STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on medical record review, observation, staff interview, review of hospital records, review of a facility statement, and review of facility policies, the facility failed to ensure a thorough skin assessment was completed when one resident (#03) returned from the hospital. This resulted in Immediate Jeopardy and serious life-threatening harm and/or injury when Resident #03 returned from the hospital with a surgical pressure compression dressing in place to his penis, which was not identified by the facility to be present until removal 13 days after admission, with no documented assessment of the skin breakdown present under the compression dressing documented for three days after the dressing was removed. At the time the dressing was removed, Certified Nurse Practitioner (CNP) #01 documented the glans of Resident #03's penis with necrotic, hard tissue present. Resident #03 required hospitalization for surgical interventions of debridement of the necrotic tissue and removal of the tip of the penis. This affected one (#03) of three (#03, #12, and #13) residents reviewed for pressure ulcers. Additionally, the facility failed to ensure wound treatments were administered as ordered by the physician which placed a second resident (#12) at risk for the potential for more than minimal harm that is not Immediate Jeopardy. This affected one (#12) of three (#03, #12, and #13) residents reviewed for pressure ulcers. The facility identified three residents residing in the facility with pressure ulcers. The facility census was 50. On 11/17/22 at 4:56 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 10/24/22 at 11:07 P.M. when Resident #03 returned from the hospital following suprapubic catheter surgical replacement with a pressure/compression dressing, an ACE bandage, wrapped around his penis. Documentation in the medical record from readmission on 10/24/22 through 11/09/22 failed to mention the presence of any dressings to Resident #03's penis. On 11/06/22 at 4:05 A.M., Registered Nurse (RN) #200 removed the Ace bandage from Resident #03's penis, only documenting the presence of a Stage 2 pressure area of excoriation to the upper scrotum. On 11/09/22 at 2:37 P.M., CNP #01 documented Resident #03 had an ACE bandage wrapped around his penis. On examination, the head of the penis was necrotic and hard, with the area surrounding the necrotic are to be slightly excoriated. Resident #03 was subsequently admitted to the hospital and underwent extensive debridement of the penile shaft due to necrosis of the glans penis and partial necrosis to the penis shaft. The Immediate Jeopardy was removed on 11/09/22 at 6:30 P.M. when the facility implemented the following corrective actions: On 11/08/22, the DON informed Resident #03's attending physician of the skin breakdown on the resident's penis and obtained a treatment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/08/22, the DON and Assistant DON (ADON) completed audits of all new admissions, including skin sweeps, to assess for the presence of unidentified dressings or areas of skin breakdown. On 11/08/22, the facility initiated a Quality Assurance Performance Improvement (QAPI) meeting with the Medical Director and CNP #01 addressing resident needs and plan of action. On 11/09/22, the DON and ADON assessed the skin of all residents in the facility. Treatments and splints were verified. On 11/09/22, the DON educated all nurses on admission/readmission assessments; comprehensive skin checks; reporting assessment findings; obtaining orders for treatments and admission responsibilities shift to shift. The education was completed on 11/09/22 at 6:30 P.M. On 11/09/22, the DON initiated weekend admission audits to be completed by the on-call nurse. On 11/09/22, the DON initiated daily wound and admission audits, including QAPI, every Friday at 3:00 P.M. These will be completed by either the DON or the ADON. On 11/11/22 at 3:34 P.M., the facility had a QAPI Ad Hoc meeting with the Medical Director to review the incident with Resident #03 and develop a plan of correction. Review of the medical record for one additional resident in the facility with a pressure ulcer (Resident #13) revealed no concerns with pressure ulcer care. Although the Immediate Jeopardy was removed on 11/09/22, the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of the medical record revealed Resident #03 admitted to the facility on [DATE]. Diagnoses included quadriplegia, neuromuscular dysfunction of the bladder, supra-pubic urinary catheter, colostomy, moderate protein-calorie malnutrition, pressure ulcer to sacral region and heel, anxiety disorder, hypertension, fracture of left tibia and fibula, spinal fusion, and history of pulmonary embolism. Review of the Minimum Data Set (MDS) assessment, dated 09/01/22, revealed Resident #03 was identified with intact cognition, was dependent on staff for the completion of all activities of daily living, had an indwelling urinary catheter and colostomy, and had a Stage 4 pressure ulcer. Review of Nurses' Notes dated 10/24/22 at 11:07 A.M. revealed RN #200 documented Resident #03 readmitted to the facility. There was no documentation regarding a skin assessment. Review of the hospital discharge orders dated 10/24/22, revealed Resident #03 had undergone a surgical procedure for replacement of the suprapubic catheter. Orders included to irrigate the bladder with gentamycin solution every 48 hours for 30 days. The hospital discharge documents did not identify a dressing to Resident #03's penis was in place. