

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Concord Care Center of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 3121 Glanzman Rd Toledo, OH 43614	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS IS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, resident interview, staff interview, review of the facility's investigation, and review of facility policy, the facility failed to provide adequate supervision to prevent resident elopement. Actual Harm occurred on 06/26/25 at 11:15 P.M. when Resident #07 eloped from the facility without staff knowledge. Resident #07 was missing until 06/29/25 at 3:45 P.M. when Resident #07 called the resident representative for assistance. This affected one (#07) of four residents reviewed for elopement. The facility identified 32 (#2, #4, #7, #11, #13, #15, #17, #20, #21, #22, #24, #26, #28, #34, #36, #37, #40, #42, #45, #52, #53, #56, #57, #60, #63, #65, #66, #67, #68, #69, #74, and #78) residents at risk of elopement. The facility census was 78. Review of the medical record revealed Resident #07 was admitted on [DATE]. Diagnoses included schizoaffective disorder, bipolar type, major depressive disorder, recurrent, post-traumatic stress disorder, schizoaffective disorder, obsessive compulsive, kleptomania, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, 05/11/25, revealed the resident was moderately cognitively impaired. Review of the care plan, initiated on 8/05/19, revealed Resident #07 was at risk for elopement due to schizoaffective bipolar, depression, post-traumatic stress disorder, obsessive compulsive disorder, delusions, and history of elopement. Review of nursing progress note dated 06/27/25 at 12:30 A.M. revealed at approximately 12:30 A.M. staff notified the writer Resident #07 was not in her bed. A code brown was immediately called and a resident head count completed. The staff searched the entire facility. The protocol was initiated while staff continued to search inside and outside the premises and the surrounding neighborhood. The management, power of attorney, and physician were notified. Review of a nursing progress note dated 06/29/25 at 4:56 P.M. revealed Resident #07's family called to notify the facility a call was just received from Resident #07, requesting a ride, Resident #07 provided the family her location. The DON and Administrator immediately drove to the location that was provided, and Resident #07 was standing on the corner with a bag in hand. Resident #07 was assisted into the car and stated she was tired. The Administrator asked if she was hungry and the resident stated she had sausage and pancakes at the church. The Administrator asked if she was thirsty and noted a bottle of water in the bag. Resident #07 stated she wanted some cold water. The resident reported her feet hurt due to walking. Resident was taken back to the facility and a head-to-toe assessment was completed. Resident #07 complained of pain to bilateral feet but no other areas. Redness noted to bilateral arms and face, no noted peeling areas. Resident #07 stated the church provided sunscreen. Resident was showered and offered dinner. Resident #07 ate approximately half of the dinner, and stated she was not hungry. The guardian, family, and physician were provided an update. Ibuprofen was provided due to complaints of bilateral feet pain. Resident #07 placed on a one-on-one until further notice. Review of the social services note, dated 06/29/25, revealed the resident was observed and assessed for safety and overall well-being. No signs of distress, harm, or discomfort noted. The Resident was alert and oriented, stable mood, and affect. The resident denied any concerns or complaints at the time. No (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365030
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F 0689 Level of Harm - Actual harm Residents Affected - Few	negative psychosocial effects or issues observed or reported. Review of the skin check evaluation, dated 06/29/25, revealed redness to the face, left arm, and right arm. Resident #07 had filled blisters to the right heel, left heel, left great toe, right lateral foot, and right great toe. There were non-filled blisters to the right toe and right foot back of toes. Review of wound assessment report, dated 06/30/25, revealed a right heel blister measuring 2.20 centimeters (cm), a right plantar foot blister measuring 1.5 cm x 1.7 cm, a left heel blister measuring 1.4 cm x 2 cm, left great toe blister measuring 2.5 cm x 2.6 cm, and left mid plantar foot blister 1.7 cm x 2.3 cm. Treatment orders were provided. Review of physician skin and wound note, dated 07/01/25, revealed the service was provided on 06/30/25. Resident #07 was readmitted back to the facility and presents with multiple nonthermal blisters to her feet. Review of wound assessment report, dated 