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	02/10/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, resident interview, staff interview, surveillance video review, facility Self-Reported Incident review, review of the facility investigation, review of staff schedules, and review of facility policy, the facility failed to ensure an allegation of abuse was reported timely. This affected one (#10) of three residents reviewed for abuse and had the ability to affect 23 residents (#33, #35, #36, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #54, #55, #56, #57, #58, #59, #60) who reside in the secured behavioral unit. Facility census was 83.Findings include:Review of Resident #10's medical record revealed an admission date of 04/16/25 and resided on the secured behavioral unit. Diagnoses included schizophrenia, post-traumatic stress disorder, anxiety, and depression. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive function. Resident #10 was noted to have verbally abusive behaviors and often rejected care.Review of Resident #10's nursing progress note written by Licensed Practical Nurse (LPN) #115, dated 01/03/26 and timed 6:11 P.M. revealed Resident #10 was leaving the dining room and Certified Nursing Assistant (CNA) #200 asked the resident to place her food tray on the food cart. The resident stated, I did not think there is any more room in the tray cart. CNA #200 stated, Let me just push these other trays back for you. Resident #10 stated Why are you looking at me like that? and CNA #200 responded I am not looking at you any kind of way. I would just like for the food trays to be brought back up to the front, please. The resident then got into CNA #200's face and with an aggressive attitude stated, I am not going to let nobody gaslight me. At that point another aide, CNA #210 stepped in between CNA #200 and Resident #10 to defuse the situation. The resident walked outside to calm down with CNA #210. The resident and both CNAs were safe, and no physical harm was done, but the aide stated she should be able to come to work and feel safe to do her job. The note stated the Unit Manager #320 and physician were notified.Review of the facility's Self-Reported Incident dated 01/13/25 and timed 1:31 P.M. revealed Unit Manager #320 went to an appointment with Resident #10 and while at the appointment Resident #10 shared with the provider that an aide had gotten in her face a few days ago. Upon returning to the facility Unit Manager #320 reported the possible allegation of abuse between Resident #10 and an aide. An investigation was immediately started. Review of the investigation notes revealed Social Worker #325 interviewed Resident #10 on 01/13/26 at 3:00 P.M. and discovered there was an incident that occurred on 01/03/26 that was causing the resident emotional distress. Resident #10 stated the incident occurred in the dining room at dinner time when CNA #200 stood in close proximity to her, raised her voice, and demanded that Resident #10 return her meal tray to the food cart. Further review of the facility investigation notes dated 01/14/26 revealed it was discovered that Resident #10 had left a voicemail on admission Manager #326's phone line on 01/05/26 describing the incident. Review of the video (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveillance (no sound) with the Administrator on 01/29/26 revealed on 01/03/26 at approximately 5:25 P.M. Resident #10 was eating dinner at a table in the dining room with Resident #15, and when Resident #10 stood up to walk away from the dining room table CNA #200, who was sitting on a heater along the wall with CNA #210 looking at their phones, said something to the resident at which time Resident #10 walked over to CNA #200. When Resident #10 reached CNA #200 there was an exchange of words, followed by both CNA #200 and Resident #10 flailing their arms and pointing fingers at each other in an aggressive manner. CNA #200 was in close proximity to Resident #10 with assertive body language, Resident #10 was observed as becoming visibly distressed and crying at which time CNA #210 stood up and stepped between CNA #200 and Resident #10. CNA #210 was seen saying something to Resident #10 and then lead Resident #10 out of the dining room. While this incident was occurring Resident #15 stop eating, picked up Resident 10's tray, went over to the tray cart, placed Resident #10's tray in the food cart and then returned to the table to finish his dinner. Review of the staff schedules from 01/03/26 through 01/19/26 revealed CNA #200 worked from 2:00 P.M. until 10:00 P.M. on the secured behavioral unit on 01/03/26, 01/04/26, 01/06/26, 01/07/26, 01/08/26, 01/09/26 and 01/12/26. Interview with the Administrator on 01/29/26 at 3:50 P.M. verified on 01/03/26 Resident #10 was in an altercation with CNA #200 on the secured behavior unit dining room. The Administrator stated on 01/13/26 Resident #10 informed Unit Manager #320 that CNA #200 verbally abused her, at which time the incident was immediately reported and an investigation was started. The Administrator verified that CNA #200 was suspended on 01/13/26 when she was made aware of the incident and further verified that CNA #200 had worked multiple shifts between 01/03/26, when the incident occurred, and 01/13/26 when the she was made aware of the incident. Continued interview with the Administrator revealed on 01/14/26 Admissions Manager #326 found a voicemail left on her phone messages dated 01/05/26 from Resident #10 