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the record revealed on 10/25/22 at 6:21 A.M., RN #200 documented an assessment identifying Resident #03 was alert and oriented, makes needs known to staff, and was dependent on staff for care. There was no assessment of the resident's perineum. Review of the record revealed no assessment of Resident #03's skin was documented which revealed a pressure dressing was present on the resident's penis from admission until 11/06/22. Review of the weekly skin assessment dated [DATE] at 4:05 A.M. by RN #200 documented a Stage 2 pressure area of excoriation was present to Resident #03's upper scrotum. There was no documentation of a dressing being in place. Review of the physician orders on 11/06/22 at 8:05 A.M. revealed the physician provided an order for barrier cream to the excoriated area to the scrotum. Review of the physician orders on 11/08/22 at 4:24 P.M. revealed the DON obtained a physician order for treatment to the excoriated area to the scrotum, shaft of penis and eschar to glans. The treatment order was to cleanse with in-house wound cleanser, pat dry, paint all areas with betadine, keep open to air, and to complete each shift. There was no documentation of Resident #03's skin to the penis documented in the medical record. Review of Nurses' Notes dated 11/09/22 at 11:52 A.M. revealed CNP #01 is to be into see Resident #03's necrotic tissue to the penis. CNP #01 recommended follow up with the urologist. Urologist office contacted with return call pending per the nurse. Review of Nurses' Notes on 11/09/22 at 12:58 P.M. revealed the ADON called and spoke to the nurse at the urologist office. The ADON informed the urology office nurse there were no orders sent with this resident from the hospital regarding the dressing on the resident's penis. The urology office nurse reported the Urologist applied the dressing due to bleeding and instructed the staff at the hospital to remove the dressing in two hours after application. The ADON reported Resident #03 stated he woke up from surgery with the dressing on and was informed it was due to excess bleeding during surgery. Review of Nurses' Notes on 11/09/22 at 2:09 P.M. revealed the urology office returned a call and requested the resident to be sent to the hospital emergency room for evaluation and treatment. Review of the progress note dated 11/09/22 at 2:37 P.M., CNP #01 documented Resident #03 was recently admitted to the hospital and an ACE bandage had been wrapped around his penis due to bleeding from a procedure. However, the wrap was not removed for over seven days. On examination the head of the penis was necrotic with hard tissue. The area surrounding the necrotic area was slightly excoriated. CNP #01 recommended Resident #03 see the urologist to discuss options and debridement was not likely possible. Review of Nurses' Notes on 11/09/22 at 2:40 P.M. revealed eschar tissue was found on peritoneal area of resident per the DON. Resident #03 was sent to the emergency room for evaluation. Review of hospital documentation dated 11/09/22 at 7:08 P.M. noted Resident #03 presented with black discoloration of the penis. The note revealed a bandage was taken off the penis today and there was a black discoloration of the glans penis. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital urology consultation notes on 11/10/22 at 9:37 A.M. documented a phone call to the physician's office questioning the need for an ACE bandage and revealed the bandage was placed to Resident #03's penis for urethral bleeding at the time of his cystoscopy and suprapubic tube placement. Review of hospital surgical report documentation dated 11/11/22, revealed Resident #03 had extensive debridement of the penile shaft due to necrosis of the glans penis and partial necrosis to the penis shaft. Review of hospital documentation dated 11/13/22, revealed Resident #03 was status post debridement of the penis for necrotic tissue. The RN reported Resident #03 was very upset regarding surgical debridement and loss of tip of penis. The area of debridement shows a questionable area of further necrosis. A note on 11/15/22 documented the penis wound was assessed to have a dark scab on top. The scrotal area had a small moist ulcer. Review of an undated, untitled facility prepared statement written by the DON revealed Resident #03 went to the hospital 10/17/22 for surgical replacement of suprapubic catheter. A surgical/compression