07/09/25, revealed the right heel blister, right plantar foot blister, and left great toe blister all resolved. The left heel blister measured 1.0 cm x 1.9 cm and the left mid plantar foot blister measured 1.6 cm x 1.8 cm. Both were identified to be improving without complications. Review of the wound assessment report, dated 07/16/25, revealed the left mid planter foot blister measured 1.6 cm x 1.8 cm and the left heel blister measured 1.0 cm x 1.8 cm. The blisters were noted to be improving without complications. Review of the wound assessment report, dated 07/23/25, revealed the left mid plantar foot and left heel resolved. Review of the elopement incident, dated 06/27/25 at 12:30 A.M., revealed at approximately 12:30 A.M. LPN #246 was notified by CNA #247 that Resident #07 was not in her bed. A code brown was called immediately. Head count was completed, and the entire unit/facility was searched. The elopement protocol was initiated. Staff continued to search inside and outside the premises and surrounding neighborhood. Notification was made to management, the medical director, and the resident's guardian. Interview on 07/28/25 at 4:39 P.M. with Resident #07 revealed she had left the facility by foot and spent time in the downtown area (approximately five to six miles from the facility). Resident #07 stated she went out to smoke and was locked out of the building. Resident #07 claimed she knocked on the door but was unable to alert the staff. Resident #07 revealed she rode a city bus, and they had allowed her to ride for free. Resident #07 stated she received clothing, food, and water from a local church and had also found scissors and cut her hair. Someone had provided her a bag of coins and Resident #07 stated she bought a single cigarette, lighter, and a vape. Resident #07 stated she was not harmed or scared, but her feet hurt. Resident #07 stated she remembered her family members' phone number and called for a ride. Interview on 07/28/25 at 5:13 P.M. with Resident #07's family member stated Resident #07 had a history prior to admission to the facility of eloping and living in the downtown area for short periods at a time. The family member stated she had not had any elopement attempts and had been doing so well she received permission to take the resident out for her birthday the weekend of the elopement. Resident #07's family member stated Resident #07 has her phone number memorized and believes her feet began to hurt bad enough that she decided to call to return to the facility. The family member verified going to the facility to see the resident the day she returned and stated her feet were swollen and wrapped, but otherwise looked good. Interview on 07/29/25 at 6:12 A.M. with Certified Nursing Assistant (CNA) #233 verified on 06/26/25 slightly before 11:00 P.M. taking Resident #07 and three other residents out for the 11:00 P.M. resident supervised smoking time. CNA #223 verified supervising the residents the entire time during the smoking time and after all residents had one cigarette they went inside. CNA #233 verified the last time she saw Resident #07 was when they were coming inside from the smoke break at approximately 11:15 P.M. CNA #233 stated upon entering the facility she continued her routine duties. On 06/27/25 at approximately 12:30 A.M., an aide giving an orientation tour discovered Resident #07 was not in bed. CNA #233 stated she was sitting near Resident #07's door at the time and believed she was in bed. Interview on 07/29/25 at 6:32 A.M. with LPN #246 revealed on 06/26/25 she had worked from 11:00 P.M. to 7:00 A.M. Upon the beginning of the shift, she observed Resident #07 standing in the hall waiting to smoke. Resident #07 had asked her for a coat and LPN #246 had told the resident it was hot outside, and a coat would not be needed. Resident #07 was determined to (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wear coat, so she went to her room and obtained a coat. When Resident #07 went out to smoke she wore a pair of jeans, a nightgown, shoes, a coat, and a hat. When the residents were taken out to smoke by CNA #233 the nurse was completing medication count. LPN #246 stated she was notified at approximately 12:30 P.M. that Resident #07 was not in her room. LPN #246 stated she called a code brown (missing resident), and all facility staff began searching the inside and outside of the facility. The management staff were notified, and the Administrator, DON, and unit manager came in to search for the resident. Interview on 07/29/25 at 11:58 A.M. with the DON revealed on 06/26/25 sometime after 11:00 P.M. Resident #07 eloped, possibly on her way back into the building from the last smoking time. During the interview with CNA #233 she had stated she thought all the residents were in. The DON verified she was notified timely upon discovery