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	03/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, electronic medical record (EMR) review, review of the Medication Administration Record (MAR), review of the Treatment Administration Record (TAR), review of staff time punches, review of facility policies, and review of the facility's Self-Reported Incident (SRI) #271289, the facility failed to protect residents from neglect when it failed to ensure staff providing resident care were able to safely perform their duties and failed to intervene when Licensed Practical Nurse (LPN) #100 was reported by staff and residents to be exhibiting behaviors consistent with being under the influence of an unknown substance while providing resident care on 02/22/26.Despite multiple reports from staff and residents that LPN #100 appeared impaired, was falling asleep while standing, dozing off during conversations, and dropping medications, the facility failed to remove the nurse from resident care or ensure residents received physician-ordered medications, treatments, monitoring, and interventions.As a result, residents assigned to LPN #100 did not receive numerous physician-ordered medications, tube feedings, treatments, assessments, monitoring, and safety interventions on 02/22/26, affecting 10 residents (Residents #9, #12, #15, #24, #34, #43, #75, #77, #85, and #89) and placing residents at risk for physical harm, pain, and decline in health status. The facility census was 89.Findings include:Interview on 03/10/26 at 7:48 A.M. with Resident #40 revealed that on 02/22/26 she observed LPN #100 working and appearing to be under the influence of an unknown substance. Resident #40 stated that LPN #100 administered her medications late. Interview on 03/10/26 at 8:03 A.M. with Resident #22 revealed that on 02/22/26 she observed LPN #100 working and appearing to be under the influence of an unknown substance. Resident #22 stated that LPN #100 told her she had been up for three days. Resident #22 further stated she observed LPN #100 administer medication to Resident #81 after dropping the medications on the floor. Resident #22 stated that LPN #223 and Certified Nursing Assistant (CNA) #101 telephoned the on-call manager, LPN #105, from the facility to notify her of LPN #100's erratic behaviors. Interview on 03/10/26 at 10:13 A.M. with the Director of Nursing (DON) revealed that neither she nor the Administrator were made aware of LPN #100's erratic behavior on 02/22/26. The DON stated that calls placed by CNA #101 and LPN #223 were directed to LPN #105 and not to herself or the Administrator. The DON stated that LPN #105 notified her that facility staff reported LPN #100 was acting strange but did not notify her of the extent of the erratic behavior. The DON stated that LPN #100 completed her scheduled shift on 02/22/26 and returned to work on 02/23/26, working part of her shift. The DON stated that LPN #105 told her LPN #100 reported being tired due to not sleeping well in the days immediately prior. Review of time punches for LPN #100 revealed she worked on 02/22/26 from 6:17 A.M. through 6:18 P.M., with a lunch break from 10:30 A.M. through 11:00 A.M. Further review of time punches revealed that on 02/23/26 LPN #100 worked from 6:20 A.M. through 12:38 P.M. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/10/26 at 10:59 A.M. with LPN #105 verified she received calls from CNA #101 and LPN #223 on 02/22/26 regarding LPN #100's behavior. LPN #105 stated she notified the DON of the staff's concerns and was directed to call the facility and speak with LPN #100. LPN #105 stated that when she spoke with LPN #100 she appeared coherent and reported she was tired due to not sleeping well in the days immediately prior. LPN #105 stated she received no additional direction from the DON on 02/22/26. LPN #105 further stated that on 02/23/26 facility residents began complaining about LPN #100 and it was at that time the facility made the decision to drug test LPN #100. LPN #100 tested positive for cocaine. Interview on 03/10/26 at 11:35 A.M. with the DON revealed she asked LPN #223 why she did not contact herself or the Administrator regarding the concerns on 02/22/26. The DON stated that LPN #223 reported that LPN #105 told her she was going to contact the Administrator. Interview on 03/10/26 at 11:41 A.M. with Resident #81 revealed that on 02/22/26 LPN #100 appeared to be under the influence of an unknown substance. Resident #81 stated that LPN #100 administered his pain medication after dropping it on the floor. Resident #81 stated he reported his concerns to the DON and Administrator on 02/23/26 at approximately 10:00 A.M. Interview on 03/10/26 at 11:58 A.M. with Resident #9 revealed he did not receive his medications on 02/22/26. Interview on 03/10/26 at 12:27 P.M. with LPN #223 revealed that on 02/22/26 she observed LPN #100 appearing to be under the influence of an unknown substance. LPN #223 stated that Resident #81 informed her that LPN #100 dropped his medications and was slamming items. LPN #223 stated that LPN #100 appeared disheveled and very tired. LPN #223 stated she contacted LPN #105 to report her concerns and was told by LPN #105 she would investigate the situation and notify the Administrator. Interview on 03/11/26 at 9:52 A.M. with CNA #101 revealed she contacted LPN #105 three times on 02/22/26 at approximately 11:30 A.M., 12:41 P.M., and 2:52 P.M. CNA #101 stated she informed LPN #105 that LPN #100 was acting weird, appeared to be under the influence of an unknown substance, was falling asleep while standing up, and dozing off mid-conversation. CNA #101 further stated she informed LPN #105 that LPN #100 entered Resident #40's room and fell asleep on the resident's bed. CNA #101 stated that throughout her shift residents voiced concerns to her about not receiving medications, tube feedings, treatments, and other interventions. CNA #101 stated she observed LPN #100 drop Resident #81's medications on the floor prior to administering them. Review of the facility's substantiated Self-Reported Incident #271289 revealed residents reported to another nurse that LPN #100 was dropping pills and appeared to be under the influence of an unknown substance. The report indicated that LPN #223 contacted LPN #105; however, LPN #105 did not report the incident to the Administrator. When the Administrator was notified of the events of 02/22/26, LPN #100 was drug tested on [DATE] and tested positive for cocaine, (a highly addictive and powerful central nervous system stimulant derived from the leaves of the South American coca plant). Upon receiving the positive test result, LPN #100 was immediately suspended pending the facility investigation. 1. Review of the EMR for Resident #9 revealed an admission date of 02/13/26 with diagnoses including alcohol abuse, depression, anxiety, hypertension (HTN), insomnia, vitamin B12 deficiency, and vitamin D deficiency. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #9's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed the resident required supervision or touching assistance with functional tasks including eating, hygiene, toileting, dressing, transferring, and walking. Review of the EMR revealed a physician orders dated 02/14/26 for cholecalciferol oral tablet 25 micrograms (mcg), administer two tablets by mouth every morning (total dose 50 mcg) for supplement, cyanocobalamin oral tablet 500 mcg, administer one tablet by mouth once daily for supplement, hydrochlorothiazide (HCTZ) 25 milligrams (mg) by mouth once daily for hypertension, paroxetine HCl 30 mg by mouth once daily for depression. Review of the MAR revealed the resident did not receive the physician-ordered doses of cholecalciferol, cyanocobalamin, hydrochlorothiazide, and paroxetine HCl on 02/22/26. Review of the EMR revealed a physician order dated 02/13/26 for a pain assessment using a 0–10 pain scale every shift. Review of the TAR revealed the ordered pain assessment was not completed during the day shift on 02/22/26. During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #9 did not receive the physician-ordered doses of cholecalciferol, cyanocobalamin, hydrochlorothiazide, and paroxetine HCl on 02/22/26. The DON further confirmed the ordered day shift pain assessment was not completed on 02/22/26. 2. Review of the EMR for Resident #12 revealed an admission date of 09/17/23 with diagnoses including anoxic brain damage, personal history of sudden cardiac arrest, dissection of abdominal aorta, non-ST-elevation myocardial infarction (NSTEMI), depression, heart failure, anxiety, chronic respiratory failure with hypoxia, stage 3B chronic kidney disease (CKD3B), oropharyngeal dysphagia, seizures, pseudobulbar affect (PBA), urinary incontinence, incontinence of feces, sleep apnea, gastroesophageal reflux disease (GERD), insomnia, hyperlipidemia, dilated cardiomyopathy, major depressive disorder, and hypertension (HTN). Review of Resident #12's most recent quarterly MDS assessment revealed a BIMS score of 02, indicating severe cognitive impairment. Further review of the assessment revealed the resident required extensive assistance to total dependence for activities of daily living, including eating, hygiene, bathing, dressing, repositioning, and transferring. Review of the EMR revealed a physician order dated 02/22/26 for amlodipine 10 mg by mouth in the morning for dilated cardiomyopathy. Review of the MAR revealed the resident did not receive the physician-ordered dose of amlodipine on 02/22/26. Review of the EMR revealed a physician order dated 08/13/25 for aspirin (ASA) 81 mg by mouth in the morning for antiplatelet therapy. Review of the MAR revealed the resident did not receive the physician-ordered dose of ASA on 02/22/26. Review of the EMR revealed a physician order dated 11/13/25 for lidocaine external patch 5% to be applied topically to the lower back in the morning for pain. Review of the MAR revealed the resident did not receive the physician-ordered lidocaine patch on 02/22/26. Review of the EMR revealed a physician order dated 01/31/26 for two capsules of Nuedexta 20-10 mg by mouth in the morning for major depressive disorder. Review of the MAR revealed the resident did (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	not receive the physician-ordered dose of Nuedexta on 02/22/26. Review of the EMR revealed a physician order dated 08/13/25 for one and one-half tablets of sertraline HCl 100 mg by mouth in the morning for major depressive disorder. Review of the MAR revealed the resident did not receive the physician-ordered dose of sertraline HCl on 02/22/26. Review of the EMR revealed a physician order dated 02/02/26 for carvedilol 3.125 mg by mouth two times a