regarding the abuse allegation. The Administrator stated it was the CNA's job to take care of the residents' trays, and that CNA #200 should have handled the situation differently. The Administrator also verified that LPN #115 should have reported the incident on 01/03/26 when writing the progress note in Resident #10's medical record.Interview with Resident #10 on 02/10/26 at 9:24 A.M. revealed she had an altercation with CNA #200 in the dining room because the aide was mean to her and the aide did not like her. The resident revealed CNA #200 yelled at her and was mean.Telephone interview with CNA #200 on 02/10/26 at 10:45 A.M. revealed on 01/03/26 she was sitting on a heater in the dining room by the smoker's door observing dinner. CNA #210 was sitting with her. CNA #200 stated all residents usually bring their food tray up to the food cart when they were done eating in the dining room. CNA #200 stated that Resident #10 usually slept through dinner, but on 01/03/26 she was eating at a table with Resident #15 and when Resident #10 stood up and walked over by the food cart she asked the resident if she was going to bring her tray up and the resident became upset and started yelling. CNA #200 stated Resident #10 got in her face and kept asking her questions like Why are you looking at me? Why are you screaming at me? Why are you gas lighting me? that was when CNA #210 then came between the two of them and took Resident #10 out of the area. CNA #200 stated she has worked at the facility for 15 years and claims to have reported the incident to LPN #155 right after the incident occurred.Review of the undated facility policy titled Abuse, Neglect, and Exploitation, revealed all alleged violations of abuse should be reported to the Administrator, State Agency, Adult Protective Services and to all other required agencies immediately but not later than two hours after the allegation is made if it involves abuse or results in serious bodily injury, and no later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.As a result of the incident, the facility implemented the following corrective actions to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correct the deficient practice by 01/20/26:On 01/13/26 at 10:30 A.M. the abuse allegation was reported Unit Manager #320 by Resident #200. Unit Manager #320 reported the allegation to the Administrator, and an investigation was started immediately, and CNA #200 was placed off on Administrative leave. On 01/13/26 from 11:37 A.M. until 12:03 P.M. all interviewable residents in the secured behavioral unit were interviewed about concerns for abuse and being made to return food trays to the food cart. Interviews revealed no concerns for abuse, verbal of physical and residents stated they are not required to return food trays to the cart. On 01/13/26 at 1:31 P.M. the Administrator filed a Self-Reported Incident with the State Agency.On 01/13/26 starting at 2:16 P.M. the Nurse Managers completed skin assessments on the 23 residents of the secured behavioral unit. Assessments were completed at 3:05 P.M. with no negative findings. On 01/13/26 at 3:00 P.M. Social Worker #325 conducted an interview with Resident #10 and obtained a statement from the resident regarding the 01/03/26 incident and completed an assessment. On 01/14/26 Social Worker #325 further assessed Resident #10 with plans for continued daily check ins with Resident #10. As of 01/29/26 there had been no adverse findings. On 01/14/26 investigation into how the voicemail on admission Manager #326's was missed revealed the mailbox for which the voicemail was left was a dummy personal voicemail box set up for spam. The spam voicemail box was deleted. The Administrator provided education to Admissions Manager #326 that voicemail messages are be checked on a daily basis.On 01/15/26 at 2:46 P.M. the Administrator obtained a witness statement from CNA #210. On 01/16/26 Resident #10's family/responsible party were notified of the incident by the Administrator.On 01/16/26 Social Work #325 obtained resident witness statements. On 01/16/26 at 1:26 P.M. the Administrator interviewed and obtained a witness statement form CNA #200. On 01/17/26 the video surveillance of the 01/03/26 incident was reviewed by the Administrator.On 01/19/26 at 10:26 A.M. LPN #115 was educated by the Administrator on reporting allegations of abuse. On 01/19/26 the Administrator and designee re-educated all staff on the Abuse policy, including on where and how to report abuse, appropriate communication, maintaining personal space, trauma informed approaches when interacting with behavioral residents, how to deescalate expectations and early intervention techniques including separation between the resident and the involved staff member to prevent recurrence. The Administrator also reinforced with staff that meal tray delivery and removal are staff responsibilities and residents were not expected to perform these tasks.On 01/19/26 all residents were educated on where and how to report abuse.On 01/20/26 CNA #200 received corrective action and was told she would no longer be permitted to work in the secure behavioral unit. CNA also received education on the Abuse policy, Resident Rights, and Meal Supervision and Assistance. Starting 01/20/26 ongoing the Administrator or designee will conduct ongoing monitoring daily and reinforcement of facility policies with on the spot re-education as needed. This deficiency represents non-compliance investigated under Complaint Number 2721200.