and both she and the Administrator came in. The police were notified and came to the facility to take report. The facility had paid staff to work extra shifts for staff to drive around the area and into downtown as they suspected Resident #07 would be. On Sunday, 06/29/25 at approximately 3:45 P.M. Resident #07's family representative called to report Resident #07 had called her asking for a ride and provided the location that she was at in the downtown area. The DON and Administrator went to the location and picked up the resident. Resident #07 was observed to be in different clothing. Resident #07 reported she had received new clothing from the church and thrown away her clothes in addition to cutting her hair. The DON stated the resident reported she had not slept much because she was outside and excited. The resident could not state exactly where she had been other than to the church and baseball field and at times her story would change. Resident #07 was found to have a bag with two bottles of water. There were blisters to her feet and her skin was slightly pink but not red. The DON stated overall the resident was in good condition and did not need to go to the hospital. Review of policy, Resident Right to Freedom from Abuse, Neglect, and Exploitation policy and procedure, dated 2025, verified the facility's residents have the right to be free from abuse, neglect, and misappropriation of their property and exploitation as defined in the policy. The deficiency was corrected on 07/13/25 when the facility implemented the following corrective actions: On 06/27/25 at 12:30 A.M. Licensed Practical Nurse (LPN) #246 called a code brown (missing resident). On 06/27/25 at 12:30 A.M. facility staff searched the facility. On 06/27/25 at 12:35 A.M. facility staff searched the facility grounds. On 06/27/25 at 12:40 A.M. facility staff searched the surrounding community. On 06/27/25 at 1:06 A.M. the Administrator was notified. On 06/27/25 at approximately 2:00 A.M. the guardian, resident representative, and physician were notified. On 06/27/25 at 2:15 P.M. the local police were notified and took report. On 06/27/25 the Director of Nursing (DON) completed facility-wide elopement reassessments of all residents to identify the at-risk residents. The facility wide elopement reassessment identified 32 residents who are at risk for elopement. Beginning 06/27/25, identified residents were placed on safety checks. On 06/27/25, the elopement binder was updated with any resident identified as an elopement risk. On 06/27/25, the Medical Director was notified by the DON of the results of the assessments. On 06/27/25, the identified at-risk resident care plans were reviewed and revised by the DON/designee. On 06/27/25, the Administrator and DON reviewed the facility's policies related to elopement and supervision. The policy was determined to meet the standards of practice, and no revision was necessary. On 06/27/25, the Administrator and DON provided education to the nursing staff. The education provided was related to the policy with emphasis on redirecting wandering or exit seeking residents, to consult the residents care plan, and notify the DON/Administrator/Care Plan Nurse/Social Worker of any new worsening wandering or exit-seeking behaviors. The training included but was not limited to the staff's responsibility to provide adequate supervision to prevent elopement for a resident with a history of wandering, exit seeking, and assessed to be at risk for elopement. During smoking times, all staff were educated that a head count and environment check needed to be completed at each smoke assignment. On 06/27/25, the Administrator, DON, or designee provided the training identified above to all staff in the non-clinical departments. Any member of the staff who was not available at the time of the training (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, resident interview, and policy review, the facility failed to ensure a safe, clean, homelike environment. This affected 16 residents (#3, #4, #6, #13, #14, #16, #27, #28, #31, #35, #37, #56, #65, #58, #64, and #74) of 16 residents reviewed for a safe, clean, homelike environment. The facility census was 78. Review of Resident #28's medical chart revealed an admission date of 12/27/24. Diagnoses included paranoid schizophrenia, anxiety, hypertension, and insomnia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had severely impaired cognition. Further review of the MDS assessment revealed Resident #28 needed setup or clean-up assistance for personal hygiene. Review of Resident #28's care plan dated 07/01/25 revealed Resident #28's functional abilities were impaired as well as a self-care and mobility deficit. Furthermore Resident #28 required staff intervention to complete self-care and mobility activities. Observation on 07/28/25 at 10:54 