day for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered dose of carvedilol on 02/22/26. Review of the EMR revealed a physician order dated 11/12/25 for two capsules of Depakote Sprinkles 125 mg by mouth two times a day for increased behaviors. Review of the MAR revealed the resident did not receive the physician-ordered dose of Depakote Sprinkles on 02/22/26. Review of the EMR revealed a physician order dated 12/02/25 for diazepam 5 mg/5 mL, administer 2 mL by mouth two times a day for agitation. Review of the MAR revealed the resident did not receive the physician-ordered dose of diazepam on the morning of 02/22/26. Review of the EMR revealed a physician order dated 02/21/26 for levetiracetam 100 mg/mL, administer 5 mL by mouth two times a day for anoxic brain damage. Review of the MAR revealed the resident did not receive the physician-ordered dose of levetiracetam on the morning of 02/22/26. Review of the EMR revealed a physician order dated 02/21/26 for minoxidil 5 mg by mouth two times a day for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered dose of minoxidil on the morning of 02/22/26. Review of the EMR revealed a physician order dated 02/25/26 for buspirone 10 mg by mouth three times a day for anxiety. Review of the MAR revealed the resident did not receive two of the three physician-ordered doses of buspirone on 02/22/26 at 6:00 A.M. and 1:00 P.M. Review of the EMR revealed a physician order dated 08/13/25 for gabapentin 600 mg by mouth three times a day for agitation. Review of the MAR revealed the resident did not receive two of the three physician-ordered doses of gabapentin on 02/22/26 at 6:00 A.M. and 1:00 P.M. Review of the EMR revealed a physician order dated 08/13/25 for the head of the bed (HOB) to be elevated every shift to alleviate shortness of breath related to chronic respiratory failure. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 02/13/26 for a pain assessment using a 0–10 pain scale every shift. Review of the TAR revealed the ordered pain assessment was not completed during the day shift on 02/22/26. Review of the MAR revealed a physician order dated 09/17/25 for a diet communication order of regular diet, mechanical soft consistency, with thin liquids. Review of the TAR revealed the resident did not receive the physician-ordered diet communication on 02/22/26. Review of the EMR revealed a physician order dated 08/18/25 to monitor behaviors and document interventions every shift. Review of the TAR revealed physician-ordered behavior monitoring and interventions were not completed during the day shift on 02/22/26. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the EMR revealed a physician order dated 08/13/25 for the resident to wear t-shirts instead of nightgowns as tolerated every shift. Review of the TAR revealed the resident did not receive the physician-ordered clothing on the day shift of 02/22/26. During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #12 did not receive the physician-ordered doses of sertraline, aspirin, gabapentin, amlodipine, lidocaine patch, buspirone, Depakote Sprinkles, diazepam, Nuedexta, carvedilol, minoxidil, and levetiracetam on 02/22/26. The DON further confirmed the ordered day shift pain assessment, head-of-bed elevation, behavior monitoring, diet communication, and ordered clothing were not completed on 02/22/26. 3. Review of the EMR for Resident #15 revealed an admission date of 10/20/25 with diagnoses including anoxic brain damage, acute respiratory failure with hypoxia, nontraumatic intracerebral hemorrhage, seizures, encephalopathy, dysphagia, iron deficiency anemia, gastrostomy status, personal history of sudden cardiac arrest, congestive heart failure (CHF), other specified diseases of the liver, and cerebral infarction. Review of the most recent quarterly MDS assessment dated [DATE] revealed an Interview BIMS score of 99, indicating the cognitive assessment was unable to be completed. Further review of the assessment revealed Resident #15 required total assistance for functional areas including hygiene, dressing, repositioning, transferring, and locomotion via wheelchair. Review of the EMR revealed a physician order dated 02/22/26 for aspirin (ASA) 81 mg by mouth once daily for history of sudden cardiac arrest. Review of the MAR revealed the resident did not receive the physician-ordered dose of ASA on 02/22/26. Review of the EMR revealed a physician order dated 11/11/25 for lactulose 10 grams (g)/15 milliliters (mL), administer 10 mL by mouth once daily for elevated ammonia level. Review of the MAR revealed the resident did not receive the physician-ordered dose of lactulose on 02/22/26. Review of the EMR revealed a physician order dated 10/31/25 for MiraLAX 17 g by mouth every morning for constipation. Review of the MAR revealed the resident did not receive the physician-ordered dose of MiraLAX on 02/22/26. Review of the EMR revealed a physician order dated 10/20/25 for chlorhexidine gluconate mouth/throat solution 15 mg orally two times a day to prevent infection. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician orders dated 02/21/26 for clobazam oral film 10 mg two times per day for seizures, levetiracetam oral solution 15 mL two times a day for seizures, and valproic acid oral solution 10 mL two times per day for seizures. Review of the MAR revealed the resident did not receive the physician-ordered morning dose on 02/22/26. Review of the EMR revealed a physician order dated 02/12/26 for omeprazole 20 mg two times a day for gastroesophageal reflux disease (GERD). Review of the MAR revealed the resident did not receive the physician-ordered morning dose on 02/22/26. Review of the EMR revealed a physician order dated 10/21/25 for a pain assessment using a 0–10 pain scale every shift. Review of the TAR revealed the ordered pain assessment was not completed during the day shift on 02/22/26. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the EMR revealed a physician order dated 10/24/25 to flush the resident's percutaneous endoscopic gastrostomy (PEG) tube with 60 mL of water before and after each bolus feeding and every four hours. Review of the MAR revealed the resident did not receive the physician-ordered PEG tube flushes at 10:00 A.M. and 2:00 P.M. on 02/22/26. Review of the EMR revealed a physician order dated 10/24/25 for Jevity 1.5, administer 237 mL bolus feeding every four hours for tube feeding. Review of the MAR revealed the resident did not receive the physician-ordered Jevity 1.5 bolus feedings at 10:00 A.M. and 2:00 P.M. on 02/22/26. Review of the EMR revealed a physician order dated 10/22/25 to check PEG tube placement prior to medication administration and feedings every shift. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 10/22/25 to check gastric residuals and, if greater than 100 cubic centimeters (cc), hold the feeding for one hour, recheck after one hour, and notify the physician if still greater than 100 mL. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 10/21/25 to maintain the HOB in an elevated position as tolerated every shift to prevent or alleviate shortness of breath related to the resident's tracheostomy. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 12/09/25 to check the resident's peripheral oxygen saturation (SpO2) every shift and as needed. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26. During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #15 did not receive the physician-ordered doses of MiraLAX, lactulose, omeprazole, valproic acid, aspirin, levetiracetam, clobazam, chlorhexidine gluconate mouth/throat solution, Jevity 1.5 tube feeding, or PEG tube flushes on 02/22/26. The DON further confirmed the ordered day shift pain assessment, head-of-bed elevation, PEG tube placement checks, and residual checks were not completed on 02/22/26. 4. Review of the EMR for Resident #24 revealed an admission date of 07/13/25 with diagnoses including malignant neoplasm of the prostate, severe protein-calorie malnutrition, chronic gastritis without bleeding, viral hepatitis C, supraventricular tachycardia (SVT), thrombocytosis, alcohol abuse, osteoarthritis, chronic pain, rash, altered mental status (AMS), hypertension (HTN), urinary retention, and allergic rhinitis. Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 09, indicating the resident had moderately impaired cognition. Further review of the assessment revealed the resident required assistance with activities of daily living including eating, showering/bathing, hygiene, and transfers. Review of the EMR revealed a physician order dated 02/22/26 for amlodipine besylate 10 mg by mouth once daily for supraventricular tachycardia. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician orders dated 07/14/25 for bicalutamide 50 mg by mouth once (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	on 02/22/26. Review of the EMR revealed a physician order dated 02/23/25 for sertraline 12.5 mg (one-half tablet of 25 mg) by mouth every morning for depression. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician order dated 02/16/26 for enhanced barrier precautions (EBP) every shift. Enhanced barrier precautions require staff to wear gloves and gowns during high-contact resident care activities for residents at risk of or colonized with multidrug-resistant organisms (MDROs). Review of the TAR revealed the physician-ordered EBP were not implemented during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 12/28/25 to maintain the HOB elevated every shift to alleviate shortness of breath related to COPD. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 10/30/25 for levetiracetam 750 mg by mouth two times a day for seizures. Review of the MAR revealed the resident did not receive the physician-ordered dose during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 11/25/25 for metoprolol tartrate 25 mg by mouth two times a day. Review of the MAR revealed the resident did not receive the physician-ordered dose during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 10/30/25 for acetaminophen (APAP) 1000 mg by mouth three times a day for pain. Review of the MAR revealed the resident did not receive the physician-ordered doses in the morning and afternoon on 02/22/26. Review of the EMR revealed a physician order for baclofen 10 mg by mouth three times a day for muscle relaxation. Review of the MAR revealed the resident did not receive the physician-ordered doses in the morning and afternoon on 02/22/26. During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #34 did not receive the physician-ordered doses of baclofen, acetaminophen, aspirin, lisinopril, lidocaine patch, levetiracetam, sertraline, Anoro Ellipta, clopidogrel, or metoprolol on 02/22/26. The DON further confirmed the physician-ordered head-of-bed elevation and enhanced barrier precautions were not implemented on 02/22/26. 