STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365339	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Terrace Rehabilitation Center	2735 Darlington Rd Toledo, OH 43606

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44815 Based on review of a self-reported incident (SRI), review of staff timecards, review of staff employment status documentation, staff interview, and review of a facility policy, the facility failed to ensure an allegation of verbal abuse was thoroughly investigated. This affected one (#22) of three residents reviewed for allegations of abuse. The census was 89. Findings include: Review of an SRI created 03/06/25 at 6:25 P.M. revealed an allegation of verbal abuse by Resident #22 against Certified Nurse Aide (CNA) #365 was submitted to the State Survey Agency through the Enhanced Information Dissemination Collection (EIDC) system . Further review of the SRI revealed the Administrator suspended CNA #365 and was asked to leave the building immediately. The SRI further revealed another unnamed resident had similar concerns a few weeks earlier, and while the facility did not feel the actions were verbal abuse, CNA #365 was terminated from employment due to violating the resident care policy. There were no attachments to the SRI in the EIDC system. Interview on 04/07/25 at approximately 2:00 P.M. with the Administrator confirmed he initiated and completed the investigation of abuse for the SRI dated 03/06/25. Further, the Administrator stated he could provide no evidence of an investigation into the allegation of abuse. The Administrator stated CNA #365 was suspended at the time of the allegation and her employment was subsequently terminated. The Administrator confirmed he could not provide any statements from residents or staff, any assessment of Resident #22 or of similar residents, and could not provide any evidence of staff education regarding identifying and reporting abuse. Review of the timecards for CNA #365 revealed she clocked out on 03/06/25 at 12:18 P.M. and did not return to the facility through 03/13/25. Review of the employment status for CNA #365 revealed her last day worked was 03/06/25 and her termination date was 03/12/25. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Abuse, Neglect and Exploitation, copyright 2025, revealed an immediate investigation was warranted when suspicion of abuse occurs. Procedures included identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations. Further, the policy indicated the facility would make all efforts to ensure all residents were protected from physical and psychosocial harm, including examining the alleged victim for any sign of injury, including a psychosocial assessment if needed. Additionally, the facility would provide complete and thorough documentation of the investigation. This deficiency represents an incidental finding discovered during the complaint investigations completed 04/11/25.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a resident residing on a secured behavioral unit met the criteria for admission to the secured unit. This affected one (#90) of three residents reviewed for placement on the secured unit. The facility identified 22 residents as residing on the secured unit. The facility census was 89. Findings include: Review of the closed medical record for Resident #90 revealed an admitted [DATE], a readmitted [DATE], and a discharge date of [DATE]. Diagnoses included subdural hemorrhage, intracranial injury, hypotension, generalized anxiety disorder, and difficulty walking. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had impaired cognition. Review of the plan of care revised 03/18/25 revealed Resident #90 was at risk for elopement and wandering related to impaired safety awareness, traumatic brain injury, and impaired cognition. The resident resided on a secure unit for safety. Interventions included distracting the resident from wandering by offering pleasant diversions and structured activities. Review of the physician orders for March 2025 revealed there were no physician orders for the resident to reside on a secured unit. Further review of the medical record revealed the resident had not signed consent to reside on the secured unit. The resident had not been declared incompetent. The resident had no power of attorney or guardian. Interview on 04/07/25 at 9:23 A.M., Registered Nurse Clinical Consultant (RNCC) #302 revealed Resident #90 had not signed a consent form to reside in the secure behavioral unit and had no physician order to reside in the secure behavioral unit. RNCC #302 also verified the resident had no power of attorney or guardian and had not been deemed incompetent. RNCC #302 revealed the resident had a mental health diagnosis. Review of the undated facility policy Admission Criteria, revealed the facility would admit only those residents who's medical and nursing care needs could be met. The facility would provide notice to residents and potential resident any service limitation or special characteristics of the facility. The acceptance of residents with certain conditions or needs may require authorization or approval by the Medical Director, Director of Nursing, and/or the Administrator. Residents admitted to the secure behavioral unit would meet additional criteria to ensure nursing and medical needs would be adequate in the unit. The additional requirements included a current mental health diagnosis, psychosocial, and/or behavioral disturbance, deemed incompetent by a physician, and have a current/active power of attorney or guardian. This deficiency represents an incidental finding discovered during the complaint investigations completed 04/11/25.

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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** 44815 Based on resident interview, medical record review, review of shower schedules, review of shower documents, staff interview, and review of the facility policy, the facility failed to ensure showers were provided to residents who required assistance with showers. This affected three (#9, #34, and #88) of three residents reviewed for showers. The facility census was 89. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses of dependence on renal hemodialysis and tracheostomy status. Resident #9 discharged to an acute-care hospital on 04/02/25. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/20/25, revealed Resident #9 had intact cognition and was dependent on staff for showers. Review of the shower schedule revealed Resident #9 was scheduled for showers on Wednesdays and Saturdays during second shift. Review of the shower sheets for March 2025 and April 2025 revealed Resident #9 received a shower on 03/05/25, a bath on 03/16/25, and a shower on 03/26/25. Interview on 04/03/25 at approximately 3:45 P.M. with Assistant Director of Nursing (ADON) #208 confirmed Resident #9 received three showers or baths since 03/01/25. Further interview with ADON #208 revealed staff should complete a shower sheet every time a shower was offered and staff would document if the resident refused a shower when offered. Follow-up interview on 04/08/25 at 12:04 P.M. with ADON #208 confirmed no additional shower sheets were completed for Resident #9. 2. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of tracheostomy status and end stage renal disease. Review of the modified comprehensive admission MDS assessment, dated 03/18/25, revealed Resident #34 had intact cognition and required partial/moderate assistance for showers. Review of the shower schedule revealed Resident #34 was scheduled for showers on Wednesdays and Saturdays on first shift. Review of the shower sheets for March 2025 and April 2025 revealed Resident #34 received a bath on 03/17/25, a shower on 03/29/25, and a shower on 04/05/25. Interview on 04/03/25 at 11:07 A.M. with Resident #34 revealed she was admitted to the facility on [DATE] and the first time she was washed up was 03/29/25. Resident #34 stated she would prefer a shower to being cleaned up in bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/03/25 at approximately 3:45 P.M. with ADON #208 confirmed staff should complete a shower sheet every time a shower was offered and staff would document if the resident refused a shower when offered. Interview on 04/08/25 at 12:04 P.M. with ADON #208 confirmed the documentation revealed Resident #34 received three baths or showers since admission on 03/07/25. Further, ADON #208 confirmed no additional shower sheets were completed for Resident #34. 3. Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses of congestive heart failure, dependence on renal dialysis, and unsteadiness on feet. Review of the quarterly MDS assessment dated [DATE] revealed Resident #88 had intact cognition and required partial/moderate assistance for showers. Review of the shower schedule revealed Resident #88 was scheduled for showers on Wednesdays and Saturdays on second shift. Review of the shower sheets for March 2025 and April 2025 revealed Resident #88 received a shower on 03/12/25 and a shower on 03/20/25. Interview on 04/03/25 at 7:52 A.M. with Resident #88 revealed he wished he could get more showers. Resident #88 stated staff told him they were too busy to give him a shower, and he could not remember the last time he got a shower. Resident #88 stated he cleaned himself up in the sink and shaved his own beard. Interview on 04/03/25 at approximately 3:45 P.M. with ADON #208 confirmed staff should complete a shower sheet every time a shower was offered and staff would document if the resident refused a shower when offered. Interview on 04/08/25 at 12:04 P.M. with ADON #208 confirmed the documentation revealed Resident #88 received two showers since 03/01/25 and confirmed no additional shower sheets were completed for Resident #88. Review of the policy titled, Resident Showers, copyright 2024, revealed residents would be provided showers as per request or as per facility schedule protocols. This deficiency represents non-compliance investigated under Complaint Number OH00164263.