A.M. of Resident #28's bathroom revealed the toilet in the shared bathroom contained urine, feces, and toilet paper that accumulated to the height of the toilet seat. Feces were noted to be on the back of the toilet seat in multiple areas. Urine and an adult brief were also noted to be on the bathroom floor. Furthermore, there was a small hole that was approximately four inches in width and height in the base of the door to the shared bathroom. Observation on 07/28/25 at 2:05 P.M. of Resident #28's bathroom revealed the toilet in the shared bathroom contained more feces, toilet paper, and urine. Resident #28's bedroom had a strong foul odor. Interview on 07/28/25 at 2:08 P.M. with Certified Nurse Assistant (CNA) #275 verified the feces, urine, and toilet paper in the toilet, the brief and urine on the bathroom floor, and the hole in the shared bathroom door. 2. Review of Resident #37's medical record revealed an admission date of 10/08/24. Diagnoses included generalized anxiety disorder, schizoaffective disorder, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had intact cognition. Observation on 07/30/25 at 8:32 A.M. of Resident #37's bedroom revealed a black substance on the windowsill. Furthermore, the wall was opened and the wood behind the wall was showing through. There was also a black substance on the exposed wood. Plaster was applied to the ceiling in an unsightly manner. Concurrent interview with Resident #37 revealed that the wall and windowsill bothered her as she thought it was unsightly. Interview on 07/30/25 at 8:35 A.M. with Housekeeper #222 verified the exposed wood with a black substance and the windowsill to have a black substance. She also verified the plaster to the ceiling to be unsightly. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Residents #31 and #4 are roommates. Review of the medical record revealed Resident #31 was admitted on [DATE]. Diagnoses included major depressive disorder severe with psychotic features, Parkinson's disease with dyskinesia, mixed hyperlipidemia, epilepsy, and bipolar disorder. Review of the MDS assessment, dated 05/23/25, revealed the resident was moderately cognitively impaired. Review of the medical record revealed Resident #4 was admitted on [DATE]. Diagnoses included other specified intracranial injury without loss of consciousness, chronic obstructive pulmonary disease, hypoxic ischemic encephalopathy, dysphagia, muscle weakness, unspecified dementia, and other schizoaffective disorder. Review of the MDS assessment, dated 05/30/25, revealed the resident was moderately cognitively impaired. Observation on 07/28/25 at 2:36 P.M. of Resident #4 laying in bed and the room felt warm in temperature. The air conditioner unit in the room was above the resident's bed and the cord was observed to be unplugged. Interview on 07/28/25 at 2:38 P.M. with the Administrator verified the air conditioner unit electrical cord was unplugged and did not appear to be long enough to plug into the wall. Upon taking temperature of the room the room tempted at 81.1 degrees Fahrenheit. The Administrator verified the temperature of the room. 4. Review of the medical record revealed Resident #6 was admitted on [DATE]. Diagnoses included unspecified dementia, cognitive communication deficit, chronic obstructive pulmonary disease, schizoaffective disorder, and major depressive disorder recurrent. Review of the MDS assessment, dated 08/16/18, revealed the resident was severely cognitively impaired. Observation on 07/28/25 at 2:40 P.M. of Resident #6's room revealed the temperature was 81.9 degrees Fahrenheit. Subsequent interview with Resident #6 verified his room is always hot. Interview on 07/28/25 at 2:41 P.M. with the Administrator verified Resident #6's room temperature. 5. Resident #14 and #56 are roommates. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included paranoid schizophrenia, chronic obstructive pulmonary disease, and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 07/12/25, revealed Resident #14 was severely cognitively impaired. Review of the medical record revealed Resident #56 was admitted on [DATE]. Diagnoses included metabolic encephalopathy, chronic obstructive pulmonary disease, type two diabetes mellitus without (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and concurrent interview on 07/28/25 at 5:07 P.M. with the Director of Nursing verified the bathroom between rooms numbered 31 and 32, shared by four residents contained brown splatters on the front rim of the toilet bowl and rust at the bottom of both door frames extending from the floor up approximately 12 inches. Additionally, there was a missing section of door frame with a jagged rusted metal edge at floor level, approximately two inches by four inches, leading to room [ROOM NUMBER]. Review of facility policy dated February 2021 and titled "Homelike Environment" revealed the facility would maintain a safe, comfortable, sanitary, and homelike environment for residents. This includes comfortable and safe temperatures (71 degrees Fahrenheit to 81 degrees Fahrenheit). This deficiency represents non-compliance investigated under Complaint Number 2570409.		