6. Review of the EMR for Resident #43 revealed an admission date of 11/28/25 with diagnoses including monoplegia of the upper limb, dysphagia, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), hypertension (HTN), functional quadriplegia, dementia, dry eye syndrome, long-term use of insulin, major depressive disorder, anxiety, generalized muscle weakness, and oropharyngeal dysphagia. Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident was relatively cognitively intact. Further review of the assessment revealed the resident had impairment of the upper and lower extremities on one side and required substantial to maximal assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transfers. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the EMR revealed a physician order for aspirin (ASA) 81 mg by mouth every morning for cerebrovascular accident (CVA). Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician order for blood glucose monitoring every morning for diabetes management. Review of the MAR revealed the physician-ordered blood sugar check was not completed on 02/22/26. Review of the EMR revealed a physician order for ergocalciferol 2000 units by mouth once daily for vitamin D deficiency. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician order for vitamin B-12 500 micrograms (mcg) by mouth once daily for supplement. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician order for apixaban 5 mg by mouth two times a day for cerebrovascular accident. Review of the MAR revealed the resident did not receive the physician-ordered morning dose on 02/22/26. Review of the EMR revealed a physician order for buspirone 5 mg by mouth once daily for anxiety. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26. Review of the EMR revealed a physician order for carvedilol 25 mg by mouth two times a day for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered morning dose on 02/22/26. Review of the EMR revealed a physician order for metformin 1000 mg by mouth two times a day for type 2 diabetes mellitus. Review of the MAR revealed the resident did not receive either of the physician-ordered doses on 02/22/26. Review of the EMR revealed a physician order dated 01/13/25 for magnesium 400 mg by mouth once daily for hypomagnesemia. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order for insulin aspart FlexPen 100 units/milliliter (u/mL) to be administered subcutaneously per sliding scale before meals and at bedtime. Review of the MAR revealed the resident did not receive the physician-ordered doses at 11:00 A.M. or 4:00 P.M. on 02/22/26. Review of the EMR revealed a physician order dated 12/23/25 to maintain the HOB elevated every shift to alleviate shortness of breath related to COPD. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26. Review of the EMR revealed a physician order dated 03/18/25 to monitor behaviors and document interventions every shift. Review of the TAR revealed behavior monitoring and documentation of interventions were not completed during the day shift on 02/22/26. Review of the EMR revealed a physician order for a sign to be placed in Resident #43's room instructing the resident to call for assistance prior to self-transferring every shift. Review of the TAR revealed this physician-ordered intervention was not implemented during the day shift on 02/22/26. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #43 did not receive the physician-ordered doses of aspirin, buspirone, vitamin B12, carvedilol, metformin, apixaban, ergocalciferol, insulin aspart, and magnesium on 02/22/26. The DON further confirmed the physician-ordered behavior monitoring, blood sugar checks, and head-of-bed elevation were not implemented on 02/22/26. 7. Review of the EMR for Resident #75 revealed an admission date of 07/24/23 with diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), moderate protein-calorie malnutrition, obstructive sleep apnea (OSA), acute renal failure (ARF), heart disease, anxiety, hypertension (HTN), hypothyroidism, transient ischemic attack (TIA), mild neurocognitive disorder, schizoaffective disorder, convulsions, and restless leg syndrome (RLS). Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident's cognition was intact. Further review of the assessment revealed Resident #75 required assistance with activities of daily living including toileting, bathing, dressing, hygiene, repositioning in bed, transferring, ambulation, and locomotion via wheelchair. Review of the EMR revealed multiple physician orders for medications including amlodipine, aspirin (ASA), Breo Ellipta, doxazosin mesylate, duloxetine HCl, fexofenadine HCl, tamsulosin (Flomax), furosemide, Incruse Ellipta, insulin glargine, isosorbide mononitrate extended release, losartan potassium, paliperidone ER, potassium chloride, ProStat sugar free nutritional supplement, vitamin C, carvedilol (Coreg), cyclosporine ophthalmic emulsion, famotidine, glipizide, levetiracetam (Keppra), metformin, quetiapine fumarate, buspirone HCl, hydralazine HCl, and insulin aspart per sliding scale. Review of the MAR revealed the resident did not receive numerous physician-ordered medications on 02/22/26, including the morning doses of amlodipine, aspirin, Breo Ellipta, doxazosin, duloxetine, fexofenadine, tamsulosin, furosemide, Incruse Ellipta, insulin glargine, isosorbide mononitrate ER, losartan, palipe

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic medical record (EMR) review, review of the Medication Administration Record (MAR), review of the Treatment Administration Record (TAR), staff interview, and review of facility documentation, the facility failed to ensure residents received necessary care and services in accordance with professional standards of nursing practice and physician orders. Specifically, the facility failed to ensure physician-ordered medications, treatments, assessments, monitoring, and interventions were implemented as ordered for 10 residents (#9, #12, #15, #24, #34, #43, #75, #77, #85, and #89).The facility's failure included, but was not limited to, failure to complete physician-ordered pain assessments; failure to administer ordered medications and tube feedings; failure to perform percutaneous endoscopic gastrostomy (PEG) tube monitoring and flushes; failure to perform blood glucose monitoring; failure to implement enhanced barrier precautions; failure to maintain head-of-bed elevation as ordered for respiratory conditions; failure to complete ordered behavior monitoring; failure to implement ordered safety supervision and interventions; and failure to document completion of ordered respiratory and therapy-related interventions.These failures occurred during the day shift on 02/22/26 and resulted in multiple residents not receiving ordered care and monitoring necessary to assess, maintain, and support their health and safety. This deficient practice reflects a breakdown in the facility's systems to ensure physician orders were implemented and monitored in accordance with professional standards of practice. The facility census was 89. Findings include: 1. Review of the EMR for Resident #9 revealed an admission date of 02/13/26 with diagnoses including alcohol abuse, depression, anxiety, hypertension (HTN), insomnia, vitamin B12 deficiency, and vitamin D deficiency.Review of Resident #9's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed the resident required supervision or touching assistance with functional tasks including eating, hygiene, toileting, dressing, transferring, and walking.Review of the EMR revealed a physician order dated 02/13/26 for a pain assessment using a 0-10 pain scale every shift. Review of the TAR revealed the ordered pain assessment was not completed during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the Director of Nursing (DON) confirmed ordered day shift pain assessment was not completed on 02/22/26.2. Review of the EMR for Resident #12 revealed an admission date of 09/17/23 with diagnoses including anoxic brain damage, personal history of sudden cardiac arrest, dissection of abdominal aorta, non-ST-elevation myocardial infarction (NSTEMI), depression, heart failure, anxiety, chronic respiratory failure with hypoxia, stage 3B chronic kidney disease (CKD3B), oropharyngeal dysphagia, seizures, pseudobulbar affect (PBA), urinary incontinence, incontinence of feces, sleep apnea, gastroesophageal reflux disease (GERD), insomnia, hyperlipidemia, dilated cardiomyopathy, major depressive disorder, and hypertension (HTN).Review of Resident #12's most recent quarterly MDS assessment revealed a BIMS score of 02, indicating severe cognitive impairment. Further review of the assessment revealed the resident required extensive assistance to total dependence for activities of daily living, including eating, hygiene, bathing, dressing, repositioning, and transferring.Review of the EMR revealed a physician order dated 08/13/25 for the head of the bed (HOB) to be elevated every shift to alleviate shortness of breath related to chronic respiratory failure. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26.Review of the MAR revealed a physician order dated 09/17/25 for a diet communication order of regular diet, mechanical soft consistency, with thin liquids. Review of the TAR revealed the resident did not receive the physician-ordered diet communication on 02/22/26.Review of the EMR revealed a physician order dated 08/18/25 to monitor behaviors and document interventions every shift. Review of the TAR revealed physician-ordered behavior monitoring and interventions were not completed during the day shift on 02/22/26.Review of the EMR revealed a physician order dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	08/13/25 for the resident to wear t-shirts instead of nightgowns as tolerated every shift. Review of the TAR revealed the resident did not receive the physician-ordered clothing on the day shift of 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #12 did not receive the physician-ordered behavior monitoring, diet communication, and ordered clothing were not completed on 02/22/26.3. Review of the EMR for Resident #15 revealed an admission date of 10/20/25 with diagnoses including anoxic brain damage, acute respiratory failure with hypoxia, nontraumatic intracerebral hemorrhage, seizures, encephalopathy, dysphagia, iron deficiency anemia, gastrostomy status, personal history of sudden cardiac arrest, congestive heart failure (CHF), other specified diseases of the liver, and cerebral infarction.