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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** 44815 Based on medical record review, staff schedules, resident and staff interviews, and policy review, the facility failed to ensure residents on a mechanical ventilator received adequate care to decrease their need for ventilator dependence (wean from the ventilator). This affected one (#34) resident identified to require mechanical ventilation. The facility census was 89. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of acute respiratory failure and tracheostomy status. Review of the modified comprehensive admission Minimum Data Set (MDS) assessment, dated 03/18/25, revealed Resident #34 had intact cognition, had a tracheostomy, and used an invasive mechanical ventilator. Review of the current physician order initiated 03/26/25 revealed Resident #34 should be weaned from the ventilator at night in two-hour increments with close supervision by respiratory therapy. Interview on 04/03/25 at 11:07 A.M. with Resident #34 revealed she was not aware whether she was making progress with weaning from the ventilator. Interview on 04/07/25 at 1:01 P.M. with Respiratory Therapist (RT) #352 confirmed Resident #34 used the ventilator at night. RT #352 stated the Respiratory Nurse Practitioner recently added an order for Resident #34 to be weaned from the ventilator at night. RT #352 stated there was not enough respiratory therapy staff to work every night and the floor nurses in the facility were not trained to wean residents from a ventilator. RT #352 stated Resident #34 was not making progress at being weaned from the ventilator because the facility did not have a respiratory therapist at night. Interview on 04/07/25 at 1:51 P.M. with Registered Nurse Clinical Consultant (RNCC) #302 confirmed the facility nurses would not be able to provide appropriate care to wean Resident #34 from the ventilator. Interview on 04/08/25 at approximately 10:00 A.M. with RNCC #302 and concurrent review of the respiratory therapy staff schedules for March and April 2025 confirmed no RT staff were scheduled the nights of 03/26/25, 03/29/25, and 04/03/25. Review of the policy titled, Mechanical Ventilation, copyright 2024, revealed appropriate staff will be trained and maintain competency in the use of mechanical ventilation. This deficiency represents non-compliance investigated under Complaint Number OH00163578, and continued non-compliance from the annual and complaint surveys completed 03/20/25.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on medical record review, resident and staff interview, review of staff schedules, review of dialysis schedules, review of resident treatment tracker information, review of staff postings, review of shower schedules and shower sheets, review of the Facility Assessment, and policy review, the facility failed to ensure adequate staffing to meet the needs of the residents. This had the potential to affect all 89 residents in the facility. The facility census was 89. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE] with a readmitted [DATE]. Diagnoses included of end stage renal disease and dependence on renal dialysis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/14/25, revealed Resident #4 was rarely/never understood and received dialysis. Review of the current physician order dated 03/15/25 revealed Resident #4 received in-house hemodialysis on Mondays, Tuesdays, Wednesdays, and Fridays. Review of the medical record for Resident #6 revealed an admitted [DATE] with a diagnosis of end stage renal disease. Review of the quarterly MDS assessment, dated 02/17/25, revealed Resident #6 had intact cognition and received dialysis. Review of the current physician order dated 10/15/24 revealed Resident #6 received in-house hemodialysis on Mondays, Tuesdays, Thursdays, and Fridays. Review of the medical record for Resident #21 revealed an admitted [DATE] with a diagnosis of chronic kidney disease, stage five. Review of the quarterly MDS assessment dated [DATE] revealed Resident #21 had intact cognition and received dialysis. Review of the current physician order initiated 03/05/25 revealed Resident #21 received dialysis on Mondays, Tuesdays, Thursdays, and Fridays in the facility. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses of end stage renal disease and dependence on renal dialysis. Review of the comprehensive admission MDS assessment dated [DATE] revealed Resident #50 had intact cognition and received dialysis. Review of the physician order dated 03/21/25 revealed Resident #50 received dialysis on-site on Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the medical record for Resident #83 revealed an admitted [DATE] with diagnoses of hypotension and dependence on renal dialysis. Review of the quarterly MDS assessment, dated 02/15/25, revealed Resident #83 had intact cognition and was dependent on staff for transfers and mobility. Review of the physician order dated 03/10/25 revealed Resident #83 received dialysis on-site on Mondays, Tuesdays, Thursdays, and Fridays. Review of the posted dialysis schedule revealed Resident #4 was scheduled at 8:45 A.M., Resident #6 was scheduled at 9:00 A.M., Resident #21 was scheduled at 8:30 A.M., Resident #50 was scheduled at 12:30 p. m., Resident #68 was scheduled at 8:30 A.M., and Resident #83 was scheduled at 8:00 A.M. Review of the Patient Treatment Arrival/Departure Tracker, dated 03/24/25, revealed Resident #21 arrived three hours and five minutes late for her treatment; Resident #36 arrived one hour and ten minutes late for his treatment, and Resident #50 arrived one hour and nine minutes late for her treatment. Review of the Patient Treatment Arrival/Departure Tracker, dated 03/25/25, revealed Resident #21 was two hours and 38 minutes late for her treatment, Resident #36 was two hours and eight minutes late for his treatment, and Resident #83 was one hour and two minutes late for his treatment. Review of the Patient Treatment Arrival/Departure Tracker, dated 03/27/25, revealed Resident #21 was two hours and 45 minutes late for her treatment, and Resident #36 was two hours and eight minutes late for his treatment. Review of the Patient Treatment Arrival/Departure Tracker, dated 03/28/25, revealed Resident #6 was one hour and 55 minutes late for his treatment, and Resident #21 was one hour and 22 minutes late for her treatment. Interview on 04/02/25 at 9:56 A.M. with Dialysis Center Registered Nurse (DCRN) #364 revealed four residents were very late to dialysis on 03/25/25; including Resident #4, Resident #21, Resident #68, and Resident #83. DCRN #364 stated residents were usually late to dialysis because of staff, and stated he felt the facility was understaffed. DCRN #364 stated the residents who arrive late receive their full treatments, and the dialysis staff would stay late to ensure treatments were completed. Further interview, and review of the Patient Treatment Arrival/Departure Tracker forms dated 03/24/25 through 03/28/25, confirmed the accuracy of late resident arrival times. Interview on 04/02/25 at approximately 10:05 A.M. with Dialysis Center Technician (DCT) #370 confirmed no residents were receiving treatment during the time of the interview, though four (Resident #4, Resident #9, Resident #34, and Resident #50) residents were scheduled at 8:45 A.M. DCT #370 stated two residents refused, one resident was in the hospital, and Resident #4 was still in bed and not dressed. Observation and interview on 04/02/25 at 10:08 A.M. with Resident #4 revealed he was in bed and not dressed. Resident #4 stated he was often late to dialysis. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/02/25 at 10:10 A.M. with Assistant Director of Nursing (ADON) #208 stated Resident #4 was not at dialysis yet because staff was running behind. Interview on 04/02/25 at 10:51 A.M. with Resident #83 revealed he was late to dialysis three times in March 2025. Resident #83 stated the staff did not arrive to get him up and take him to dialysis. Resident #83 stated he felt the facility was always short-staffed which caused him to be late getting to dialysis. Interview on 04/02/25 at 12:10 P.M. with Certified Nurse Aide (CNA) #122 stated normally the dialysis staff would let her know what time residents needed to be at dialysis. CNA #122 stated she did not look at the posted dialysis times at the nurses station. Interview on 04/07/25 at 2:30 P.M. with Resident #68 revealed he was late to dialysis some days and stated it was his own choice to remain in bed. Review of the daily posted staffing information revealed 18 CNAs worked on 03/24/25, 19 CNAs worked on 03/25/25, 18 CNAs worked on 03/27/25, and 17 CNAs worked on 03/28/25. Review of the Facility Assessment Tool, updated 07/17/24, revealed the average facility census was 86 and the facility required 28 CNAs daily to meet residents' needs. Interview on 04/07/25 at 3:40 P.M. with Registered Nurse Clinical Consultant (RNCC) #302 confirmed the current Facility Assessment indicated 28 CNAs were required daily, working eight hour shifts, to meet the needs of the residents. Further interview, with review of the posted staffing information, confirmed less than 28 CNAs worked the days during which at least two residents were late for dialysis. 2. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses of dependence on renal hemodialysis and tracheostomy status. Resident #9 discharged to an acute-care hospital on 04/02/25. Review of the quarterly MDS assessment, dated 03/20/25, revealed Resident #9 had intact cognition and was dependent on staff for showers. Review of the shower schedule revealed Resident #9 was scheduled for showers on Wednesdays and Saturdays during second shift. Review of the shower sheets for March 2025 and April 2025 revealed Resident #9 received a shower on 03/05/25, a bath on 03/16/25, and a shower on 03/26/25. Interview on 04/03/25 at approximately 3:45 P.M. with Assistant Director of Nursing (ADON) #208 confirmed Resident #9 received three showers or baths since 03/01/25. Further interview with ADON #208 revealed staff should complete a shower sheet every time a shower was offered and staff would document if the resident refused a shower when offered. Follow-up interview on 04/08/25 at 12:04 P.M. with ADON #208 confirmed no additional shower sheets were completed for Resident #9. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of tracheostomy status and end stage renal disease. Review of the modified comprehensive admission MDS assessment, dated 03/18/25, revealed Resident #34 had intact cognition and required partial/moderate assistance for showers. Review of the shower schedule revealed Resident #34 was scheduled for showers on Wednesdays and Saturdays on first shift. Review of the shower sheets for March 2025 and April 2025 revealed Resident #34 received a bath on 03/17/25, a shower on 03/29/25, and a shower on 04/05/25. Interview on 04/08/25 at 12:04 P.M. with ADON #208 confirmed the documentation revealed Resident #34 received three baths or showers since admission on 03/07/25. Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses of congestive heart failure, dependence on renal dialysis, and unsteadiness on feet. Review of the quarterly MDS assessment dated [DATE] revealed Resident #88 had intact cognition and required partial/moderate assistance for showers. Review of the shower schedule revealed Resident #88 was scheduled for showers on Wednesdays and Saturdays on second shift. Review of the shower sheets for March 2025 and April 2025 revealed Resident #88 received a shower on 03/12/25 and a shower on 03/20/25. Interview on 04/08/25 at 12:04 P.M. with ADON #208 confirmed the documentation revealed Resident #88 received two showers since 03/01/25 and confirmed no additional shower sheets were completed for Resident #88. Interview on 04/08/25 at 8:18 A.M. with Licensed Practical Nurse (LPN) #242 confirmed there were times showers did not get completed because of inadequate staffing. Interview on 04/08/25 at 9:22 A.M. with CNA #380 revealed staffing occasionally caused difficulty with getting showers completed. Review of the posted staffing information for Wednesdays and Saturdays from 03/05/25 through 03/29/25 revealed 26 CNAs worked on 03/05/25, 22 CNAs worked on 03/08/25, 24 CNAs worked on 03/12/25, 20 CNAs worked on 03/15/25, 18 CNAs worked on 03/19/25, 18 CNAs worked on 03/22/25, 18 CNAs worked on 03/26/25, and 18 CNAs worked on 03/29/25. 3. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of acute respiratory failure and tracheostomy status. Review of the modified comprehensive admission MDS assessment, dated 03/18/25, revealed Resident #34 had intact cognition, had a tracheostomy, and used an invasive mechanical ventilator. Review of the current physician order initiated 03/26/25 revealed Resident #34 should be weaned from the ventilator at night in two-hour increments with close supervision by respiratory therapy. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/07/25 at 1:01 P.M. with Respiratory Therapist (RT) #352 confirmed Resident #34 used the ventilator at night. RT #352 stated the Respiratory Nurse Practitioner recently added an order for Resident #34 to be weaned from the ventilator at night. RT #352 stated there was not enough respiratory therapy staff to work every night and the floor nurses in the facility were not trained to wean residents from a ventilator. RT #352 stated Resident #34 was not making progress at being weaned from the ventilator because the facility did not have a respiratory therapist at night. Interview on 04/07/25 at 1:51 P.M. with Registered Nurse Clinical Consultant (RNCC) #302 confirmed the facility nurses would not be able to provide appropriate care to wean Resident #34 from the ventilator. Interview on 04/08/25 at approximately 10:00 A.M. with RNCC #302 and concurrent review of the respiratory therapy staff schedules for March and April 2025 confirmed no RT staff was scheduled the nights of 03/26/25, 03/29/25, and 04/03/25. Review of the policy titled, Nursing Services and Sufficient Staff, copyright 2025, revealed the facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: a. Licensed nurses; and b. Other nursing personnel, including but not limited to nurse aides. This deficiency represents non-compliance investigated under Complaint Number OH00164263, Complaint Number OH00164158, and Complaint Number OH00163578.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 35033 Based of review of personnel records, review of staff training, and staff interview, the facility failed to ensure certified nurse aides (CNAs) received no less than 12 hours of annual in-service training. This affected five (#107, #115, #134, #130, and #107) of five CNAs reviewed and had the potential to affect all 89 residents. The facility census was 89. Findings include 1. Review of the personnel record for CNA #107 revealed a hire date of 10/20/22. Further review of personnel file revealed no documentation of the required 12 hours of annual inservice training. 2. Review of the personnel record for CNA #115 revealed a hire date of 11/23/22. Further review of personnel file revealed no documentation of the required 12 hours of annual inservice training. 3. Review of the personnel record for CNA #134 revealed a hire date of 01/19/23. Further review of personnel file revealed no documentation of the required 12 hours of annual inservice training. 4. Review of the personnel record for CNA #130 revealed a hire date of 05/31/23. Further review of personnel file revealed no documentation of the required 12 hours of annual inservice training. 5. Review of the personnel record for CNA #107 revealed a hire date of 05/31/23. Further review of personnel file revealed no documentation of the required 12 hours of annual inservice training. Review of records provided by the facility included an undated list of CNAs with a description after each name with documentation of, Message received, and copies of several facility policies. There was no documentation of dates of in-services, description of in-services, or documentation of attendance to an in-service. Interview on 04/08/25 at 11:57 A.M., with Director of Human Resources (DHR) #187 revealed the facility had no documentation of in-service dates, in-service times, in-service topics, or in-service attendance. DHR #187 revealed the CNAs were provided policies to read. This deficiency represents an incidental finding discovered during the complaint investigations completed 04/11/25.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44815 Based on observation and staff interview, the facility failed to ensure the nursing staffing information was printed and posted daily. This affected all 89 residents in the facility. The census was 89. Findings include: Observation on 04/03/25 at approximately 10:00 A.M. revealed the facility nursing staffing information was posted inside a glass-fronted cabinet near the main entrance to the facility. Further observation revealed the posted nursing staffing information was dated 04/01/25. Observation on 04/07/25 at approximately 8:00 A.M. revealed the facility posted nursing staffing information remained dated 04/01/25. Interview on 04/08/25 at 2:14 P.M. with Receptionist #279, and concurrent observation of the posted nursing staffing information, revealed the posted information was dated 04/07/25. Receptionist #279 verified the nursing staffing information was not updated and posted daily and no staffing information was available for 04/02/25 through 04/06/25. This deficiency represents an incidental finding discovered during the complaint investigations completed 04/11/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on medical record review and staff interview, the facility failed to ensure medications were ordered with instructions for the correct indication of use. This affected one (#83) of three residents reviewed for medications. The census was 89. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE] with diagnoses of hypotension and dependence on renal dialysis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/15/25, revealed Resident #83 had intact cognition. Review of the current physician order, dated 03/30/24, revealed Resident #83 received Midodrine 10 milligrams (mg), one tablet by mouth three times daily for hypotension (low blood pressure) with instructions to hold for systolic blood pressure (SBP) less than 110 millimeters of mercury (mmHg). Interview on 04/07/25 at 10:04 A.M. with the Director of Nursing (DON) revealed Midodrine was used to treat low blood pressure. The DON further confirmed the physician order indicating the medication should be held for low SBP and did not reflect the way the medication was intended to work. The DON stated Midodrine should be given when SBP was low and should not be given when Resident #83's SBP was elevated. The DON stated he would correct the physician's order to reflect Midodrine should be held for SBP higher than 110. This deficiency represents an incidental finding discovered during the complaint investigations completed 04/11/25.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on observation, medical record review, review of a fire and rescue run report, review of hospital documentation, review of narcotic/controlled drug records, staff interviews, interview with the pharmacist, and review of the policy on controlled substances, the facility failed to ensure Resident #86 was free from a significant mediation error, failed to report missing Fentanyl medication patches, failed to accurately assess the resident, and failed to immediately investigate and implement immediate interventions to ensure an accurate system was in place for monitoring Fentanyl patch placement. This resulted in Immediate Jeopardy and potential serious life-threatening harm, injuries, negative health outcomes, and/or death for Resident #86 when on 03/29/25 at 9:47 A.M., Licensed Practical Nurse (LPN) #355 administered Resident #86 a Fentanyl 50 microgram (mcg) 72-hour patch (potent opioid medication used to treat pain) after not being able to locate or remove the resident's previously administered Fentanyl patch. LPN #355 had not reported the missing patch until after the resident overdosed. On 03/29/25 at approximately 1:30 P.M., Resident #86 was lethargic, and unable to walk or sit upright. LPN #242 checked the resident's vital signs but failed to complete a head-to-toe assessment. LPN #242 called Nurse Practitioner (NP) #359 who ordered to send the resident to the emergency room . Emergency Medical Services (EMS) arrived at 1:52 P.M. and after assessment, the resident was found wearing two Fentanyl patches requiring the administration of one milligram of Narcan (a medication which rapidly reverses an opioid overdose). Resident #86 was transferred to the hospital for further evaluation and diagnosed with an accidental overdose requiring laboratory testing, a computed tomography (CT) scan, and intravenous fluids. The resident returned to the facility on [DATE] after 5:30 P.M. This affected one (#86) of three residents (#42, #50, and #86) reviewed for controlled substance use. The facility identified one current resident (#86) with physician orders for Fentanyl. The facility census was 89. On 04/07/25 at 11:38 A.M., the Administrator, Director of Nursing (DON), and Registered Nurse Clinical Consultant (RNCC) #302 were notified Immediate Jeopardy began on 03/29/25 at 9:47 A.M. when LPN #355 administered Resident #86 a second Fentanyl pain patch without reporting the previously administered Fentanyl patch could not be located and was not reported. LPN #242 then failed to complete a thorough assessment of Resident #86 when the resident was found to be lethargic, and unable to walk or sit upright. LPN #242 called Nurse Practitioner (NP) #359 who ordered to send the resident to the emergency room . EMS arrived and found the resident unable to ambulate, drooling, with pinpoint pupils and unable able to sit up. EMS administered Narcan one milligram and removed a second Fentanyl patch found on the resident before transporting the resident to the hospital and diagnosed with an accidental overdose. The facility had not initiated an incident investigation or implemented immediate interventions to ensure an accurate monitoring system for Fentanyl patch placement was established. The Immediate Jeopardy was removed on 04/07/25 at 4:33 P.M., when the facility implemented the following corrective actions: On 04/03/25, the DON completed a skin sweep on Resident #86 to ensure there were no additional patches applied. On 04/03/25, the DON completed a review of Resident #86's care plan and verified to show chronic pain and potential side effects. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/03/25, the DON completed a skin sweep on a like resident (Resident #50) who had discontinued orders for Fentanyl patches. The DON verified there were no patches present. On 04/03/25, RNCC #302 educated the Administrator and DON on reporting risk events and initiating investigation and implementing interventions. On 04/03/25, the Narcotic Pain Patch Policy was updated to include: Both nurses, oncoming and off going to check placement and document in medication administration record at shift change beginning on 04/06/25, and removal of Fentanyl pain patch to be completed by two nurses and documented in the controlled substance/narcotic log with two nurses for disposal beginning on 04/04/25. On 04/04/25, the DON updated Resident #86's orders to include documentation of Fentanyl patch location. On 04/04/25, the DON updated Resident #86's order to check Fentanyl patch placement every shift to also include location observed. On 04/07/25, the DON provided a standard list of locations and abbreviations placed on the unit for staff reference to ensure correct abbreviation documentation. On 04/06/25, the DON placed a reminder sheet in the narcotic book for the nurses to physically go to check narcotic placement at shift change. On 04/06/25 and 04/07/25, the DON provided education on the narcotic pain patch policy to include: Checking patch physically during count and documenting in the record; disposal of patch with two nurses and to fold patch and dispose by flushing and both nurses to document on the controlled substances/narcotic log with both nurses signing the log; using the standard list of locations and abbreviations to ensure correct abbreviation of location of Fentanyl patch; and on call manager to be notified immediately if Fentanyl patch missing. On 04/07/25, a root cause analysis was completed by the Interdisciplinary Team (IDT) including Medical Director (MD) #102, the Administrator, the DON, Assistant Director of Nursing (ADON) #208, and RNCC #302 with an ad hoc QAPI meeting on 04/07/25. Auditing includes DON or designee to review shift to shift count with physical checking of patch placement is completed, validating placement of patch to match the medical record once daily for two weeks, then four times a week for four weeks. Initial audit date of 04/04/25. Auditing to include DON or designee to audit removal of Fentanyl patch to be with two nurses and documented accurately in the narcotic log daily for two weeks, then four times a week for four weeks. Interviews on 04/07/25 from 2:21 P.M. through 3:10 P.M., with LPN #248, LPN #244, LPN #242, and LPN #231 revealed education on the new policy and procedures had been provided. On 04/08/25, the DON provided education to LPN #242 on completing head-to-toe assessments. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 04/08/25 from 9:07 A.M. through 9:20 A.M., with LPN #233, LPN #311, and LPN #248 revealed education on anatomical location abbreviations had been provided and a list was observed in each controlled substance binder. Although the Immediate Jeopardy was removed on 04/07/25 at 4:33 P.M., the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the medical record for Resident #86 revealed an admitted d of 07/10/23. Diagnoses included dementia, schizoaffective disorder, depression, anxiety, hypertension, Alzheimer's disease, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required supervision with transfers, toileting, and set up assistance for ambulation. Review of the care plan initiated on 07/10/23 and last revised on 11/21/23 revealed the resident experienced chronic pain with an intervention to monitor and document side effects of pain medication. Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician. Also, to observe/report changes in usual routine, sleep patterns, decreased in functional ability, decreased range of motion, and withdrawal or resistance to care. Review of a physician order dated 08/04/24 revealed an order for a Fentanyl transdermal patch 72-hour, 50 micrograms (mcg)/hour, apply 50 mcg transdermal every 72 hours for pain. Review of an order dated 05/21/24 revealed to verify placement of the Fentanyl patch every shift for patch placement. An order dated 03/23/25 revealed to remove the used Fentanyl patch prior to applying new patch in the morning every three days for patch disposal. There were no orders to remove and document the removal of the Fentanyl patch prior to 03/23/25. Review of the medication administration record (MAR) from 03/01/25 through 03/31/25 revealed no documentation of Fentanyl patch removal until 03/23/25. Further review of the MAR revealed Resident #86 was administered a Fentanyl 50 mcg 72-hour patch on 03/05/25 at 8:29 A.M. to the left front shoulder. Documented verification of patch placement on each shift from 03/05/25 through 03/08/25 at 6:00 A.M. revealed the patch was incorrectly documented as located on the right back shoulder or the right scapula. Review of the MAR on 03/08/25 at 12:20 P.M. revealed a new Fentanyl patch was administered on the left arm. Verification of patch placement from 03/08/25 through 03/11/25 at 6:00 A.M. revealed the patch was incorrectly documented as located either on the right shoulder or the right scapula. Review of the MAR on 03/11/25 at 7:01 A.M. revealed a new Fentanyl patch was administered to the left front shoulder. Verification of patch placement from 03/11/25 through 03/14/25 at 6:00 A.M. revealed the patch was located on the left chest, left scapula, and right scapula. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the MAR on 03/14/25 at 8:58 A.M. revealed a new Fentanyl patch was administered to the right forearm. Verification of placement from 03/14/25 through 03/17/25 at 6:00 A.M. revealed the patch was incorrectly documented as located on the right scapula, left arm, and left scapula. Review of the MAR on 03/17/25 at 9:56 A.M. revealed a new Fentanyl patch was administered to the right arm. Verification of patch placement from 03/17/25 through 03/20/25 at 6:00 A.M. revealed the patch was incorrectly documented as located on the left arm, and right scapula. There were two verifications of the patch located on the right upper arm. Review of the MAR on 03/20/25 at 8:04 A.M. revealed a new Fentanyl patch was administered to the left front shoulder. Verification of patch placement from 03/20/25 through 03/23/25 at 6:00 A.M. revealed the patch was incorrectly documented as located on the right scapula, left scapula, left chest, and right chest. Review of the MAR on 03/23/25 at 10:17 A.M., a new Fentanyl patch was administered to the right front shoulder and the prior patch had been removed. Verification of patch placement from 03/23/25 through 03/26/25 at 6:00 A.M. revealed the patch was located on the right chest, right scapula, left middle back and later was found not in place at 6:00 P.M. on 03/25/25. Review of an electronic medication administration record (EMAR) note dated 03/25/25 at 11:16 P.M. revealed no Fentanyl patch was found during verification of Fentanyl patch placement. There was no notification made to the physician or the Director of Nursing (DON). Further review of the nurses notes from 03/01/25 through 03/31/25 revealed there was no documentation the resident had any history of removing or relocating the Fentanyl patch. On 03/26/25 at 6:00 A.M. verification of patch placement was noted as yes with no location documented. Review of the MAR on 03/26/25 at 8:40 A.M., revealed a new Fentanyl patch was administered to the right front shoulder. Verification of patch placement from 03/26/25 through 03/29/25 revealed the patch was incorrectly documented as located on the left arm, right chest or right upper chest with one verification on 03/28/25 at 6:00 A.M. with no location documented. Review of the MAR dated 03/29/25 at 9:47 A.M. revealed a new Fentanyl patch was administered to the right front shoulder. Further review of the MAR revealed documentation stating not applicable indicating the previous Fentanyl patch had not been removed prior to applying the new patch. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a fire and rescue department patient care record dated 03/29/25 revealed the 911 called was received at 1:46 P.M. for stroke-like symptoms. EMS arrived at Resident #86 at 1:52 P.M. The primary impression was noted as an overdose. The resident signs and symptoms included altered mental status, stupor, drooling, and somnolence with pinpoint pupils with an onset time of 1:30 P.M. EMS arrived at the scene in a dining area with resident seated at a table, slumped over, drooling, responsive to verbal but disoriented and slurred speech following some commands. Per staff, the resident had his Fentanyl patch replaced, went outside for a walk, and upon coming back inside, could barely walk and progressed to current state, with no history of same. The resident was noted to have a new Fentanyl patch to his upper right chest, staff swears they removed the old one. The resident was checked from waist up while vitals obtained for additional patches, none found. Resident pupils pinpoint, presented more like overdose than stroke. One milligram Narcan given as diagnostic tool. Resident with some improvement after Narcan administration. Resident skin checked again; second Fentanyl patch found on right upper arm which was covered by the blood pressure cuff on initial assessment. Confirmed the other patch was present on the right upper chest as well. Patch removed from right upper arm and resident's mental status improving but transported to the emergency room at 2:25 P.M. for observation. The resident was noted as slightly combative at times during transport. Review of the hospital record dated 03/29/25 revealed the resident arrived at 2:23 P.M. from nursing home where he was found wearing two Fentanyl patches and then one Fentanyl patch was removed. One mg Narcan given and resident now alert and oriented to baseline. The resident was diagnosed with an accidental overdose. The resident received laboratory testing, a CT scan and was administered intravenous fluids. The resident was discharged at 5:07 P.M. and was awaiting transport back to the nursing home. Review of a nurses note dated 03/29/25 at 6:42 P.M. revealed the resident was sent to the emergency room . The resident was lethargic, could not walk or sit up and kept leaning to the left side. Nurse Practitioner (NP) #359 was notified and ordered to send the resident to the emergency room . EMS arrived and tried to start an intravenous line and removed the resident's sweater. Upon removing the sweater, EMS noticed there were two Fentanyl patches on the resident. EMS administered Narcan and the resident started to communicate. The resident's family was notified of transport to the emergency room . Review of the MAR revealed no verification of Fentanyl patch placement was completed on 03/29/25 on the 12-hour night shift. There was no verification of placement on 12-hour day shift or night shift on 03/30/25. On 03/31/25, the Fentanyl patch was noted on the right upper arm and right upper shoulder. Review of the MAR for Resident #86 revealed on 04/01/25 at 8:52 A.M., a new Fentanyl patch was administered to the left rear shoulder. On 04/01/25 verification of placement revealed the Fentanyl patch was incorrectly documented on the left upper arm. Observation on 04/02/25 at 9:42 A.M., with LPN #252 revealed Resident #86 had a Fentanyl patch dated 04/01/25 and initialed on his left upper back. There was tape in place over the Fentanyl patch. Interview on 04/02/25 at 9:53 A.M., Certified Nursing Assistant (CNA) #120 revealed on 03/29/25, Resident #86 had gone outside and came back in and could not sit up straight and the ambulance was called. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/02/25 at 1:48 P.M., the Administrator revealed he was not sure he was aware of any specifics of Resident #86's overdose. The Administrator revealed he was not aware of an investigation, incident report or if anything was put in place. The Administrator revealed the DON should know and would be the one to investigate. Interview on 04/02/25 at 2:51 P.M., EMS Responder #301 revealed upon arrival to the facility, Resident #86 was sitting in a chair in the dining area drooling and nearly unresponsive. EMS Responder #301 revealed the resident was assessed. After about ten minutes they removed the blood pressure cuff and found a second Fentanyl patch on the resident's right upper arm. EMS Responder #301 revealed the resident was administered one milligram of Narcan intravenously and the resident perked right up. Interviews beginning on 04/02/25 at 12:50 P.M., the DON revealed Resident #86 was leaning to the side and the nurse questioned if the resident was having a cerebral vascular accident. The DON stated he told the nurse to assess the resident and to send to the emergency room if needed. The DON revealed the nurse notified him EMS arrived and found a second Fentanyl patch on the resident. The DON revealed the medication from the second patch should not have caused the overdose but then stated each patient metabolizes medications at different rates. The DON revealed he had not investigated the incident or implemented any new interventions because he had to work the floor over the weekend and was off work on Monday. The DON also verified he had not been notified of the Fentanyl patch missing on 03/25/25. Additional interview with the DON revealed the nursing staff were not accurately documenting the location of the resident's Fentanyl patch and education would be completed. The DON incorrectly stated documentation of the removal of the resident's patch would not require documentation by two nurses to dispose of a removed Fentanyl patch. Interview on 04/02/25 at 3:42 P.M., Assistant Director of Nursing (ADON) #208 revealed to administer a Fentanyl patch, first remove the old