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure residents could reach their call lights. This affected three residents (#51, #69, and #70) of three residents reviewed for call lights. The facility census was 78. 1. Review of Resident #51's medical record revealed an admission date of 01/21/21. Diagnoses included borderline personality disorder, major depressive disorder, bipolar disorder, and insomnia. Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition. Observation on 07/28/25 at 9:52 A.M. of Resident #51's call light revealed the call light to be tangled underneath Resident #51's bed which was out of reach for Resident #51. Interview on 07/28/25 at 9:59 A.M. with Licensed Practical Nurse (LPN) #239 verified the call light was tangled under the resident's bed. 2. Review of Resident #69's medical record revealed an admission date of 03/14/25. Diagnoses included schizophrenia, asthma, and major depressive disorder. Review of Resident #69's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69's cognition was moderately impaired. Observation on 07/30/25 at 7:50 A.M. of Resident #69's call light revealed it was underneath Resident #69's bed which was out of reach for Resident #69. Concurrent interview with Certified Nurse Assistant (CNA) #263 verified the call light to be underneath of Resident #69's bed and out of reach for Resident #69. 3. Review of Resident #70's medical record revealed an admission date of 04/01/22. Diagnoses included schizophrenia, major depressive disorder, and chronic obstructive pulmonary disease (COPD). Review of Resident #70's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had moderately impaired cognition. Observation on 07/30/25 at 7:50 A.M. of Resident #70's call light revealed it was underneath Resident #70's bed which was out of reach for Resident #70. Concurrent interview with Certified Nurse Assistant (CNA) #263 verified the call light to be underneath of Resident #69's bed and out of the resident's reach. Review of the facility policy titled Call System, Residents with a last revision date of September 2022 revealed each resident is provided with a means to call staff directly for assistance from his/her bed or from the bathing/toileting facilities.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of self-reported incidents (SRI), staff interview, and review of facility policy the facility failed to report incidents of resident elopement. This affected two (#7 and #13) of two residents reviewed for actual elopements. The facility census was 78. 1. Review of the medical record revealed Resident #7 was admitted on [DATE]. Diagnoses included schizoaffective disorder bipolar type, major depressive disorder recurrent, post-traumatic stress disorder, schizoaffective disorder, obsessive compulsive disorder, kleptomania, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, 05/11/25, revealed the resident was moderately cognitively impaired. Review of nursing progress note, dated 06/27/25 at 12:30 A.M., revealed at approximately 12:30 A.M. staff notified the writer Resident #07 was not in her bed. A code brown was immediately called and head count completed. The staff searched the entire unit and facility. The elopement protocol was initiated. Staff continued to search inside and outside the premises and the surrounding neighborhood. Management, power of attorney, and physician were notified. Resident #07 returned to the facility on [DATE] at 4:35 P.M. after being picked up by facility staff in the downtown area (approximately five to six miles away) after being notified by family of Resident #07's location. 2. Review of the medical record revealed Resident #13 was admitted on [DATE] with re-entry on 11/25/24. Diagnoses included schizoaffective disorder depressive type, delusional disorders, mood disorder due to known physiological condition, chronic kidney disease stage 3, auditory hallucinations, essential hypertension, type two diabetes mellitus without complications, schizophrenia, chronic obstructive pulmonary disease, and unspecified systolic heart failure. Review of the Minimum Data Set (MDS) assessment, dated 06/04/25, revealed the resident was cognitively intact. The influenza vaccine was documented as offered and declined. Review of the nursing progress notes, dated 05/28/25 at 9:43 A.M., revealed during the morning change of shift staff noted during rounds Resident #13 was not in her room. A code brown was called and a facility search occurred. Resident #13 was found to be outside in front of the building attempting to cross the street. Review of self-reported incidents dated since 05/28/25 revealed no alleged neglect incidents had been reported for either resident elopement. Interview on 07/29/25 at 11:01 A.M. with the Administrator verified no Self-Reported Incident was completed for resident elopements. Review of policy, Resident Right to Freedom from Abuse, Neglect, and Exploitation policy and procedure, dated 2025, verified the facility's residents have the right to be free from abuse, neglect, and misappropriation of their property and exploitation as defined in the policy. The facility will ensure alleged violations of neglect are reported in the proper time frame pursuant to the policy.