dressing was applied to the penis during the procedure due to bleeding. The physician had told hospital staff who transported Resident #03 back up to his hospital room to relay to nursing staff to remove the bandage after two hours. Resident #03 returned from the hospital 10/24/22. There were no orders for the bandage when he returned and no mention of it on the re-admission assessment completed by the facility. On 11/06/22 the night nurse and night aide noticed changes of skin condition to Resident #03's scrotum. The nurse removed the bandage and called the physician for new orders. A note and incident report were completed at this time. The next day the DON was called to Resident #03's room by the resident to inspect the penis. The DON immediately reached out to the primary care physician for follow up and obtained new treatment orders. When CNP #01 assessed Resident #03's skin she recommended urology assess the resident. After several calls to obtain a urology consult the facility was able to send Resident #03 to the hospital to be assessed by the urologist the resident had seen on his last stay. Resident #03 was currently at the hospital and has undergone an incision and drainage for the necrotic penial tissue. The resident was also given medication to aide in restoring blood flow to the penis. Interview via telephone on 11/17/22 at 1:05 P.M., CNP #01 stated she was called in to evaluate Resident #03's penis. The resident was in his room and no dressing was applied to the penis. CNP #01 stated the penis was assessed as described in the progress note. CNP #01 was not aware of the resident having any orders to wrap the penis and had not evaluated prior to 11/09/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/17/22 at 2:20 P.M. with the DON revealed on 11/06/22 RN #200 discovered Resident #03 with a gauze dressing and an ACE bandage wrapped around his penis. RN #200 removed both dressings and contacted the physician for a treatment to the excoriation on the resident's scrotum. The DON confirmed no documentation identified skin breakdown to the penis on 11/06/22. The DON stated on 11/08/22 at approximately 8:30 A.M., Resident #03 requested the DON to speak with him. Resident #03 requested the DON to look at his penis. The resident's penis was observed to be open to air under an adult incontinence brief. No dressing was in place. The glans of the penis was hard and necrotic. The penial shaft was excoriated with pink/shearing tissue. The DON was informed by Resident #03 of a dressing having been applied to the penis since his hospital stay. The DON spoke with CNP #02 and described Resident #03's skin breakdown to the penis. The DON requested CNP #02 to evaluate the resident's skin. It was not until 11/09/22 when CNP #01 was in the area of the facility that Resident #03's skin was assessed. CNP #01ordered the resident to be evaluated by a urologist. The DON confirmed the physician did not assess the wound. Interview via telephone on 11/17/22 at 4:06 P.M., Physician #01 revealed he was contacted on 10/25/22 to confirmed admission orders for Resident #03. The physician was not informed of a dressing, or an Ace bandage being applied to the resident's penis. On 11/06/22 the physician was notified Resident #03 had an excoriated area of tissue to the scrotum. The physician stated the nurse did not report the resident had a gauze dressing and an ACE bandage wrapped around the penis. The physician was unaware the resident was assessed with necrotic tissue to the glans of the penis. Review of the facility policy titled Admission Notes, revised September 2012, revealed when a resident is admitted to the nursing unit, the admitting nurse must document in the nurses' notes, on the admission form, or other appropriate place as designated by facility protocol the presence of a dressing. Review of the facility policy titled Admission Assessment and Follow Up: Role of the Nurse, revised September 2012, revealed an admission assessment included a physical assessment including the following systems: eyes, ears, nose, throat, neurological, musculoskeletal, gastrointestinal, genitourinary, and skin. Information should be recorded in the record including all relevant assessment data obtained during the assessment. 2. Review of the medical record revealed Resident #12 admitted to the facility on [DATE]. Diagnoses included paraplegia, chronic obstructive pulmonary disease, major depression, unstageable pressure ulcer to sacral region, Stage 4 pressure ulcer to bilateral buttocks, acute kidney failure, anemia, hypertension, urogenital implants, colostomy, and hydronephrosis with renal and ureteral calculus obstruction. Review of the MDS assessment, dated 10/13/22, revealed Resident #12 had intact cognition, was dependent on staff for the completion of activities of daily living, and had three Stage 4 pressure ulcers. Review of the plan of care initiated on 08/25/22 and revised on 11/15/22 revealed Resident #12 had pressure ulcers and potential for further pressure ulcer development. The interventions included to administer treatments as ordered and monitor for effectiveness. Review of Nurses' Notes on 11/03/22 at 7:58 A.M. revealed Resident #12 returned to the facility following a brief hospitalization from [DATE]. No new wounds were discovered. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of wound documentation dated 11/04/22 revealed the resident had a Stage IV sacral pressure ulcer measuring 6.5 centimeters (cm) long by 8.2 cm wide by 1.0 cm deep. The right buttocks had a Stage IV pressure ulcer measuring 5.8 cm long by 4.8 cm wide by 1.2 cm deep. The left buttock had a Stage IV pressure ulcer measuring 3.5 cm long by 2.5 cm wide by 3.0 cm deep. Review of the physician orders, dated 11/04/22, revealed the treatment orders included cleanse sacral/left buttocks/right buttocks wounds with in-house wound cleanser, pat dry, cover exposed bone area with Adaptic, pack with alginate, and fill with Kerlix. Change daily and as needed every evening shift for wound care. Review of wound documentation dated 11/11/22 revealed the Stage IV sacral pressure ulcer measured 4.7 cm long by 8.5 cm wide by 1.3 cm deep. The right buttocks Stage IV pressure ulcer measured 4.7 cm long by 4.2 cm wide by 1.5 deep. The left buttock Stage IV pressure ulcer measured 3.2 cm long by 2.7 cm wide by 2.7 cm deep. Review of the physician orders revealed on 11/11/22 the treatment orders were changed to cleanse sacral/left buttocks/right buttocks wounds with in-house wound cleanser, pat dry, pack with dry calcium alginate, cover with foam dressing, and change twice daily and as needed. Review of the November 2022 Treatment Administration Record (TAR) revealed no documentation the pressure ulcer treatments were completed on the evening shift of 11/14/22 and 11/15/22. Observation on 11/16/22 at 6:40 A.M. revealed Licensed Practical Nurse (LPN) #203 obtained wound dressing supplies to complete Resident #12's pressure ulcer dressing changes. The supplies included dry calcium alginate and a silicone foam border dressing. LPN #203 then proceeded to Resident #12's room. Resident #12 was positioned to the left side and the existing dressing was exposed. LPN #203 removed two large abdominal (ABD) dressings followed by Kerlix gauze, which was packed into the three pressure ulcer wounds. LPN #203 cleansed the wound with wound cleanser and packed the wounds with dry calcium alginate followed by covering with a silicone foam bordered dressing. Interview on 11/16/22 at 6:56 A.M., LPN #203 confirmed the treatment removed from Resident #12's pressure ulcers was not the current treatment ordered on 11/11/22. Interview on 11/16/22 at 7:14 A.M., Regional Director of Clinical Services #01 confirmed the dressing removed from Resident #12's pressure ulcer wounds was not the current dressing order originating on 11/11/22. Interview on 11/16/22 at 8:35 A.M., with Regional Registered Nurse (RRN) #01 confirmed Resident #12 was not provided with the current wound treatment which included the application of calcium alginate and cover with silicone border dressing. Review of the facility policy titled Wound Care, revised October 2010, revealed the physician order for the treatment was to be verified prior to application of the procedure. This deficiency represents non-compliance investigated under Master Complaint Number OH00137571, Complaint Number OH00137544 and Complaint Number OH00137456 and is an example of continued noncompliance from the survey dated 10/19/22.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, resident interview, and review of facility policy, the facility failed to ensure colostomy care was provided in accordance with physician orders. This affected one (#12) of two residents reviewed for the provision of colostomy care and maintenance. The facility identified three residents with ostomies. The facility census was 50. Findings include: Review of the medical record revealed Resident #12 admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included paraplegia, chronic obstructive pulmonary disease, major depression, unstageable pressure ulcer to sacral region, Stage 4 pressure ulcer to bilateral buttocks, acute kidney failure, anemia, hypertension, urogenital implants, colostomy, and hydronephrosis with renal and ureteral calculus obstruction. Review of the Minimum Data Set assessment, dated 10/13/22, revealed Resident #12 had intact cognition, was dependent on staff for the completion of activities of daily living, and utilizes an indwelling urinary catheter, colostomy, and had three stage 4 pressure ulcers. Review of the plan of care initiated on 08/25/22 revealed a care plan addressing Resident #12's alteration in gastro-intestinal status related to diverting colostomy. Interventions included colostomy care/bag change as per orders and per facility protocol. Review of hospital discharge physician orders dated 11/03/22 revealed colostomy care to be provided daily/per facility protocol. Orders included to change appliance every 72 hours