patch, apply the new patch with date and label and cover with Tegaderm. ADON #208 revealed the patch was to remain in the same location for 72 hours. ADON #208 revealed two nurses during shift change should witness disposal of the old patch but were not required to sign off on the disposal. ADON #208 revealed the physician, and DON should be notified when a Fentanyl patch was found missing during the verification of placement. Interview on 04/02/25 at 4:05 P.M., Staffing and Scheduling Coordinator (SSC) #266 revealed overhearing a resident on the locked unit was found wearing two or three Fentanyl patches. Review of the MAR revealed on 04/02/25, verification of the Fentanyl patch was completed at 6:00 A.M. and 6:00 P.M. The location placement was noted as back. Interview on 04/03/25 at 8:05 A.M., LPN #233 revealed before administering a Fentanyl patch, ensure there were no other patches on the resident. LPN #233 revealed nurses should have a witness when a new patch was administered and to sign and date the patch then place a clear adhesive dressing over the patch. LPN #233 revealed the location of the patch should be documented when applied and removed, and staff should sign with another nurse when the old patch was discarded. Review of the MAR dated 04/03/25 at 6:00 A.M., LPN #233 incorrectly documented the location of the Fentanyl patch as on the left shoulder. Observation on 04/03/25 at 8:14 A.M., with LPN #233 revealed Resident #86's Fentanyl patch was on his left upper back dated 04/01/25 and initialed. There was tape over the patch. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/03/25 at 9:41 A.M., LPN #242 revealed a nursing assistant indicated Resident #86 was not acting his normal self. LPN #242 revealed there was an agency nurse working on the resident's behavioral unit. LPN #242 revealed she went and assessed Resident #86. LPN #242 revealed the resident was not with it, and was unable to stand. LPN #242 thought the resident could be having a stroke. LPN #242 revealed the resident's vital signs and blood sugar levels were within normal limits. LPN #242 revealed during the resident's assessment she had not looked over the skin on his body. LPN #242 revealed EMS was called. LPN #242 revealed she was unaware the resident was receiving Fentanyl during her assessment of the resident. LPN #242 revealed EMS removed the resident's shirt and the resident was wearing two Fentanyl patches, one on his front left chest and one on his back right shoulder. LPN #242 revealed EMS administered Narcan and the resident started to come to. LPN #242 revealed the agency nurse stated she had removed the resident's old Fentanyl patch before applying a new one. LPN #242 revealed two nurses should witness the removal and disposal of a Fentanyl patch and should make a progress note on who verified. LPN #242 revealed the location of the Fentanyl patch should be documented when administered and removed also during verification of placement. Further interview on 04/07/25 at 7:53 A.M., LPN #242 revealed the Fentanyl patch remained in place at the same location for 72 hours after it was administered. LPN #242 revealed incorrectly the anatomical location rsc refers to the right shoulder chest. Interview on 04/03/25 at 9:58 A.M., Pharmacist #303 revealed a patient wearing multiple Fentanyl patches could overdose if the old patch was not removed before administering a new patch. Interview on 04/03/25 at 2:44 P.M., LPN #241 revealed on 03/26/25 Resident #86 was administered a new Fentanyl patch. LPN #241 revealed she could not find the old Fentanyl patch to remove. LPN #241 revealed finding a Fentanyl patch in the resident's bed a couple of times. LPN #241 revealed she had not reported the missing patch on 03/26/25 or the patches previously found in the resident's bed to the physician or the nursing management team. LPN #241 revealed she had documented on 03/26/25 at 6:00 A.M. of the patch placement but not the location. LPN #241 revealed she was no longer employed by the facility. Interview on 04/07/25 at 1:41 P.M., RNCC #302 revealed the DON and Administrator had not notified her of Resident #86's overdose on 03/29/25 until 04/02/25. RNCC #302 revealed the DON should have reported the incident to the Administrator and the risk management team and immediately began an investigation and implemented interventions. Interview on 04/07/25 at 2:09 P.M., the DON revealed he was notified on 03/29/25 when Resident #86 was found wearing two Fentanyl patches. The DON revealed after Resident #86 overdosed, he found out LPN #355 could not locate the resident's previous Fentanyl patch and applied a new patch. The DON verified he notified the Administrator on 03/29/25 of the incident. The DON revealed the anatomical location rsc refers to the right scapula. The DON revealed the facility had no standard anatomical abbreviations in place for the nursing staff. (continued on next page)

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	365339	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Terrace Rehabilitation Center	2735 Darlington Rd Toledo, OH 43606

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/08/25 at 7:45 A.M., LPN #355 revealed she worked for agency and on 03/29/25 she was scheduled in the facility to work as a certified nursing assistant. LPN #355 revealed she had been a CNA for ten years and just received her nurse's license a couple weeks prior but had not yet worked as a nurse. LPN #355 revealed the facility needed a nurse on the secured behavioral unit and the DON told her she was going to be the nurse. LPN #355 revealed she had not trained in the facility as a nurse and felt pressured by the DON to take the assignment. LPN #355 revealed she told the DON she was not comfortable with the assignment. LPN #355 revealed it was a horrible day, just a nightmare. LPN #355 revealed she was handed the keys to the cart around 9:00 A.M. and had not received report from the previous nurse because she was upset about staying over. LPN #355 revealed Resident #86 was supposed to have a Fentanyl patch removed. LPN #355 revealed she looked up where the patch was last located in the electronic medical record. LPN #355 revealed she checked Resident #86, and the patch was not there. LPN #355 revealed she was unaware the missing patch needed to be reported. LPN #355 revealed Resident #86 was then administered a new Fentanyl patch. LPN #355 revealed later a nursing assistant notified her the resident had a change in condition. LPN #355 revealed she went and got LPN #242. LPN #355 revealed the resident had really small pupils. LPN #355 revealed LPN #242 took over the resident's care. Interview on 04/08/25 at 10:27 A.M., the DON revealed LPN #355 indicated she was licensed to work as a nurse but indicated she was scared but never said she had not wanted the assignment. The DON revealed LPN #355 was listed on the agency website as able to work as either a nurse or a nursing assistant. The DON revealed LPN #355 was competent to complete the assignment without additional training. Interview on 04/08/25 at 10:44 A.M. with Customer Service Representative (CSR) #360 from the staffing agency verified LPN #355 was approved to work as either a nurse or a nursing assistant. Review of the facility policy Controlled Substance Administration and Accountability, dated 2024, revealed the facility would have safeguards in place for controlled substances to prevent loss, diversion, or accidental exposure. All controlled drug patches removed from patients are disposed of in such a manner as to prevent diversion. Disposal of patches should be witnessed and cosigned in the MAR in the blanks provided with each controlled drug patch order. Two signatures are required for documentation of controlled drug patch disposal. Further review of the policy revealed no guidelines for the administration and verification of Fentanyl patch locations. This deficiency represents non-compliance investigated under Complaint Number OH00164275 and Complaint Number OH00164205.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on resident interview, medical record review, staff interview, and policy review, the facility failed to ensure residents were screened for therapy services, and failed to ensure therapy staff pursued authorization to provide therapy services. This affected two (#9 and #68) of three residents reviewed for therapy services. The facility census was 89. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses of dependence on renal hemodialysis and tracheostomy status. Resident #9 discharged to an acute-care hospital on 04/02/25. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/20/25, revealed Resident #9 had intact cognition and was dependent on staff for showers and toileting. Review of the multidisciplinary care conference documentation, dated 07/30/24, revealed Resident #9 and Resident #9's son attended the care conference. Further review revealed Resident #9 would be referred for rehabilitation services for strengthening, endurance, and ambulation. Review of the multidisciplinary care conference documentation, dated 03/20/25, revealed Resident #9 and Resident #9's son attended the care conference. Further review revealed a special request for Resident #9 to strengthen her muscles by being up in a wheelchair in the hall to use leg muscles. Interview on 04/07/25 at 3:10 P.M. with Director of Rehabilitation (DOR) #150 revealed he started the DOR position in February 2025. Further interview revealed he had no awareness of Resident #9 having a wheelchair. DOR #150 stated the facility attempted twice to request therapy for Resident #9 but she was denied by insurance both times. DOR #150 stated he could not access the denial records because it occurred prior to him taking the position. Follow-up interview on 04/08/25 at 9:58 A.M. with DOR #150 revealed Resident #9 was evaluated by physical therapy (PT) on 08/22/24 and discharged from PT on 09/20/24 without receiving any treatments because no authorization was received from insurance. Further, DOR #150 stated Resident #9 was evaluated by occupational therapy (OT) on 08/23/24 and discharged from OT on 10/21/24 without receiving any treatments because no authorization was received from insurance. DOR #150 stated no denial letter was received, and he could not verify whether anyone followed up with the insurance company to pursue services. DOR #150 stated his process was to follow up with insurance companies if no response was received, but DOR #150 could not speak to what process was followed prior to him taking the position in February 2025. Continued interview with DOR #150 on 04/08/25 at 9:58 A.M. revealed residents should be screened quarterly by each therapy, PT, OT, and speech therapy (ST) to determine any changes or needs for each resident. DOR #150 could not provide evidence of Resident #9 being screened by therapy since the evaluations in August 2024. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/08/25 at 10:25 A.M. with PT Assistant (PTA) #278 verified a wheelchair was folded and stored in Resident #9's closet. Follow-up interview with DOR #150 on 04/08/25 at 10:58 A.M. confirmed he had no knowledge of Resident #9's wheelchair. Interview on 04/08/25 at 11:39 A.M. with Social Services Director (SSD) #268 revealed she was present during Resident #9's care conference. SSD #268 stated Resident #9 wanted to transfer to another facility and was told the best way to improve her breathing was to exercise. Resident #9 and her family requested Resident #9 be helped into the wheelchair where she could use her legs to move herself up and down the hall and therefore gain strength. SSD #268 stated she notified the therapy department, but could provide no evidence of the notification. 2. Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses of gout, chronic obstructive pulmonary disease, and right foot drop. Review of the quarterly MDS assessment dated [DATE] revealed Resident #68 had intact cognition and was receiving no therapy. Resident #68 was independent for all activities of daily life except for setup/cleanup for shower/bathing. Interview and observation on 04/07/25 at 2:30 P.M. revealed Resident #68 lying in bed on his stomach and was able to reposition himself in bed. Resident #68 stated he was supposed to start therapy but did not know why therapy never started. Interview on 04/07/25 at 3:10 P.M. with DOR #150 revealed Resident #68 was evaluated by PT on 12/11/24 and PT recommended services to provide for bilateral lower extremity strengthening, standing balance, and to relieve pain. Resident #68 was discharged from PT services on 12/30/24 without receiving treatment because no approval was received from the insurance company. Additionally, DOR #150 confirmed he could find no evidence Resident #68 was screened by OT since 07/01/24, nor any evidence Resident #68 was screened by PT since 12/30/24. DOR #150 confirmed screening by therapy should be completed quarterly. Follow-up interview on 04/08/25 at 9:58 A.M. with DOR #150 revealed DOR #150 could find no evidence Resident #68 was denied by insurance and further verified DOR #150 could find no evidence any staff followed up with the insurance company to pursue coverage for Resident #68's therapy services. Review of the undated policy titled, Therapy Screen, revealed therapy screens will be completed quarterly on all residents when time permits. If time restricts the therapist from completing the screen quarterly, a screen will be completed as soon as time permits. This deficiency represents non-compliance investigated under Complaint Number OH00164263.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35033 Based on medical record review, review of a self-reported incident (SRI), review of hospital documentation, review of a fire and rescue report, review of dialysis resident tracking records, review of the Facility Assessment, review of daily posted staffing documentation, review of personnel job descriptions, and staff interview, the administration team failed to use its resources effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being of each resident when the facility failed to ensure measures were in place to prevent a medication overdose and investigation and put follow-up interventions in place to be prevent recurrence, failed to ensure allegations of staff-to-resident verbal abuse were thoroughly investigated, failed to ensure medical records were accurate, and failed to ensure adequate staffing to meeting resident needs for ventilators, bathing, and dialysis services. This deficient practice had the potential to affect all 89 residents residing in the facility. The facility census was 89. Findings include: 1. Review of the medical record including hospital documentation and a fire and rescue report for Resident #86 revealed on 03/29/25 the resident had an accidental overdose after discovering the resident was wearing two Fentanyl (narcotic) pain patches and had physician orders to remove one patch before administering a new patch. The Administrator and Director of Nursing (DON) failed to ensure an immediate investigation of the incident was completed and to implement immediate interventions. Interview on 04/02/25 at 12:50 P.M., the DON revealed the incident had not been investigated and no interventions had been put in place to ensure a similar situation would not happen again. The DON revealed he had to work on the floor over the weekend then had Monday off. Interview on 04/02/25 at 1:48 P.M., with the Administrator revealed he was not sure he was aware of any specifics of Resident #86's overdose. The Administrator revealed he was not aware of an investigation, incident report, or if anything was put in place. The Administrator revealed the DON should know and would be the one to investigate. Interview on 04/07/25 at 1:41 P.M., Registered Nurse Clinical Consultant (RNCC) #302 revealed the DON was responsible to ensure the medical record was accurate and to follow up on any concerns and discrepancies. RNCC #302 revealed the DON should have immediately investigated the overdose incident for Resident #86 and implemented interventions. RNCC #302 revealed the incident should have been immediately reported to the Administrator and the risk management team. RNCC #302 revealed the Administrator should have ensured the investigation was completed and reported to his supervisor. 2. Review of the medical record for Resident #83 revealed physician orders for the medication midodrine had been entered incorrectly into the medical record, and was ordered to be held when the systolic blood pressure was low. Interview on 04/07/25 at 10:04 A.M., with the DON verified Resident #83's physician orders for midodrine were not correct to ensure the medication was administered for the intended effects. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/07/25 at 1:41 P.M., Registered Nurse Clinical Consultant (RNCC) #302 revealed the DON was responsible to ensure the medical record was accurate and to follow up on any concerns and discrepancies. 3. Review of an SRI dated 03/06/26 at 6:25 P.M. revealed Resident #22 alleged verbal abuse by Certified Nurse Aide (CNA) #365. Interview on 04/07/25 at approximately 2:00 P.M. with the Administrator confirmed he initiated and completed the investigation of abuse dated 03/06/25. Further, the Administrator stated he could provide no evidence of an investigation into the allegation of abuse. The Administrator stated CNA #365 was suspended at the time of the allegation and her employment was subsequently terminated. The Administrator confirmed he could not provide any statements from residents or staff, any assessment of Resident #22 or of similar residents, and could not provide any evidence of staff education regarding identifying and reporting abuse. 