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	04/30/2025

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

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility incident and accident log, review of the Electronic Information Dissemination and Collection (EIDC - system used by facilities to report incidents to the State Survey Agency [SSA]) system, review of the facility Self-Reported Incidents (SRI), staff interview and review of the facility policy, the facility failed to report an incident of resident elopement to the SSA for Resident #3 and further failed to ensure allegations of abuse were thoroughly investigated for four (#26, #28, #30, and #31) residents reviewed for abuse. The facility census was 87. Findings include: 1. Review of the incident and accident log for the past three months revealed an incident of elopement for Resident #3 on 04/12/25. Review of the medical record for Resident #3 revealed an admission date of 03/28/25 with diagnoses of senile degeneration of the brain, anxiety, and diabetes mellitus type II. Review of the admission Minimum Data Set (MDS) assessment, dated 04/04/25, revealed Resident #3 was cognitively impaired and had no wandering behaviors. Review of the nursing progress note dated 04/12/25 at 6:08 P.M. revealed Resident #3 was spotted in the parking lot of the facility, walking and heading toward [NAME] Road (a four-lane road). Staff were notified and Resident #3 was brought back into the facility and nurses and aides were informed of the situation and told to keep an eye on the patient. The Director of Nursing (DON) and Nurse Practitioner (NP) were notified. Interview on 4/29/25 at 2:40 P.M. with Licensed Practical Nurse (LPN) #354 verified Resident #3 eloped from the facility on 04/12/25. LPN #354 stated she was in the parking lot, attending to another resident, when she noticed Resident #3 heading toward the road. LPN #354 stated she alerted another staff member and Resident #3 was returned to the facility. Review of the EIDC system from 04/01/25 through 04/29/25 revealed the facility did not report Resident #3's elopement to the SSA. 2. Review of the medical record for Resident #26 revealed an admission date of 01/28/25 with diagnoses of acute respiratory failure, chronic obstructive pulmonary disease (COPD). Review of the quarterly MDS assessment, dated 03/21/25, revealed Resident #26 was cognitively intact. (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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(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 - Some	Review of the facility submitted SRI, created on 04/05/25 at 3:17 P.M. and completed on 04/11/25 at 3:32 P. M., revealed the facility reported an allegation of verbal abuse after Resident #26 alleged a facility Certified Nursing Assistant (CNA) was verbally abusive. Review of the facility investigation for the SRI revealed the file only included a copy of the SRI submitted to the SSA. Further review revealed no evidence a thorough investigation, including staff interviews or statements, resident statements, assessment of like residents, or staff education was completed. 3. Review of the medical record for Resident #28 revealed an admission date of 05/31/23 with a diagnosis of dementia. Review of the annual MDS assessment, dated 03/15/25, revealed Resident #28 was cognitively impaired. Review of the facility submitted SRI, created on 04/18/25 at 11:33 A.M. and completed on 04/28/25 (one day past the investigation due date) at 1:12 P.M., revealed the facility reported an injury of unknown source to the SSA when Resident #28 was found with a bump and a bruise to the eyebrow. Review of the facility investigation for the SRI revealed the file only included a copy of the SRI submitted to the SSA. Further review revealed no evidence a thorough investigation, including staff interviews or statements, resident statements, assessment of like residents, or staff education was completed. 4. Review of the medical record for Resident #30 revealed an admission date of 03/30/25 with diagnoses of Alzheimer's dementia and Parkinson's. Review of the admission MDS assessment, dated 04/06/25, revealed Resident #30 was cognitively intact. Review of the facility submitted SRI, created on 04/08/25 at 6:24 P.M. and completed on 04/18/25 (one day past the investigation due date) at 11:56 A.M., revealed the facility reported an allegation of physical abuse to the SSA when Resident #30 alleged another resident hit him with a cane. Request for the facility investigation related to the allegation revealed the facility had no documentation related to an investigation. 5. Review of the medical record for Resident #31 revealed an admission date of 03/31/23 with a diagnosis of Parkinson's and multiple sclerosis. Review of the quarterly MDS assessment, dated 03/19/25, revealed Resident #31 was cognitively intact. Review of the facility submitted SRI, created on 04/08/25 at 10:58 A.M. and completed on 04/18/25 (three days past the investigation due date) at 11:51 A.M. revealed Resident #31 alleged a facility Certified Nursing Assistant (CNA) did not treat her properly. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation for the SRI revealed the file only included a copy of the SRI submitted to the SSA. Further review revealed no evidence a thorough investigation, including staff interviews or statements, resident statements, assessment of like residents, or staff education was completed. Interview on 4/29/25 at 3:20 P.M. with the Administrator revealed her first day in her role at the facility was the day prior. The Administrator stated that what was included in the investigation files for the SRIs was all of the information she had and. Further interview with the Administrator verified complete and thorough investigations were not completed for each of the SRIs and further confirmed she was unable to locate any file or documentation for the SRI created on 04/18/24 involving Resident #30's allegation of resident-to-resident physical abuse. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated January 2025, revealed investigation would occur immediately when suspicion of abuse, neglect, or exploitation or reports of abuse, neglect or exploitation occurred. Further review revealed the written procedure included identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations and providing complete and thorough documentation of the investigation. Additionally, reporting of alleged violations to the Administrator, state agency, adult protective services, and all other required agencies would occur no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. This deficiency represents non-compliance investigated under Complaint Number OH00164991 and is continued non-compliance from the survey dated 04/11/25.