Resident #65 was prescribed Percocet oral tablet 10-325 mg (oxycodone with acetaminophen) with the resident to be administered one tablet by mouth two times a day, at 9:00 A.M. and 9:00 P.M. for pain. Review of the physician order initiated [DATE], and not yet discontinued, revealed Resident #65 was prescribed Percocet oral tablet 10-325 mg (oxycodone with acetaminophen), one tablet by mouth every 12 hours as needed for pain at 2:00 P.M. and 2:00 A.M., as needed.Observation of the 200 hall medication cart on [DATE] at 7:27 A.M. with LPN #229 revealed in the locked narcotic drawer of the medication cart there were 22 tablets of Percocet for Resident #65. Interview with LPN #229 on [DATE] at 7:27 A.M. following the observation of the 200 hall medication cart verified Residents #70, #63 and #65 were no longer in the facility and that each of the residents had narcotic medications in the medication cart. Interview on [DATE] at 8:23 A.M. with the Interim Director of Nursing (IDON) revealed she was aware expired narcotics remained in the nurse's carts. The IDON stated the secured drawer in her office was missing the second key and therefore the narcotics could not be stored securely except in the double locked medication carts. The IDON stated expired narcotics were always destroyed onsite and would require two nurses or a nurse and a pharmacist to destroy the narcotics.Telephone interview Pharmacist #308 on [DATE] at 2:03 P.M. revealed every facility varied as how the narcotics were disposed of for expired and discharged residents. The Pharmacist stated those medications were not to be kept in the medications carts and should be disposed of as soon as possible. Review of the facility policy titled Controlled Medications revised on [DATE] revealed discontinued controlled substance medications are removed from the patient care area and temporarily stored at the facility in a securely locked area until such time that they are destroyed as directed by state law. This was an incidental finding identified during the Complaint Survey completed [DATE].

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	03/26/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and review of the daily menu, the facility failed to ensure residents on a pureed diet received the planned menu. This affected three (#11, #15, and #56) of three residents identified on a pureed diet. The facility census was 51. Findings include:1. Review of the medical record for Resident #56 revealed an admission date of 02/08/24 with diagnoses of Alzheimer's disease, hypertension, chronic obstructive pulmonary disease, restlessness and agitation, anxiety, dementia, and dysphagia.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had severe cognitive impairment, was dependent on staff for eating, activities of daily living and mobility.Review of the current physician orders revealed an order dated 03/20/26 for a regular diet with pureed texture, nectar consistency, with liquids provided via straw, and an order dated 02/26/26 for med pass 2.0, 120 milliliters (ml) twice daily for weight loss, give before lunch and before dinner.2. Review of the medical record for Resident #11 revealed an admission date of 09/17/24, diagnoses included Alzheimer's disease, coronary artery disease, congestive heart failure, end stage renal disease, type II diabetes mellitus, and anxiety. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #11 had severe cognitive impairment, was dependent for activities of daily living, required set up assistance and supervision for meals. Review of Resident #11's physician orders revealed orders dated 11/18/25 for the resident to have a regular diet with pureed texture, to use a divided plate and sippy cup, and to be fed for all meals.3. Review of the medical record for Resident #15 revealed an admission date of 09/27/24, diagnoses included hypertension, insomnia, nontraumatic subarachnoid hemorrhage, repeated falls.Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment, required supervision and touching assistance for meals, was dependent for toileting and transfers. Review of the physician orders revealed Resident #15 had an order dated 4/21/25 for a magic cup with meals for weight loss and an order dated 10/30/24 for a regular diet with pureed texture. Interview on 03/24/26 at 11:10 A.M. with [NAME] #303 revealed she prepared the pureed meals for Resident #11, Resident #15 and Resident #56. [NAME] #303 stated residents on a pureed diet received the same menu items (in pureed form) as residents on a regular diet.Observation of the daily menu provided by Dietary Manager #302 on 03/24/26 at 11:13 A.M. revealed the evening meal was oven fried chicken, mashed sweet potatoes, asparagus, and chocolate banana marble cake.Observation on 03/24/26 at 4:42 P.M. revealed Resident #56 in the dining room with a plate of pureed food in front of her, one mound of green puree, one mound of orange puree, and one mound of beige puree. Resident #56 also had a nutrition supplement ice cream. Continued observation of Resident #34's regular-texture meal revealed fried chicken, mashed sweet potatoes, and asparagus spears. Interview on 03/24/26 at 4:44 P.M. with Dietary Aide (DA) #301 revealed the dessert was chocolate banana marble cake. DA #301 stated no pureed cake was available for Resident #56.Interview on 03/24/26 at 5:00 P.M. with [NAME] #305 revealed the evening meal was pureed by the morning cook, [NAME] #303. [NAME] #305 called [NAME] #303 on the telephone to ask [NAME] #303 what vegetables were prepared for residents on a pureed diet for the evening meal. [NAME] #305 stated [NAME] #303 prepared a broccoli blend for the three residents on a pureed diet. Additionally, [NAME] #305 stated no pureed cake was prepared and the pureed dessert was ice cream. Interview on 3/26/26 at 2:45 P.M. with [NAME] #310 confirmed Residents on a pureed diet should receive the same menu items as residents on a regular diet, except when accounting for preferences or allergies. Further, [NAME] #310 confirmed asparagus could be pureed to an appropriate texture for residents on a pureed diet.Review of the facility policy titled Meal Supervision and Assistance, revised 02/18/26 stated the resident will be prepared for a well-balanced meal in a calm environment, location of preference and with adequate supervision and assistance to prevent (continued on next page)

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	366410	A. Building B. Wing	03/26/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidents, provide adequate nutrition, and ensure an enjoyable event. When serving the resident, staff are to check the tray prior to serving the food to the resident to ensure they are receiving the correct diet and that the food is in the consistency that is ordered. This deficiency represents non-compliance investigated under Complaint Number 2727791.

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	366410	A. Building B. Wing	03/26/2026

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of meal order ticket, staff interview, and facility policy review, the facility failed to provide meals per resident preferences. This affected one (#11) of one resident reviewed for food preferences and had the ability to affect all residents that receive food from the kitchen. The facility identified all 51 residents receive meals from the kitchen. The facility census was 51.Findings include:Review of Resident #11's medical record revealed an admission date of 09/17/24. Diagnoses included Alzheimer's, congestive heart failure, anxiety, and seizures.Review of Resident #11's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had a cognitive deficit. The resident was dependent on staff for all care.Review of Resident #11's most recent care plan revealed the resident required supervision and sometimes feeding assistance. Observation of breakfast service on 03/25/26 at 7:35 A.M. revealed Resident #11 was served pureed sausage, scrambled eggs, pureed toast, and cranberry juice in the appropriate divided place, sippy cup, and build up silverware. Review of Resident #11's meal ticket dated 03/25/26 revealed the resident would be served yogurt, 1/2 a banana, tea daily, and no juice or soda.Interview with Certified Nursing Assistant (CNA) #208 on 03/25/26 at 7:43 A.M. verified Resident failed to be supplied the ordered food and was served juice. CNA #208 stated the residents' preferences changed often.Review of the facility policy titled Accommodation of Food Preferences revised 03/25/26 revealed alternate menu items shall be available to accommodate individualized resident needs, food preferences, including religious, ethnic and cultural food preferences, restrictions, and requests. Resident's food preferences shall be listed in the tray ticket system ither manually or electronically. This violation represents non-compliance investigated under Complaint Number 2727791.