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, indicating the cognitive assessment was unable to be completed. Further review of the assessment revealed Resident #15 required total assistance for functional areas including hygiene, dressing, repositioning, transferring, and locomotion via wheelchair.Review of the EMR revealed a physician order dated 10/21/25 for a pain assessment using a 0-10 pain scale every shift. Review of the Treatment Administration Record (TAR) revealed the ordered pain assessment was not completed during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 10/24/25 to flush the resident's PEG tube with 60 mL of water before and after each bolus feeding and every four hours. Review of the MAR revealed the resident did not receive the physician-ordered PEG tube flushes at 10:00 A.M. and 2:00 P.M. on 02/22/26.Review of the EMR revealed a physician order dated 10/22/25 to check PEG tube placement prior to medication administration and feedings every shift. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 10/22/25 to check gastric residuals and, if greater than 100 cubic centimeters (cc), hold the feeding for one hour, recheck after one hour, and notify the physician if still greater than 100 cc. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 10/21/25 to maintain the HOB in an elevated position as tolerated every shift to prevent or alleviate shortness of breath related to the resident's tracheostomy. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 12/09/25 to check the resident's peripheral oxygen saturation (SpO2) every shift and as needed. Review of the TAR revealed this physician-ordered intervention was not completed during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #15 did not have the PEG tube placement, residual or flushes completed during the day shift on 02/22/26. The DON further confirmed the ordered day shift pain assessment, head-of-bed elevation, and a check of Resident #15's oxygen saturation was not completed on 02/22/26.4. Review of the EMR for Resident #24 revealed an admission date of 07/13/25 with diagnoses including malignant neoplasm of the prostate, severe protein-calorie malnutrition, chronic gastritis without bleeding, viral hepatitis C, supraventricular tachycardia (SVT), thrombocytosis, alcohol abuse, osteoarthritis, chronic pain, rash, altered mental status (AMS), hypertension (HTN), urinary retention, and allergic rhinitis.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 09, indicating the resident had moderately impaired cognition. Further review of the assessment revealed the resident required assistance with activities of daily living including eating, showering/bathing, hygiene, and transfers.Review of the EMR revealed a physician order dated 07/14/25 for a pain assessment using a 0-10 pain scale every shift. Review of the TAR revealed the ordered pain assessment was not completed during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON the physician-ordered pain assessment during the day shift was not completed on 02/22/26.5. Review of the EMR for Resident #34 revealed an admission date of 01/29/24 with diagnoses including central cord syndrome at the C5 level of the cervical spinal cord, severe protein-calorie malnutrition, transient ischemic attack (TIA), chronic obstructive pulmonary disease (COPD), asthma, epilepsy, quadriplegia, acute renal failure (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	(ARF), gangrene and necrosis of lung, acquired absence of kidney, pneumonia, dysphagia, sepsis, displaced intertrochanteric fracture of the right femur, generalized muscle weakness, cognitive communication deficit, anemia, sensorineural hearing loss, peripheral vascular disease, age-related nuclear cataract, left knee contracture, major depressive disorder, hyperlipidemia, nicotine dependence, hypertension (HTN), cervical spondylosis, right knee contracture, post-traumatic seizures, and hypotension.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed Resident #34 had bilateral impairment of the upper and lower extremities and required total assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transferring.Review of the EMR revealed a physician order dated 02/16/26 for enhanced barrier precautions (EBP) every shift. Enhanced barrier precautions require staff to wear gloves and gowns during high-contact resident care activities for residents at risk of or colonized with multidrug-resistant organisms (MDROs). Review of the TAR revealed the physician-ordered EBP were not implemented during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 12/28/25 to maintain the head of the HOB elevated every shift to alleviate shortness of breath related to COPD. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., DON confirmed the physician-ordered head-of-bed elevation and enhanced barrier precautions were not implemented on 02/22/26.6. Review of the EMR for Resident #43 revealed an admission date of 11/28/25 with diagnoses including monoplegia of the upper limb, dysphagia, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), hypertension (HTN), functional quadriplegia, dementia, dry eye syndrome, long-term use of insulin, major depressive disorder, anxiety, generalized muscle weakness, and oropharyngeal dysphagia.Review of the most recent quarterly MDS assessment dated [DATE] revealed an Interview BIMS score of 13, indicating the resident was relatively cognitively intact. Further review of the assessment revealed the resident had impairment of the upper and lower extremities on one side and required substantial to maximal assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transfers.Review of the EMR revealed a physician order for blood glucose monitoring every morning for diabetes management. Review of the MAR revealed the physician-ordered blood sugar check was not completed on 02/22/26.Review of the EMR revealed a physician order dated 12/23/25 to maintain the HOB elevated every shift to alleviate shortness of breath related to COPD. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26.Review of the EMR revealed a physician order for a sign to be placed in Resident #43's room instructing the resident to call for assistance prior to self-transferring every shift. Review of the TAR revealed this physician-ordered intervention was not implemented during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON the physician-ordered behavior monitoring, blood sugar checks, and head-of-bed elevation were not implemented on 02/22/26.7. Review of the EMR for Resident #75 revealed an admission date of 07/24/23 with diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), moderate protein-calorie malnutrition, obstructive sleep apnea (OSA), acute renal failure (ARF), heart disease, anxiety, hypertension (HTN), hypothyroidism, transient ischemic attack (TIA), mild neurocognitive disorder, schizoaffective disorder, convulsions, and restless leg syndrome (RLS).Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident's cognition was intact. Further review of the assessment revealed Resident #75 required assistance with activities of daily living including toileting, bathing, dressing, hygiene, repositioning in bed, transferring, ambulation, and locomotion via wheelchair.Review of the EMR further revealed a physician order dated 09/25/24 to maintain the HOB elevated every shift to alleviate shortness of breath related to COPD. Review of the TAR revealed the HOB was not elevated during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 02/18/24 for a pain assessment using a 0-10 pain scale every shift. Review of the TAR revealed the ordered pain (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	assessment was not completed during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 10/24/25 for thromboembolic deterrent (TED) hose to be applied in the morning and removed at night for hypotension. Review of the TAR revealed this physician-ordered intervention was not implemented on 02/22/26.Review of the EMR revealed a physician order dated 08/18/25 to monitor behaviors and document interventions every shift. Review of the TAR revealed behavior monitoring and documentation of interventions were not completed during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed the physician-ordered behavior monitoring, pain assessment, head-of-bed elevation, and other ordered interventions were not implemented on 02/22/26.8. Review of the EMR for Resident #77 revealed an admission date of 07/27/19 with diagnoses including monoplegia of the upper limb following a cerebral infarction affecting the left non-dominant side, HTN, depression, GERD, hyperlipidemia, atherosclerotic heart disease, aphasia following cerebral infarction, DM2, drug-induced secondary parkinsonism, dysarthria and anarthria, and peripheral vascular disease.Review of Resident #77's most recent annual MDS assessment, dated 12/05/25, revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review of this assessment revealed Resident #77 had impairment in one upper and one lower limb and required assistance with all functional abilities, including eating, hygiene, bathing, dressing, transferring, and toileting.EMR review also revealed a physician order dated 07/03/19 for a 0-10 pain scale assessment every shift. MAR review revealed this ordered pain assessment was not completed during the day shift on 02/22/26.EMR review revealed a physician order dated 08/18/25 to monitor behaviors and document interventions every shift. TAR review revealed this physician-ordered behavior monitoring and documentation was not completed during the day shift on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #77 did not receive the physician-ordered assessment and behavior monitoring were not implemented on 02/22/26.9. Review of the EMR revealed Resident #85 had an admission date of 07/25/25 with diagnoses including COPD, major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder (PTSD), nightmare disorder, colostomy status, personal history of military deployment, personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus, severe protein-calorie malnutrition, unspecified abnormalities of gait and mobility, non-pressure chronic ulcer of skin of other sites with fat layer exposed, HTN, hearing loss, repeated falls, and bradycardia.The most recent quarterly MDS assessment, dated 02/01/26, revealed a BIMS score of 14, indicating the resident was cognitively intact. Further review of this assessment revealed Resident #85 required partial to maximal assistance with functional abilities including, but not limited to, eating, hygiene, bathing, dressing, repositioning, transferring, and wheeling in a wheelchair.EMR review also revealed a physician order dated 08/18/25 to monitor behaviors and document