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure baseline care plans were completed. This affected one (#53) of one resident reviewed for baseline care plans. The facility census was 87. Findings include: Review of the medical record for Resident #53 revealed an admission date of 04/26/25 with diagnoses of acute respiratory failure, tracheostomy status, malignant neoplasm of the lung and supraglottis (upper part of the larynx), anxiety, and chronic obstructive pulmonary disease (COPD). Review of the admission assessment, dated 04/26/25, revealed Resident #53 was cognitively intact. Further review revealed a baseline care plan was not part of the admission assessment. Additional review of Resident #53's medical record revealed no evidence a baseline care plan was completed. Interview on 4/30/25 at 1:05 P.M. with the interim Director of Nursing (DON) verified a baseline care plan was not completed for Resident #53. Review of the facility policy titled Baseline Care Plan, undated, revealed the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident. The baseline care plan would be developed within 48 hours of the resident's admission. This deficiency was an incidental finding discovered during the complaint investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure person-centered care plans were completed. This affected one (#3) of four residents reviewed for care plans. The facility census was 87. Findings include: Review of the medical record for Resident #3 revealed an admission date of 03/28/25 with admitting diagnoses of senile degeneration of the brain, diabetes mellitus type II, and anxiety. Review of the admission Minimum Data Set (MDS) assessment dated , 04/04/25, revealed Resident #3 was cognitively impaired. Review of a nursing progress note dated 04/12/25 revealed Resident #3 was spotted in the parking lot, walking toward the street. Review of the physician orders revealed on 04/14/25, Resident #3 was admitted to the secure memory care unit. Review of Resident #3's plan of care revealed on 04/14/25, a focus area was initiated for the resident having a behavior problem as evidenced by elopement. Two interventions were implemented, medications as ordered and anticipate the resident's needs. Further review revealed no evidence of person-centered interventions or the resident's admission to the secured memory care unit. Interview on 04/29/25 at 4:27 P.M. with the Director of Nursing (DON) verified the elopement care plan for Resident #3 did not reflect a person-centered approach for appropriate interventions for elopement. Review of the facility policy titled, Elopements and Wandering Residents, dated January 2025, revealed the facility ensured that residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Review of the facility policy titled, Comprehensive Care Plans, undated, revealed the policy of the facility was to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs, and all services that were identified in the resident's comprehensive assessment. This deficiency was an incidental finding discovered during the complaint investigation.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on review of the facility incident and accident log, staff interview, medical record review and review of the facility policy, the facility failed to provide adequate supervision to prevent resident elopement and further failed to timely implement interventions to ensure resident safety following an incident of elopement. This affected one (#3) of one resident reviewed for elopement. The facility census was 87. Findings include: Review of the incident and accident log for the past three months revealed an incident of elopement for Resident #3 on 04/12/25. Review of the medical record for Resident #3 revealed an admission date of 03/28/25 with diagnoses of senile degeneration of the brain, anxiety, and diabetes mellitus type II. Review of the admission Minimum Data Set (MDS) assessment, dated 04/04/25, revealed Resident #3 was cognitively impaired and had no behaviors of wandering. Review of the admission Wandering Risk Assessment, dated 03/28/25, revealed Resident #3 had no previous wandering, was cognitively impaired with poor decision-making skills, spoke of desire to go home, and talked about going on a trip or packing bags. Further review revealed the assessment did not reflect a score or other indication of what the resident's assessed risk was. Review of the nursing progress note dated 04/12/25 at 6:08 P.M. revealed Resident #3 was spotted in the parking lot of the facility, walking and heading toward [NAME] Road (a four-lane road). Staff were notified and Resident #3 was brought back into the facility and nurses and aides were informed of the situation and told to keep an eye on the patient. The Director of Nursing (DON) and Nurse Practitioner (NP) were notified. Review of the Wandering Risk Assessment, dated 04/12/25 and completed following Resident #3's elopement, revealed the resident was cognitively impaired with poor decision-making skills and wandering placed the resident at significant risk of getting to a potentially dangerous place (stairs, outside the facility). Further review revealed the assessment did not reflect a score or other indication of what the resident's assessed risk was. Review of a physician order dated 04/14/25 revealed Resident #3 was admitted to the secured memory care unit. unit. Review of a nursing progress note dated 04/14/25 at 4:42 P.M. revealed Resident #3 to be transferred to the secure memory care unit. Review of the care plan, revised 04/14/25, revealed Resident #3 had a behavior problem as evidenced by elopement. Interventions included to administer medications as ordered and anticipate resident's needs. Further review revealed no evidence the resident had care plan interventions related to elopement or wandering prior to 04/14/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #3's medical record revealed no evidence of increased supervision or other interventions implemented following the resident's elopement on 04/12/25 until 04/14/25. Interview on 4/29/25 at 2:40 P.M. with Licensed Practical Nurse (LPN) #354 revealed on 04/12/25, she was in the parking lot, attending to another resident who had fallen, when she saw Resident #3 heading toward the road. LPN #354 stated she alerted another staff member and Resident #3 was returned to the facility. Prior to the elopement, LPN #354 stated Resident #3 wandered all over the facility in his wheelchair but did not display any exit seeking behaviors. LPN #354 stated the incident occurred at the end of her shift and verified she did not implement any interventions to ensure the resident's safety. Interview on 04/29/25 at 4:27 P.M. with the DON revealed he was not notified of Resident #3's elopement at the time of the occurrence but stated the resident was immediately placed on one-to-one staff observation until he was moved to the secured memory care unit on 04/14/25. Review of Resident #3's medical record, with the DON, confirmed there was no evidence of one-to-one staff monitoring or other interventions implemented following the elopement to ensure the resident's safety and further verified the only monitoring documented in the resident's medical record was to keep eyes on patient. The DON further stated Resident #3 was moved to the secured memory care unit on the Monday following the elopement (elopement occurred on Saturday), when administration learned of the elopement. Review of the facility policy titled, Elopements and Wandering Residents, dated January 2025, revealed the facility ensured that residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. This deficiency was an incidental finding discovered during the complaint investigation.