and as needed (PRN). Review of the medical record lacked documentation the colostomy was assessed or care for daily. There was no documentation indicating when the colostomy appliance had been changed. Observation on 11/16/22 at 3:07 P.M. noted the colostomy bag attached to Resident #12's abdomen. The colostomy bag was soiled and the adhesive to the colostomy wafer was pealing off. Interview with the resident at the time revealed the colostomy application had not been changed since September 2022. Review of the facility policy titled Colostomy Care, revised October 2010, revealed medical record documentation to be recorded included the date and time the colostomy care was provided, the name and title of the individual (s) who provided the colostomy care and the signature of the person recording the data. Interview on 11/16/22 at 8:35 A.M. with Regional Registered Nurse (RRN) #1 confirmed Resident #12 was to have the colostomy application (bag, wafer) changed every 72 hours and as needed. RRN #1 verified no documentation was in the medical record indicating the treatments were administered as ordered. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00137544 and Complaint Number OH00137456

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 15816 Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure medications were administered with an error rate of less than 5% . This affected three (#1, #6, #8) of six residents reviewed for medication administration. There were four medication errors out of 25 opportunities for a medication error rate of 16.0%.The facility census was 50. Findings include: 1. Observation of medication administration on 11/15/22 at 8:45 A.M. noted Licensed Practical Nurse (LPN) #201 to obtain the medication for Resident #6 from the medication cart. The medication was identified as Creon capsule delayed release 6000-19000 units, a pancreatic enzyme to treat malabsorption syndrome. Further observation noted the electronic medication administration record (EMAR) screen displayed the medication in red. Interview with LPN #201 confirmed the medication was scheduled for administration at 7:30 A.M. according to the EMAR and proceeded to provide the medication to the resident whole with applesauce. Review of Resident #6's medical record noted the medication Creon capsule delayed release 6000-19000 units ordered on 11/08/22 to be administered before meals scheduled at 7:30 A.M., 11:00 A.M. and 4:00 P. M. 2. Observation of medication administration on 11/15/22 at 9:16 A.M. revealed LPN #202 obtaining medications for Resident #1 from the medication cart. Observation of the electronic medication administration record (EMAR) noted the screen to have a red background. LPN #202 stated Resident #1's Lantus insulin was not available on the cart and it was due at 8:00 A.M. LPN #202 proceeded to check the facility contingency box. At 9:21 A.M. LPN #202 returned to the medication cart and stated the Lantus was not available and the pharmacy would be contacted. LPN #202 proceeded to administered multiple medications by mouth and omitted the Lantus insulin. Review of Resident #1's medical record revealed an order dated 08/29/22 for Lantus insulin solution 20 units one time daily at 8:00 A.M. Interview on 11/15/22 at 9:35 A.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #1 confirmed Resident #1's Lantus insulin was not available in the facility. 3. Observation on 11/15/22 at 9:28 A.M. revealed LPN #202 displayed Resident #8's medications on the EMAR and the screen illuminated in red. Interview at this time LPN #202 stated Resident #8 was to receive two types of insulin at 7:30 A.M. and 8:00 A.M. However, they had not been administered. LPN #202 was observed to obtain the blood glucose meter from the medication cart and proceeded into Resident #8's room and obtained a blood sugar reading of 166. LPN #202 returned to the medication cart obtained Novolog insulin 2 units per insulin syringe and a Detemir Solution pen with 30 units of insulin. LPN #202 proceeded to administer both insulins at 9:42 A.M. Interview at the time of the observation with with LPN #202 confirmed both insulins were administered past the ordered time frames. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's medical record revealed a physician order on 09/01/22 for Novolog insulin solution before meals and at bedtime. Scheduled times were noted to be at 7:30 A.M. 11:00 A.M., 4:00 P.M. , 9:00 P. M. and according to sliding scale results inject subcutaneously before meals and at bedtime. Sliding scale doses were as follows: 151-200=2 Units (U); 201-250=4 U; 251-300=6 U; 301-350=8 U; 351-400=10 U; 401-450=12 U; 451-500=14 U. The record also revealed a physician order dated 08/31/22 for the insulin Detemir solution inject 30 units subcutaneously in the morning. The medication was scheduled for 8:00 A.M. administration. Interview on 11/15/22 at 9:42 A.M. wth LPN #202 confirmed both the Detemir and the Novolog insulin were administered past the ordered time frames. Review of the facility policy titled Administering Medications, revised April 2019, revealed medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time, unless otherwise specified. Interview on 11/15/22 at 9:45 A.M. interview with Assistant Director of Nursing (ADON) #2 confirmed the residents did not receive medications as ordered within the facility policy time frames or as ordered by the physician. The medication administration revealed a total of four errors out of 25 opportunities for a medication error rate of 16%. This deficiency represents non-compliance investigated under Master Complaint Number OH00137571, Complaint Number OH00137456, and Complaint Number OH00137092.