interventions every shift. TAR review revealed this physician-ordered behavior monitoring and documentation of interventions were not completed during the day shift on 02/22/26.Additionally, EMR review revealed a physician order dated 01/30/26 for increased supervision after meals to assist the resident with transfers in and out of bed for safety. TAR review revealed this physician-ordered intervention was not completed after breakfast and lunch on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed the physician-ordered behavior monitoring and increased supervision after meals to assist with transfers in and out of bed for safety were not implemented on 02/22/26.10. Review of the EMR revealed Resident #89 had an admission date of 05/06/25 with diagnoses including chronic respiratory failure, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, benign prostatic hyperplasia (BPH), other idiopathic peripheral autonomic neuropathy, atrial fibrillation, HTN, obstructive sleep apnea (OSA), COPD, generalized anxiety disorder, fracture of unspecified part of the neck of the right femur, elevated white blood cells (WBC), chronic peripheral venous insufficiency, nasal congestion, urinary retention, and idiopathic progressive neuropathy.The most recent quarterly MDS assessment, dated 01/10/26, revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review of this assessment revealed Resident #89 required (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	maximal assistance or was dependent for functional abilities including, but not limited to, oral hygiene, toileting, bathing, dressing, hygiene, repositioning, transferring, and wheeling in a wheelchair.EMR review further revealed physician orders dated 02/27/26 for enhanced barrier precautions (EBP) every shift; 10/20/25 to maintain the HOB elevated every shift to alleviate shortness of breath related to chronic respiratory failure; 10/07/25 for oxygen at three liters per minute via nasal cannula each shift; 10/20/25 for transfer and range-of-motion exercises with PT/OT two times daily; and 02/23/26 to utilize the blue Acapella device at bedside four times daily with nebulizer treatments for secretion clearance. TAR review revealed the physician-ordered EBP and HOB elevation were not implemented during the day shift on 02/22/26, and monitoring associated with the oxygen and therapy interventions was not documented during the day shift. TAR review also revealed the physician ordered Acapella device intervention was not completed on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., DON confirmed the physician-ordered EBP and HOB elevation were not implemented on 02/22/26.Review of the facility Resident Agreement, dated 11/24/24, reveled the facility must protect and promote the rights of the residents. Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that will compromise necessary and appropriate care consistent with the program for which the resident is contracted.Review of the undated facility policy titled, Medication Administration, revealed medications are administered in accordance with professional standards of practice, in a manner to prevent contamination or infection. This deficiency represents non-compliance investigated under Complaint Number 2793023.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic medical record (EMR) review, review of the Medication Administration Record (MAR), staff interview, and review of facility documentation, the facility failed to ensure a resident receiving enteral nutrition received tube feeding and associated care in accordance with physician orders and professional standards of nursing practice. Specifically, the facility failed to administer physician-ordered tube feedings and required percutaneous endoscopic gastrostomy (PEG) tube flushes for one of one resident (#15) reviewed for tube feeding management. The facility census was 89. Findings include: Review of the EMR for Resident #15 revealed an admission date of 10/20/25 with diagnoses including anoxic brain damage, acute respiratory failure with hypoxia, nontraumatic intracerebral hemorrhage, seizures, encephalopathy, dysphagia, iron deficiency anemia, gastrostomy status, personal history of sudden cardiac arrest, congestive heart failure (CHF), other specified diseases of the liver, and cerebral infarction.Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating the cognitive assessment was unable to be completed. Further review of the assessment revealed Resident #15 required total assistance for functional areas including hygiene, dressing, repositioning, transferring, and locomotion via wheelchair.Review of the EMR revealed a physician order dated 10/24/25 to flush the resident's PEG tube with 60 milliliters (mLs) of water before and after each bolus feeding and every four hours. Review of the MAR revealed the resident did not receive the physician-ordered PEG tube flushes at 10:00 A.M. and 2:00 P.M. on 02/22/26.Review of the EMR revealed a physician order dated 10/24/25 for Jevity 1.5, administer 237 mL bolus feeding every four hours for tube feeding. Review of the MAR revealed the resident did not receive the physician-ordered Jevity 1.5 bolus feedings at 10:00 A.M. and 2:00 P.M. on 02/22/26.Review of the facility Resident Agreement, dated 11/24/24, revealed the facility must protect and promote the rights of the residents. Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that will compromise necessary and appropriate care consistent with the program for which the resident is contracted.Review of the undated facility policy titled, Medication Administration, revealed medications are administered in accordance with professional standards of practice, in a manner to prevent contamination or infection. This deficiency represents non-compliance investigated under Complaint Number 2793023.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on electronic medical record (EMR) review, review of the Medication Administration Record (MAR), Treatment Administration Record (TAR) review, staff interview, and review of facility documentation, the facility failed to provide routine and emergency medications and biologicals to meet the needs of each resident and failed to ensure medications were available and administered in accordance with physician orders and professional standards of practice. Specifically, the facility failed to ensure the availability and administration of physician-ordered medications for nine (#9, #12, #15, #24, #34, #43, #75, #77, and #89) of ten residents reviewed for medication administration. The facility census was 89. Findings include: 1. Review of the EMR for Resident #9 revealed an admission date of 02/13/26 with diagnoses including alcohol abuse, depression, anxiety, hypertension (HTN), insomnia, vitamin B12 deficiency, and vitamin D deficiency.Review of Resident #9's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed the resident required supervision or touching assistance with functional tasks including eating, hygiene, toileting, dressing, transferring, and walking.Review of the EMR revealed a physician orders dated 02/14/26 for cholecalciferol oral tablet 25 micrograms (mcg), administer two tablets by mouth every morning (total dose 50 mcg) for supplement, and cyanocobalamin oral tablet 500 mcg, administer one tablet by mouth once daily for supplement. Review of the MAR revealed the resident did not receive the physician-ordered doses of cholecalciferol and cyanocobalamin on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the Director of Nursing (DON) confirmed Resident #9 did not receive the physician-ordered doses of cholecalciferol and cyanocobalamin on 02/22/26.2. Review of the EMR for Resident #12 revealed an admission date of 09/17/23 with diagnoses including anoxic brain damage, personal history of sudden cardiac arrest, dissection of abdominal aorta, non-ST-elevation myocardial infarction (NSTEMI), depression, heart failure, anxiety, chronic respiratory failure with hypoxia, stage 3B chronic kidney disease (CKD3B), oropharyngeal dysphagia, seizures, pseudobulbar affect (PBA), urinary incontinence, incontinence of feces, sleep apnea, gastroesophageal reflux disease (GERD), insomnia, hyperlipidemia, dilated cardiomyopathy, major depressive disorder, and hypertension (HTN).Review of Resident #12's most recent quarterly MDS assessment revealed a BIMS score of 02, indicating severe cognitive impairment. Further review of the assessment revealed the resident required extensive assistance to total dependence for activities of daily living, including eating, hygiene, bathing, dressing, repositioning, and transferring.Review of the EMR revealed a physician order dated 08/13/25 for aspirin (ASA) 81 mg by mouth in the morning for antiplatelet therapy. Review of the MAR revealed the resident did not receive the physician-ordered dose of ASA on 02/22/26.Review of the EMR revealed a physician order dated 11/13/25 for lidocaine external patch 5% to be applied topically to the lower back in the morning for pain. Review of the MAR revealed the resident did not receive the physician-ordered lidocaine patch on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #12 did not receive the physician-ordered doses of aspirin and lidocaine patch on 02/22/26.3. Review of the EMR for Resident #15 revealed an admission date of 10/20/25 with diagnoses including anoxic brain damage, acute respiratory failure with hypoxia, nontraumatic intracerebral hemorrhage, seizures, encephalopathy, dysphagia, iron deficiency anemia, gastrostomy status, personal history of sudden cardiac arrest, congestive heart failure (CHF), other specified diseases of the liver, and cerebral infarction.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, indicating the cognitive assessment was unable to be completed. Further review of the assessment revealed Resident #15 required total assistance for functional areas including hygiene, dressing, repositioning, transferring, and locomotion via wheelchair.Review of the EMR revealed a physician order dated 02/22/26 for (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	aspirin (ASA) 81 mg by mouth once daily for history of sudden cardiac arrest. Review of the Medication Administration Record (MAR) revealed the resident did not receive the physician-ordered dose of ASA on 02/22/26.Review of the EMR revealed a physician order dated 10/31/25 for MiraLAX 17 g by mouth every morning for constipation. Review of the MAR revealed the resident did not receive the physician-ordered dose of MiraLAX on 02/22/26.Review of the EMR revealed a physician order dated 10/20/25 for chlorhexidine gluconate mouth/throat solution 15 mg orally two times a day to prevent infection. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #15 did not receive the physician-ordered doses of MiraLAX, ASA and chlorhexidine gluconate on 02/22/26.4. Review of the EMR for Resident #24 revealed an admission date of 07/13/25 with diagnoses including malignant neoplasm of the prostate, severe protein-calorie malnutrition, chronic gastritis without bleeding, viral hepatitis C, supraventricular tachycardia (SVT), thrombocytosis, alcohol abuse, osteoarthritis, chronic pain, rash, altered mental status (AMS), hypertension (HTN), urinary retention, and allergic rhinitis.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 09, indicating the resident had moderately impaired cognition. Further review of the assessment revealed the resident required assistance with activities of daily living including eating, showering/bathing, hygiene, and transfers.Review of the EMR revealed a physician order dated 07/14/25 for cetirizine 10 mg by mouth once daily for allergies. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 07/14/25 for magnesium 400 mg by mouth once daily for supplement. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 07/14/25 for a multivitamin by mouth once daily for supplement. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 07/14/25 for pantoprazole 40 mg by mouth every morning for gastroesophageal reflux disease (GERD). Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 08/24/25 for potassium chloride (KCl) 20 milliequivalents (mEq) by mouth once daily for hypokalemia. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 07/19/25 for Vitamin D3 50 micrograms (mcg) by mouth once daily for general health and osteoporosis prevention. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #24 did not receive the physician-ordered doses of pantoprazole, vitamin D3, potassium chloride, multivitamin, magnesium, or cetirizine on 02/22/26.5. Review of the EMR for Resident #34 revealed an admission date of 01/29/24 with diagnoses including central cord syndrome at the C5 level of the cervical spinal cord, severe protein-calorie malnutrition, transient ischemic attack (TIA), chronic obstructive pulmonary disease (COPD), asthma, epilepsy, quadriplegia, acute renal failure (ARF), gangrene and necrosis of lung, acquired absence of kidney, pneumonia, dysphagia, sepsis, displaced intertrochanteric fracture of the right femur, generalized muscle weakness, cognitive communication deficit, anemia, sensorineural hearing loss, peripheral vascular disease, age-related nuclear cataract, left knee contracture, major depressive disorder, hyperlipidemia, nicotine dependence, hypertension (HTN), cervical spondylosis, right knee contracture, post-traumatic seizures, and hypotension.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed Resident #34 had bilateral impairment of the upper and lower extremities and required total assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transferring.Review of the EMR revealed a physician order dated 10/31/25 for aspirin (ASA) 81 milligrams (mg) by mouth once daily for anticoagulation. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 10/31/25 for lidocaine external (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	patch 5% to be applied topically to the lower back in the morning for pain. Review of the MAR revealed the resident did not receive the physician-ordered lidocaine patch on 02/22/26.Review of the EMR revealed a physician order dated 10/30/25 for acetaminophen (APAP) 1000 mg by mouth three times a day for pain. Review of the MAR revealed the resident did not receive the physician-ordered doses in the morning and afternoon on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #34 did not receive the physician-ordered doses of acetaminophen, aspirin, or lidocaine patch 02/22/26.6. Review of the EMR for Resident #43 revealed an admission date of 11/28/25 with diagnoses including monoplegia of the upper limb, dysphagia, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), hypertension (HTN), functional quadriplegia, dementia, dry eye syndrome, long-term use of insulin, major depressive disorder, anxiety, generalized muscle weakness, and oropharyngeal dysphagia.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident was relatively cognitively intact. Further review of the assessment revealed the resident had impairment of the upper and lower extremities on one side and required substantial to maximal assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transfers.Review of the EMR revealed a physician order for aspirin (ASA) 81 milligrams (mg) by mouth every morning for cerebrovascular accident (CVA). Review of the Medication Administration Record (MAR) revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order for ergocalciferol 2000 units by mouth once daily for vitamin D deficiency. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order for vitamin B-12 500 micrograms (mcg) by mouth once daily for supplement. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 01/13/25 for magnesium 400 mg by mouth once daily for hypomagnesemia. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #43 did not receive the physician-ordered doses of aspirin, vitamin B12, ergocalciferol, and magnesium on 02/22/26.7. Review of the EMR for Resident #75 revealed an admission date of 07/24/23 with diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), moderate protein-calorie malnutrition, obstructive sleep apnea (OSA), acute renal failure (ARF), heart disease, anxiety, hypertension (HTN), hypothyroidism, transient ischemic attack (TIA), mild neurocognitive disorder, schizoaffective disorder, convulsions, and restless leg syndrome (RLS).Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident's cognition was intact. Further review of the assessment revealed Resident #75 required assistance with activities of daily living including toileting, bathing, dressing, hygiene, repositioning in bed, transferring, ambulation, and locomotion via wheelchair.Review of the EMR revealed multiple physician orders for medications including aspirin (ASA), potassium chloride, ProStat sugar free nutritional supplement, vitamin C, cyclosporine ophthalmic emulsion, and famotidine.Review of the MAR revealed the resident did not receive numerous physician-ordered medications on 02/22/26, including the morning doses of aspirin, potassium chloride, ProStat, vitamin C, cyclosporine ophthalmic drops, and famotidine.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #75 did not receive multiple physician-ordered medications on 02/22/26, including famotidine, potassium chloride, cyclosporine ophthalmic drops, aspirin, vitamin C, and ProStat.8. Review of the EMR for Resident #77 revealed an admission date of 07/27/19 with diagnoses including monoplegia of the upper limb following a cerebral infarction affecting the left non-dominant side, HTN, depression, GERD, hyperlipidemia, atherosclerotic heart disease, aphasia following cerebral infarction, DM2, drug-induced secondary parkinsonism, dysarthria and anarthria, and peripheral vascular disease.Review of Resident #77's most recent annual MDS assessment, dated 12/05/25, revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	this assessment revealed Resident #77 had impairment in one upper and one lower limb and required assistance with all functional abilities, including eating, hygiene, bathing, dressing, transferring, and toileting.Review of the EMR revealed a physician order dated 02/15/24 for ASA 81 mg every morning for DVT prevention. MAR review revealed the resident did not receive the physician-ordered dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #77 did not receive the physician-ordered dose of ASA on 02/22/26.9. Review of the EMR revealed Resident #89 had an admission date of 05/06/25 with diagnoses including chronic respiratory failure, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, benign prostatic hyperplasia (BPH), other idiopathic peripheral autonomic neuropathy, atrial fibrillation, HTN, obstructive sleep apnea (OSA), COPD, generalized anxiety disorder, fracture of unspecified part of the neck of the right femur, elevated white blood cells (WBC), chronic peripheral venous insufficiency, nasal congestion, urinary retention, and idiopathic progressive neuropathy.The most recent quarterly MDS assessment, dated 01/10/26, revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review of this assessment revealed Resident #89 required maximal assistance or was dependent for functional abilities including, but not limited to, oral hygiene, toileting, bathing, dressing, hygiene, repositioning, transferring, and wheeling in a wheelchair.EMR review revealed a physician order dated 10/08/25 for a multivitamin once daily for supplement; 10/08/25 for polyethylene glycol powder 17 g once daily for constipation; and 10/08/25 for vitamin D 2000 units once daily for vitamin deficiency. MAR review revealed the resident did not receive these physician-ordered medications on 02/22/26.Additional EMR review revealed physician orders dated 10/07/25 for azelaic acid external gel 15% applied topically two times daily for rash; 10/07/25 for potassium chloride (KCl) 20 mEq two times daily for hypokalemia; and 10/07/25 for sennosides-docusate sodium 8.6-50 mg two times daily for constipation. MAR review revealed the resident did not receive the physician-ordered morning doses of these medications on 02/22/26.Further EMR review revealed physician orders dated 10/24/25 for Ensure 8 ounces two times daily for nutritional supplementation. MAR review revealed the resident did not receive the physician-ordered morning dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the Director of Nursing (DON) confirmed Resident #89 did not receive the physician-ordered doses of azelaic acid, vitamin D, apixaban, multivitamin, KCl, polyethylene glycol, sennosides-docusate, and Ensure on 02/22/26.Review of the facility Resident Agreement, dated 11/24/24, reveled the facility must protect and promote the rights of the residents. Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that will compromise necessary and appropriate care consistent with the program for which the resident is contracted.Review of the undated facility policy titled, Medication Administration, revealed medications are administered in accordance with professional standards of practice, in a manner to prevent contamination or infection. This deficiency represents non-compliance investigated under Complaint Number 2793023.