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to obtain Preadmission Screening and Resident Review (PASARR) results for Resident #06. Furthermore, the facility failed to obtain a level two PASARR as indicated for Resident #21. This affected two residents (#06 and #21) of two residents reviewed for PASARR. The facility census was 78. 1. Review of Resident #06's medical record revealed an admission date of 01/14/25. Diagnoses included dementia, cognitive communication deficit, schizoaffective disorder, chronic viral hepatitis C, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #06 had severe cognitive impairment. Review of Resident #06's medical record revealed the results from the Preadmission Screening and Resident Review (PASARR) were not present in the chart. Interview on 07/30/25 at 9:48 A.M. with Human Resources (HR) #228 verified the results from the PASARR were not present in the medical chart. 2. Review of Resident #21's medical record revealed an admission date of 01/16/23. Diagnoses included bipolar disorder, depression, schizoaffective disorder, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed Resident #21 had intact cognition. Review of Resident #21's medical record revealed Resident #21 required a level two PASARR to be completed. Interview on 07/30/25 at 9:48 A.M. with Human Resources (HR) #228 verified the level two PASARR was not completed for Resident #21. Review of the undated facility policy titled Resident Assessment Policy and Procedure revealed residents with an intellectual disability should have a PASARR completed to determine the level of services needed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident interview, staff interview, and policy review, the facility failed to provide the necessary services related to grooming and personal hygiene. This affected one resident (#28) of two residents reviewed for grooming and personal hygiene. The facility census was 78. Review of Resident #28's medical record revealed an admission date of 12/27/24. Diagnoses included paranoid schizophrenia, anxiety, hypertension, and insomnia. Review of the quarterly Minimum Data Sat (MDS) assessment dated [DATE] revealed Resident #28 had severely impaired cognition. Further review of the MDS assessment revealed Resident #28 needed setup or clean-up assistance for personal hygiene. Review of Resident #28's care plan dated 07/01/25 revealed Resident #28's functional abilities were impaired as well as a self-care and mobility deficit. Furthermore Resident #28 required staff intervention to complete self-care and mobility activities. Observation on 07/28/25 at 10:52 A.M. revealed Resident #28 had a large amount of hair on her chin. Concurrent interview with Resident #28 revealed it bothered her to have facial hair. Resident #28 stated a staff person who she could not identify told her they would shave her face today if they had time. Observation on 07/28/25 at 2:05 P.M. revealed Resident #28's facial hair remained unshaven. Interview on 07/28/25 at 2:08 P.M. with Certified Nurse Aide (CNA) #275 verified Resident #28 had a large amount of hair on her chin and stated she would shave it. Review of the facility policy titled Activities of Daily Living (ADL), Supporting with a last revision date of March 2018 revealed appropriate care and services will be provided for residents who are unable to carry out ADLs independently which included grooming and personal hygiene.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident interviews, and review of facility policy, the facility failed to ensure residents received services and equipment to adequately maintain vision. This affected two (Resident #09 and Resident #62) of two residents reviewed for vision. The facility census was 78. 