4. Review of the medical records for Resident #34 revealed physician orders to wean the resident from the ventilator at night with close supervision of respiratory therapy. Interview on 04/07/25 at 1:01 P.M., Respiratory Therapist (RT) #352 revealed there were not enough respiratory staff to work every night and the nursing staff were not trained to wean residents from a ventilator. RT #352 revealed Resident #34 was not making progress at being weaned from the ventilator as there was not always a respiratory therapist working at night. Interview on 04/07/25 at 1:51 P.M. with RNCC #302 confirmed the facility nurses would not be able to provide appropriate care to wean Resident #34 from the ventilator. Follow-up interview with RNCC #302 revealed during concurrent review the respiratory therapy staff schedules for March and April 2025 confirmed no RT staff was scheduled the nights of 03/26/25, 03/29/25, and 04/03/25. Review of the medical records including dialysis patient tracking forms for Resident #4, Resident #6, Resident #21, Resident #50, and Resident #83 revealed the residents were one to three hours late to dialysis on 03/24/25, 03/25/25, 03/27/25, 03/28/25, and 04/02/25. Review of the daily posted staffing information on revealed 18 CNAs worked on 03/24/25, 19 CNAs worked on 03/25/25, 18 CNAs worked on 03/27/25, and 17 CNAs worked on 03/28/25. Review of the Facility Assessment Tool, updated 07/17/24, revealed the average facility census was 86 and the facility required 28 CNAs daily to meet residents' needs. Interview on 04/02/25 at 9:56 A.M. with Dialysis Center Registered Nurse (DCRN) #364 revealed four residents were very late to dialysis on 03/25/25 including Resident #4, Resident #21, Resident #68, and Resident #83. DCRN #364 stated residents were usually late to dialysis because of staff, and stated he felt the facility was understaffed. DCRN #364 confirmed the late arrivals of the residents on 03/24/25, 03/25/25, 03/27/25, 03/28/25, and 04/02/25. Interview on 04/02/25 at 10:10 A.M. with Assistant Director of Nursing (ADON) #208 stated Resident #4 was not at dialysis yet because staff were running behind. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/02/25 at 10:51 A.M. with Resident #83 revealed he was late to dialysis three times in March 2025. Resident #83 stated the staff did not arrive to get him up and take him to dialysis. Resident #83 stated he felt the facility was always short-staffed which caused him to be late getting to dialysis. Interview on 04/07/25 at 3:40 P.M. with RNCC #302 confirmed the current Facility Assessment indicated 28 CNAs were required daily, working eight hour shifts, to meet the needs of the residents. Further interview, with review of the posted staffing information, confirmed less than 28 CNAs worked the days during which at least two residents were late for dialysis. 5. Review of the medical records for Resident #9, Resident #34, Resident #88 revealed the resident were not given showers or bathed as scheduled. Review of the posted staffing information for Wednesdays and Saturdays from 03/05/25 through 03/29/25 revealed 26 CNAs worked on 03/05/25, 22 CNAs worked on 03/08/25, 24 CNAs worked on 03/12/25, 20 CNAs worked on 03/15/25, 18 CNAs worked on 03/19/25, 18 CNAs worked on 03/22/25, 18 CNAs worked on 03/26/25, and 18 CNAs worked on 03/29/25. Per the facility assessment 28 certified nurse aides were required daily to meet the needs of the residents. Interview on 04/08/25 at 8:18 A.M. with Licensed Practical Nurse (LPN) #242 confirmed there were times showers did not get completed because of inadequate staffing. LPN #242 could not provide any specifics. Interview on 04/08/25 at 9:22 A.M. with CNA #380 revealed staffing occasionally caused difficulty with getting showers completed. CNA #380 could provide no specific resident concerns. Review of the facility job description titled, Director of Nursing, signed by the DON on 02/17/25, revealed the DON would plan, develop, organize, implement, evaluate, and direct the overall operations of the nursing services department, as well as its programs, and activities, in accordance with current state and federal laws and regulations. Also, to interpret and communicate policies and procedures to nursing staff, and monitors staff practices and implementation including discipline according to operational polices. Additionally, the DON would oversee resident incidents and concerns daily to identify any unusual occurrences and report them promptly to the Administrator and/or state agency for appropriate action. Review of the facility job description titled, Administrator, signed by the Administrator on 03/05/25, revealed the administrator evaluates work performance of department heads and maintains accountability across all departments for expected performance outcomes. The Administrator would lead, guide, and direct the operations of the healthcare facility in accordance with local, state and federal regulations, standards, and establish facility policies and procedures to provide appropriate care and services to residents. This deficiency represents an incidental finding discovered during the complaint investigations completed 04/11/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff and resident interview, and policy review, the facility failed to ensure accurate documentation was in the medical record and failed to ensure the medical record reflected care and services provided. This affected three (#21, #74, and #42) of nine residents reviewed for accuracy of the medical record. The facility census was 89. Findings include: 1. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included depression and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had intact cognition. Review of the physician orders for March 2025 revealed the resident had orders for supplemental vitamin D 2000 units at bedtime, lamotrigine 75 milligrams (mg) twice daily for seizures, and Miralax 17 grams twice a day for constipation. Review of Resident #21's medication administration record (MAR) for 03/30/25 revealed no documentation the resident was administered vitamin D, lamotrigine or Miralax on 03/30/25 at 7:00 P.M. 2. Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included schizophrenia, cirrhosis of liver, heart failure, major depressive disorder, and anxiety disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #74 had intact cognition. Review of the physician orders for March 2025 revealed the resident had orders for metoprolol 75 mg twice a day, latanoprost 0.005 percent (%) with instructions for one drop in each eye at bed time, trihexyphenidyl two (2) mg twice daily, hydralazine 50 mg for hypertension, atropine one (1) % with instructions for two drops sublingually at bedtime for excessive salivation, Clozaril 100 mg twice a day for schizophrenia, trazadone 75 mg at bed time for major depressive disorder, hydroxyzine 25 mg three times a day for schizophrenia, cyclobenzaprine 10 mg at bedtime for muscle spasms, and Lexapro 15 mg at bedtime for depression/anxiety. Review of Resident #74's MAR dated 03/30/25 revealed there was no documentation the resident was administered the metoprolol, latanoprost, trihexyphenidyl, hydralazine, atropine, Clozaril, trazodone, cyclobenzaprine, and Lexapro as scheduled at 7:00 P.M. Interview on 04/07/25 at 7:55 A.M. with Resident #74 revealed he received his medications on 03/30/25. 3. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included anxiety, dementia, type two diabetes mellitus, schizoaffective disorder, and major depressive disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #42 had intact cognition. Review of the physician orders for March 2025 revealed orders for lorazepam 1 mg three times a day for anxiety, clozapine 200 mg with instructions for 2 tables at bedtime for schizoaffective disorder, divalproex extended release 250 mg 2 tablets twice daily for mood disturbance, metoprolol 25 mg at bedtime for hypertension, metformin 1000 mg twice daily for type two diabetes mellitus, trazodone 100 mg at bedtime for insomnia, potassium chloride 20 milliequivalents twice daily for hypokalemia, tamsulosin 0.4 mg at bedtime for urinary retention, docusate 100 mg twice daily for stool softener, and rivastigmine 1.5 mg twice daily for mood disturbance. Review of Resident #74's MAR dated 03/30/25 revealed no documentation the resident was administered lorazepam, clozapine, divalproex, metoprolol, metformin, trazodone, potassium chloride, tamsulosin, docusate, and rivastigmine as scheduled at 7:00 P.M. Interview on 04/03/25 at 3:57 P.M., the Director of Nursing (DON) verified there was no documentation on 03/30/25 the residents on the secured locked behavioral unit were administered evening medications, including Resident #21, Resident #42, and Resident #74. The DON revealed the medication aide forgot her badge and was unable to document the administration of the medications in the electronic record. The DON also verified there was also no documentation on a paper MAR the medications were administered. Interview on 04/07/25 at 7:44 A.M., Resident #42 revealed he usually received his medications but was unable to recall if his medications were administered on 03/30/25. Review of a medication administration audit report dated 03/30/25 revealed on 03/30/25 there was no documentation Resident #21, Resident #42, and Resident #74 were administered evening medications on 03/30/25. Review of the facility policy, Documentation in Medical Record, dated 2024, revealed each resident's record would contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. This deficiency represents non-compliance investigated under Complaint Number OH00164275. 44815