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 15816 Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to provide medications in accordance with physicians orders which resulted in medication omissions and significant medication errors. This affected three (#1, #6, #8) of six residents reviewed for medication administration. The facility census was 50. Findings include: 1. Observation of medication administration on 11/15/22 at 8:45 A.M. noted Licensed Practical Nurse (LPN) #201 to obtain the medication for Resident #6 from the medication cart. The medication was identified as Creon capsule delayed release 6000-19000 units, a pancreatic enzyme to treat malabsorption syndrome. Further observation noted the electronic medication administration record (EMAR) screen displayed the medication in red. Interview with LPN #201 confirmed the medication was scheduled for administration at 7:30 A.M. according to the EMAR and proceeded to provide the medication to the resident whole with applesauce. Review of Resident #6's medical record noted the medication Creon capsule delayed release 6000-19000 units ordered on 11/08/22 to be administered before meals scheduled at 7:30 A.M., 11:00 A.M. and 4:00 P. M. 2. Observation of medication administration on 11/15/22 at 9:16 A.M. revealed LPN #202 obtaining medications for Resident #1 from the medication cart. Observation of the electronic medication administration record (EMAR) noted the screen to have a red background. LPN #202 stated Resident #1's Lantus insulin was not available on the cart and it was due at 8:00 A.M. LPN #202 proceeded to check the facility contingency box. At 9:21 A.M. LPN #202 returned to the medication cart and stated the Lantus was not available and the pharmacy would be contacted. LPN #202 proceeded to administered multiple medications by mouth and omitted the Lantus insulin. Review of Resident #1's medical record revealed an order dated 08/29/22 for Lantus insulin solution 20 units one time daily at 8:00 A.M. Interview on 11/15/22 at 9:35 A.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #1 confirmed Resident #1's Lantus insulin was not available in the facility. 3. Observation on 11/15/22 at 9:28 A.M. revealed LPN #202 displayed Resident #8's medications on the EMAR and the screen illuminated in red. Interview at this time LPN #202 stated Resident #8 was to receive two types of insulin at 7:30 A.M. and 8:00 A.M. However, they had not been administered. LPN #202 was observed to obtain the blood glucose meter from the medication cart and proceeded into Resident #8's room and obtained a blood sugar reading of 166. LPN #202 returned to the medication cart obtained Novolog insulin 2 units per insulin syringe and a Detemir Solution pen with 30 units of insulin. LPN #202 proceeded to administer both insulins at 9:42 A.M. Interview at the time of the observation with with LPN #202 confirmed both insulins were administered past the ordered time frames. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's medical record revealed a physician order on 09/01/22 for Novolog insulin solution before meals and at bedtime. Scheduled times were noted to be at 7:30 A.M. 11:00 A.M., 4:00 P.M. , 9:00 P. M. and according to sliding scale results inject subcutaneously before meals and at bedtime. Sliding scale doses were as follows: 151-200=2 Units (U); 201-250=4 U; 251-300=6 U; 301-350=8 U; 351-400=10 U; 401-450=12 U; 451-500=14 U. The record also revealed a physician order dated 08/31/22 for the insulin Detemir solution inject 30 units subcutaneously in the morning. The medication was scheduled for 8:00 A.M. administration. Interview on 11/15/22 at 9:42 A.M. wth LPN #202 confirmed both the Detemir and the Novolog insulin were administered past the ordered time frames. Review of the facility policy titled Administering Medications, revised April 2019, revealed medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time, unless otherwise specified. Interview on 11/15/22 at 9:45 A.M. interview with Assistant Director of Nursing (ADON) #2 confirmed the residents did not receive medications as ordered within the facility policy time frames or as ordered by the physician. This deficiency represents non-compliance investigated under Master Complaint Number OH00137571, Complaint Number OH00137456, and Complaint Number OH00137092.