1. Review of the medical record for Resident #62 revealed an admission date of 07/02/20. Diagnoses included glaucoma, alcohol-induced dementia, altered mental status, and major depressive disorder. Interview on 07/28/25 at 9:35 A.M. with Resident #62 revealed he had two pairs of glasses that were both broken. Concurrent observation revealed one pair of silver glasses had a missing temple arm on the left side and were ill-fitting due to being bent at the right temple arm. A second pair of black glasses was missing the left lens. Interview on 07/31/25 at 12:25 P.M. with the Director of Nursing confirmed there was no documentation available to confirm Resident #62 had seen an eye doctor. Continued interview revealed Resident #62 was not on the patient list as being seen at the last facility visit made by the eye doctor. The Director of Nursing declined to provide a copy of the patient list stating this was a directive from corporate. Interview on 07/31/25 at 2:15 P.M. with the Director of Nursing confirmed Resident #62 had two pairs of glasses that were broken. 2. Review of the medical record revealed Resident #09 was admitted on [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, muscle weakness, unspecified psychosis, essential hypertension, type two diabetes mellitus without complications, and muscle wasting and atrophy. Review of the MDS assessment, dated 06/23/25, revealed the resident was cognitively intact. Review of optical services documentation, dated 04/25/19, revealed Resident #09 received glasses. Interview on 07/28/25 at 10:57 A.M. with Resident #09 revealed he had previously had glasses but does not have them anymore. Resident #09 stated he needs glasses. Interview on 07/31/25 at 11:32 A.M. with Licensed Practical Nurse (LPN) #239 and Certified Nursing Assistant (CNA) #263 verified familiarity with Resident #09 and stated they have not seen him with glasses. Interview on 07/31/25 at 12:35 P.M. with the DON verified Resident #09 was not on the list to see the optometrist and did not see them at the last visit to the facility approximately six months ago. Review of policy, Hearing and Vision Services, dated 2025, verified all residents shall have access to hearing and vision services and receive adaptive equipment as indicated.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to administer oxygen per physician orders. This affected one resident (#37) of one resident reviewed for oxygen administration. The facility census was 78. Review of Resident #37's medical record revealed an admission date of 10/08/24. Diagnoses included chronic obstructive pulmonary disease, anemia in chronic kidney disease, and dependence on supplemental oxygen. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had intact cognition. Review of Resident #37's physician's orders revealed an order for oxygen at two to three liters per minute via nasal cannula as needed for shortness of breath. Observation on 07/28/25 at 11:25 A.M. of Resident #37's oxygen concentrator revealed her oxygen to be running at four liters per minute via nasal cannula. Observation on 07/28/25 at 3:17 P.M. of Resident #37's oxygen concentrator revealed her oxygen to be running at four liters per minute via nasal cannula. Interview on 07/28/25 at 3:22 P.M. with Licensed Practical Nurse (LPN) #276 verified Resident #37's oxygen concentrator was running at four liters per minute via nasal cannula and the physician order is for three liters per minute via nasal cannula. Review of the undated facility policy titled Oxygen Safety revealed Licensed staff using oxygen will be trained upon hire regarding usage requirements.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on medical record review, staff interview, and review of facility policy the facility failed to obtain laboratory testing as ordered. This affected one (Resident #62) of one resident reviewed for laboratory testing. The facility census was 78. Review of the medical record for Resident #62 revealed an admission date of 07/02/20. Diagnoses included glaucoma, alcohol-induced dementia, altered mental status, and major depressive disorder. Continued review of this medical record revealed provider orders dated 05/08/25 for laboratory testing in January and June. Interview on 07/31/25 at 12:00 P.M. with [NAME] President of Clinical Services #301 confirmed Resident #62 had provider orders for laboratory testing to be completed in June and the testing had not been processed. Review of facility policy dated November 2018 titled Lab and Diagnostic Test Results - Clinical Protocol revealed staff would arrange for ordered laboratory testing.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and review of facility policy the facility failed to ensure residents had access to dental services. This affected one (#09) of two residents reviewed for dental services. The facility census was 78. Review of the medical record revealed Resident #09 was admitted on [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, muscle weakness, unspecified psychosis, essential hypertension, type two diabetes mellitus without complications, and muscle wasting and atrophy. Review of the Minimum Data Set (MDS) assessment, dated 06/23/25, revealed the resident was cognitively intact. Review of care plan, revised on 03/22/21, revealed Resident #09 has some/all missing natural teeth due to poor dental hygiene. The Resident wears upper and lower dentures. Interventions included to coordinate arrangements for dental care, transportation as needed and as ordered. Interview on 07/28/25 at 10:55 A.M. with Resident #09 revealed all of his teeth were missing and he would like to have dentures. Observation on 07/28/25 at 10:56 A.M. revealed Resident #09 opened his mouth to show that he had no teeth. Interview on 07/31/25 at 12:35 P.M. with the Director of Nursing (DON) verified Resident #09 had not seen the dentist and was not on the list to see the dentist. Review of policy, Dental Services, dated 2025, verified the facility shall assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review, resident interview, staff interviews, and review of facility policy, the facility failed to accurately document in the medical record. This affected one (Resident #03) of one resident reviewed for accuracy of documentation. The facility census was 78. Review of the medical record for Resident #03 revealed an admission date of 06/03/25, diagnoses included hemiplegia and hemiparesis affecting the left side following cerebral infarction (stroke), depression, anxiety, heart disease, and bone density disorders. Further review of the medical record for Resident #03 revealed progress notes dated 06/03/25, 06/04/25, 06/06/25, 06/08/25, and 06/27/25 indicating Resident #03 participated in physical therapy. Review of provider orders for Resident #03 revealed there were no orders for physical therapy on admission, nor had physical therapy orders been initiated since admission. Interview on 07/28/25 at 10:00 A.M. with Resident #03 revealed she was not receiving physical therapy services. Interview on 07/30/25 at 10:35 A.M. with Physical Therapist #300 revealed Resident #03 had not received physical therapy. Interview on 07/30/25 at approximately 3:00 P.M. with [NAME] President of Clinical Services #301 confirmed the progress notes for Resident #03 dated 06/03/25, 06/04/25, 06/06/25, 06/08/25, and 06/27/25 indicated the resident participated in physical therapy. Continued interview confirmed Resident #03 did not have orders for physical therapy on admission, nor had physical therapy orders been initiated since admission. Review of facility policy dated July 2017 titled Charting and Documentation indicated documentation in the medical record would be accurate.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, resident interview, review of the admission packet and review of facility policy the facility failed to offer influenza vaccines as required. This affected one (#13) of five residents reviewed for influenza vaccinations. The facility census was 78. Review of the medical record revealed Resident #13 was admitted on [DATE] with re-entry on 11/25/24. Diagnoses included schizoaffective disorder depressive type, delusional disorders, mood disorder due to known physiological condition, chronic kidney disease stage 3, auditory hallucinations, essential hypertension, type two diabetes mellitus without complications, schizophrenia, chronic obstructive pulmonary disease, and unspecified systolic heart failure. Review of the Minimum Data Set (MDS) assessment, dated 06/04/25, revealed the resident was cognitively intact. The influenza vaccine was documented as offered and declined. Review of immunization documentation, dated 10/14/24, revealed the influenza vaccine was marked as refused. Review of Resident #13 census documentation revealed the resident was out to the hospital from [DATE] to 11/25/24. Review of Informed Consent for Influenza Vaccine, no date, revealed Resident #13 provided consent for the facility to administer the influenza vaccine. Review of Informed Consent for Influenza Vaccine, 11/26/23, revealed Resident #13 provided consent for the facility to administer the influenza vaccine. Interview on 07/31/25 at 8:35 A.M. with Assistant Director of Nursing (ADON) #226 revealed Resident #13 was manic at the time the influenza vaccine was offered in the fall and did not receive the vaccine. The ADON #226 verified there is no evidence it was offered again after readmission. Interview on 07/31/25 at 8:55 A.M. with Resident #13 revealed she would want the annual influenza vaccine. Review of the Resident admission Packet, dated, revealed the informed consent for influenza vaccine was included. The informed consent stated the resident is being offered the influenza vaccine because it is recommended by the Advisory Committee on Immunization Practices for your age group to prevent influenza. Vaccine Information Statement for influenza vaccine was also included. Review of the policy, Influenza Vaccine, dated March 2022, verified all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.		