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic medical record (EMR) review, review of the Medication Administration Record (MAR), staff interview, and review of facility documentation, the facility failed to ensure residents were free from significant medication errors. Specifically, the facility failed to administer numerous physician-ordered medications, including antihypertensives, anticoagulants, antiepileptics, psychotropic medications, insulin, and respiratory medications, as prescribed for 10 (#9, #12, #15, #24, #34, #43, #75, #77, #85, and #89) of 10 residents reviewed for medication administration. The facility census was 89.Findings include: 1. Review of the EMR for Resident #9 revealed an admission date of 02/13/26 with diagnoses including alcohol abuse, depression, anxiety, hypertension (HTN), insomnia, vitamin B12 deficiency, and vitamin D deficiency.Review of Resident #9's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed the resident required supervision or touching assistance with functional tasks including eating, hygiene, toileting, dressing, transferring, and walking.Review of the EMR revealed physician orders dated 02/14/26 for hydrochlorothiazide (HCTZ) 25 milligrams (mg) by mouth once daily for hypertension and paroxetine HCl 30 mg by mouth once daily for depression. Review of the MAR revealed the resident did not receive the physician-ordered dose of hydrochlorothiazide or the dose of paroxetine HCL on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the Director of Nursing (DON) confirmed Resident #9 did not receive the physician-ordered doses of cholecalciferol, cyanocobalamin, hydrochlorothiazide, and paroxetine HCl on 02/22/26.2. Review of the EMR for Resident #12 revealed an admission date of 09/17/23 with diagnoses including anoxic brain damage, personal history of sudden cardiac arrest, dissection of abdominal aorta, non-ST-elevation myocardial infarction (NSTEMI), depression, heart failure, anxiety, chronic respiratory failure with hypoxia, stage 3B chronic kidney disease (CKD3B), oropharyngeal dysphagia, seizures, pseudobulbar affect (PBA), urinary incontinence, incontinence of feces, sleep apnea, gastroesophageal reflux disease (GERD), insomnia, hyperlipidemia, dilated cardiomyopathy, major depressive disorder, and hypertension (HTN).Review of Resident #12's most recent quarterly MDS assessment revealed a BIMS score of 02, indicating severe cognitive impairment. Further review of the assessment revealed the resident required extensive assistance to total dependence for activities of daily living, including eating, hygiene, bathing, dressing, repositioning, and transferring.Review of the EMR revealed a physician order dated 02/22/26 for amlodipine 10 mg by mouth in the morning for dilated cardiomyopathy. Review of the MAR revealed the resident did not receive the physician-ordered dose of amlodipine on 02/22/26.Review of the EMR revealed a physician order dated 01/31/26 for two capsules of Nuedexta 20-10 mg by mouth in the morning for major depressive disorder. Review of the MAR revealed the resident did not receive the physician-ordered dose of Nuedexta on 02/22/26.Review of the EMR revealed a physician order dated 02/02/26 for carvedilol 3.125 mg by mouth two times a day for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered dose of carvedilol on 02/22/26.Review of the EMR revealed a physician order dated 11/12/25 for two capsules of Depakote Sprinkles 125 mg by mouth two times a day for increased behaviors. Review of the MAR revealed the resident did not receive the physician-ordered dose of Depakote Sprinkles on 02/22/26.Review of the EMR revealed a physician order dated 12/02/25 for diazepam 5 mg/5 mL, administer 2 mL by mouth two times a day for agitation. Review of the MAR revealed the resident did not receive the physician-ordered dose of diazepam on the morning of 02/22/26.Review of the EMR revealed physician orders dated 02/21/26 for levetiracetam 100 mg/mL, administer 5 mL by mouth two times a day for anoxic brain damage, and minoxidil 5 mg by mouth two times a day for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered dose of levetiracetam or the dose of minoxidil on the morning of 02/22/26.Review of the EMR revealed a (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician order dated 02/25/26 for buspirone 10 mg by mouth three times a day for anxiety. Review of the MAR revealed the resident did not receive two of the three physician-ordered doses of buspirone on 02/22/26 at 6:00 A.M. and 1:00 P.M.Review of the EMR revealed a physician order dated 08/13/25 for gabapentin 600 mg by mouth three times a day for agitation. Review of the MAR revealed the resident did not receive two of the three physician-ordered doses of gabapentin on 02/22/26 at 6:00 A.M. and 1:00 P.M.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #12 did not receive the physician-ordered doses of sertraline, gabapentin, amlodipine, buspirone, Depakote Sprinkles, diazepam, Nuedexta, carvedilol, minoxidil, and levetiracetam on 02/22/26.3. Review of the EMR for Resident #15 revealed an admission date of 10/20/25 with diagnoses including anoxic brain damage, acute respiratory failure with hypoxia, nontraumatic intracerebral hemorrhage, seizures, encephalopathy, dysphagia, iron deficiency anemia, gastrostomy status, personal history of sudden cardiac arrest, congestive heart failure (CHF), other specified diseases of the liver, and cerebral infarction.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, indicating the cognitive assessment was unable to be completed. Further review of the assessment revealed Resident #15 required total assistance for functional areas including hygiene, dressing, repositioning, transferring, and locomotion via wheelchair.Review of the EMR revealed a physician order dated 11/11/25 for lactulose 10 grams (g)/15 milliliters (mL), administer 10 mL by mouth once daily for elevated ammonia level. Review of the MAR revealed the resident did not receive the physician-ordered dose of lactulose on 02/22/26.Review of the EMR revealed physician orders dated 02/21/26 for levetiracetam oral solution 15 mL two times a day for seizures, and valproic acid oral solution 10 mL two times per day for seizures. Review of the MAR revealed the resident did not receive the physician-ordered doses of levetiracetam and valproic acid in the morning on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #15 did not receive the physician-ordered doses of lactulose, omeprazole, valproic acid, levetiracetam, and clobazam on 02/22/26.4. Review of the EMR for Resident #24 revealed an admission date of 07/13/25 with diagnoses including malignant neoplasm of the prostate, severe protein-calorie malnutrition, chronic gastritis without bleeding, viral hepatitis C, supraventricular tachycardia (SVT), thrombocytosis, alcohol abuse, osteoarthritis, chronic pain, rash, altered mental status (AMS), hypertension (HTN), urinary retention, and allergic rhinitis.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 09, indicating the resident had moderately impaired cognition. Further review of the assessment revealed the resident required assistance with activities of daily living including eating, showering/bathing, hygiene, and transfers.Review of the EMR revealed a physician order dated 02/22/26 for amlodipine besylate 10 mgs by mouth once daily for supraventricular tachycardia. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 07/14/25 for bicalutamide 50 mg by mouth once daily for prostate cancer. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 07/14/25 for tamsulosin HCl 0.4 mg by mouth once daily for benign prostatic hyperplasia (BPH). Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #24 did not receive the physician-ordered doses of bicalutamide, amlodipine,, or tamsulosin on 02/22/26.5. Review of the EMR for Resident #34 revealed an admission date of 01/29/24 with diagnoses including central cord syndrome at the C5 level of the cervical spinal cord, severe protein-calorie malnutrition, transient ischemic attack (TIA), chronic obstructive pulmonary disease (COPD), asthma, epilepsy, quadriplegia, acute renal failure (ARF), gangrene and necrosis of lung, acquired absence of kidney, pneumonia, dysphagia, sepsis, displaced intertrochanteric fracture of the right femur, generalized muscle weakness, cognitive communication deficit, anemia, sensorineural hearing loss, peripheral vascular disease, age-related nuclear cataract, left knee contracture, major depressive disorder, hyperlipidemia, nicotine dependence, hypertension (HTN), (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cervical spondylosis, right knee contracture, post-traumatic seizures, and hypotension.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Further review of the assessment revealed Resident #34 had bilateral impairment of the upper and lower extremities and required total assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transferring.Review of the EMR revealed a physician order dated 02/22/26 for Anoro Ellipta 62.5-25 mcg per actuation (mcg/act), administer one puff by mouth once daily for COPD. Review of the Medication Administration Record (MAR) revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 02/24/25 for lisinopril 5 mg by mouth once daily for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 02/23/25 for sertraline 12.5 mg (one-half tablet of 25 mg) by mouth every morning for depression. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order dated 10/30/25 for levetiracetam 750 mg by mouth two times a day for seizures. Review of the MAR revealed the resident did not receive the physician-ordered dose during the day shift on 02/22/26.Review of the EMR revealed a physician order dated 11/25/25 for metoprolol tartrate 25 mg by mouth two times a day. Review of the MAR revealed the resident did not receive the physician-ordered dose during the day shift on 02/22/26.Review of the EMR revealed a physician order for baclofen 10 mg by mouth three times a day for muscle relaxation. Review of the MAR revealed the resident did not receive the physician-ordered doses in the morning and afternoon on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #34 did not receive the physician-ordered doses of baclofen, lisinopril, levetiracetam, sertraline, Anoro Ellipta, clopidogrel, or metoprolol on 02/22/26.6. Review of the EMR for Resident #43 revealed an admission date of 11/28/25 with diagnoses including monoplegia of the upper limb, dysphagia, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), hypertension (HTN), functional quadriplegia, dementia, dry eye syndrome, long-term use of insulin, major depressive disorder, anxiety, generalized muscle weakness, and oropharyngeal dysphagia.Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident was relatively cognitively intact. Further review of the assessment revealed the resident had impairment of the upper and lower extremities on one side and required substantial to maximal assistance with activities of daily living including eating, hygiene, dressing, repositioning, and transfers.Review of the EMR revealed a physician order for apixaban 5 mg by mouth two times a day for cerebrovascular accident. Review of the MAR revealed the resident did not receive the physician-ordered morning dose on 02/22/26.Review of the EMR revealed a physician order for buspirone 5 mg by mouth once daily for anxiety. Review of the MAR revealed the resident did not receive the physician-ordered dose on 02/22/26.Review of the EMR revealed a physician order for carvedilol 25 mg by mouth two times a day for hypertension. Review of the MAR revealed the resident did not receive the physician-ordered morning dose on 02/22/26.Review of the EMR revealed a physician order for metformin 1000 mg by mouth two times a day for type 2 diabetes mellitus. Review of the MAR revealed the resident did not receive either of the physician-ordered doses on 02/22/26.Review of the EMR revealed a physician order for insulin aspart FlexPen 100 units/milliliter (u/mL) to be administered subcutaneously per sliding scale before meals and at bedtime. Review of the MAR revealed the resident did not receive the physician-ordered doses at 11:00 A.M. or 4:00 P.M. on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #43 did not receive the physician-ordered doses of buspirone, carvedilol, metformin, apixaban, and insulin aspart on 02/22/26.7. Review of the EMR for Resident #75 revealed an admission date of 07/24/23 with diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), moderate protein-calorie malnutrition, obstructive sleep apnea (OSA), acute renal failure (ARF), heart disease, anxiety, hypertension (HTN), hypothyroidism, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transient ischemic attack (TIA), mild neurocognitive disorder, schizoaffective disorder, convulsions, and restless leg syndrome (RLS).Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating the resident's cognition was intact. Further review of the assessment revealed Resident #75 required assistance with activities of daily living including toileting, bathing, dressing, hygiene, repositioning in bed, transferring, ambulation, and locomotion via wheelchair.Review of the EMR revealed multiple physician orders for medications including amlodipine, Breo Ellipta, doxazosin mesylate, duloxetine HCl, fexofenadine HCl, tamsulosin (Flomax), furosemide, Incruse Ellipta, insulin glargine, isosorbide mononitrate extended release, losartan potassium, paliperidone ER, carvedilol (Coreg), cyclosporine ophthalmic emulsion, famotidine, glipizide, levetiracetam (Keppra), metformin, quetiapine fumarate, buspirone HCl, hydralazine HCl, and insulin aspart per sliding scale.Review of the MAR revealed the resident did not receive numerous physician-ordered medications on 02/22/26, including the morning doses of amlodipine, Breo Ellipta, doxazosin, duloxetine, fexofenadine, tamsulosin, furosemide, Incruse Ellipta, insulin glargine, isosorbide mononitrate ER, losartan, paliperidone ER, carvedilol, cyclosporine ophthalmic drops, famotidine, glipizide, levetiracetam, metformin, and quetiapine, multiple scheduled doses of buspirone at 8:00 A.M. and 11:00 A.M., hydralazine at 8:00 A.M. and 2:00 P.M., and sliding scale insulin doses of the insulin aspart at 7:00 A.M., 11:00 A.M., and 4:30 P.M.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #75 did not receive multiple physician-ordered medications on 02/22/26, including Breo Ellipta, famotidine, quetiapine, fexofenadine, cyclosporine ophthalmic drops, glipizide, insulin glargine, tamsulosin, Incruse Ellipta, furosemide, duloxetine, metformin, insulin aspart, levetiracetam, isosorbide mononitrate, amlodipine, carvedilol, doxazosin, losartan, paliperidone, hydralazine, buspirone, and glipizide.8. Review of the EMR for Resident #77 revealed an admission date of 07/27/19 with diagnoses including monoplegia of the upper limb following a cerebral infarction affecting the left non-dominant side, HTN, depression, GERD, hyperlipidemia, atherosclerotic heart disease, aphasia following cerebral infarction, DM2, drug-induced secondary parkinsonism, dysarthria and anarthria, and peripheral vascular disease.Review of Resident #77's most recent annual MDS assessment, dated 12/05/25, revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review of this assessment revealed Resident #77 had impairment in one upper and one lower limb and required assistance with all functional abilities, including eating, hygiene, bathing, dressing, transferring, and toileting.Additionally, EMR review revealed a physician order dated 05/13/25 for insulin aspart FlexPen 100 u/mL, to be administered subcutaneously per sliding scale before meals and at bedtime. MAR review revealed the resident did not receive the physician-ordered doses at 7:00 A.M., 11:00 A.M., or 4:00 P.M. on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #77 did not receive the physician-ordered doses insulin aspart on 02/22/26.9. Review of the EMR revealed Resident #85 had an admission date of 07/25/25 with diagnoses including COPD, major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder (PTSD), nightmare disorder, colostomy status, personal history of military deployment, personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus, severe protein-calorie malnutrition, unspecified abnormalities of gait and mobility, non-pressure chronic ulcer of skin of other sites with fat layer exposed, HTN, hearing loss, repeated falls, and bradycardia.The most recent quarterly MDS assessment, dated 02/01/26, revealed a BIMS score of 14, indicating the resident was cognitively intact. Further review of this assessment revealed Resident #85 required partial to maximal assistance with functional abilities including, but not limited to, eating, hygiene, bathing, dressing, repositioning, transferring, and wheeling in a wheelchair.Review of the EMR revealed a physician order for Coreg 3.125 mg two times a day for HTN. MAR review revealed the resident did not receive the physician-ordered morning dose on 02/22/26. EMR review revealed a physician order dated 02/21/26 for minoxidil 2.5 mg two times a day for HTN. MAR review revealed the resident did not receive the physician-ordered morning dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #85 did not (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive the physician-ordered doses of Coreg and minoxidil on 02/22/26.10. Review of the EMR revealed Resident #89 had an admission date of 05/06/25 with diagnoses including chronic respiratory failure, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, benign prostatic hyperplasia (BPH), other idiopathic peripheral autonomic neuropathy, atrial fibrillation, HTN, obstructive sleep apnea (OSA), COPD, generalized anxiety disorder, fracture of unspecified part of the neck of the right femur, elevated white blood cells (WBC), chronic peripheral venous insufficiency, nasal congestion, urinary retention, and idiopathic progressive neuropathy.The most recent quarterly MDS assessment, dated 01/10/26, revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review of this assessment revealed Resident #89 required maximal assistance or was dependent for functional abilities including, but not limited to, oral hygiene, toileting, bathing, dressing, hygiene, repositioning, transferring, and wheeling in a wheelchair.EMR review revealed a physician order dated 10/08/25 for amiodarone 100 mg once daily for arrhythmia. MAR review revealed the resident did not receive the physician-ordered dose on 02/22/26. EMR review further revealed physician orders dated 11/25/25 for citalopram hydrobromide 10 mg once daily for depression; 10/08/25 for Lasix 40 mg once daily for edema; 10/08/25 for loratadine 10 mg once daily for inflammation; 10/08/25 for a multivitamin once daily for supplement; 10/08/25 for polyethylene glycol powder 17 g once daily for constipation; and 10/08/25 for vitamin D 2000 units once daily for vitamin deficiency. MAR review revealed the resident did not receive these physician-ordered medications on 02/22/26.EMR review also revealed physician orders for Spiriva Respimat inhalation aerosol solution 2.5 mcg/act, two puffs once daily for COPD, and Advair Diskus inhalation powder 250/50 mcg/act two times daily for COPD. MAR review revealed the resident did not receive these physician-ordered medications on 02/22/26.Additional EMR review revealed physician orders dated 02/26/25 for apixaban 5 mg two times daily for anticoagulation therapy; 10/07/25 for azelaic acid external gel 15% applied topically two times daily for rash; and 10/07/25 for tamsulosin 0.4 mg two times daily for prostate symptoms. MAR review revealed the resident did not receive the physician-ordered morning doses of these medications on 02/22/26.Further EMR review revealed a physician orders dated 02/22/26 for guaifenesin 600 mg, two tablets two times daily for COPD. MAR review revealed the resident did not receive the physician-ordered morning dose on 02/22/26. EMR review also revealed a physician order dated 02/21/26 for buspirone 30 mg three times daily for anxiety. MAR review revealed the resident did not receive the physician-ordered morning and afternoon doses on 02/22/26.Additional EMR review revealed a physician order dated 02/12/26 for ipratropium-albuterol solution 0.5-2.5 mg/mL, 3 mL every six hours for COPD. MAR review revealed the resident did not receive the physician-ordered afternoon dose on 02/22/26.During an interview on 03/11/26 at 12:54 P.M., the DON confirmed Resident #89 did not receive the physician-ordered doses of buspirone, guaifenesin, citalopram, Lasix, Advair Diskus, Spiriva, loratadine, amiodarone, azelaic acid, apixaban, tamsulosin, sennosides-docusate, and ipratropium-albuterol on 02/22/26.Review of the facility Resident Agreement, dated 11/24/24, reveled the facility must protect and promote the rights of the residents. Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that will compromise necessary and appropriate care consistent with the program for which the resident is contracted.Review of the undated facility policy titled, Medication Administration, revealed medications are administered in accordance with professional standards of practice, in a manner to prevent contamination or infection. This deficiency represents non-compliance investigated under Complaint Number 2793023.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, medical record review, review of resident admission agreements, review of facility job descriptions, review of facility self-reported incidents (SRIs), review of facility corrective action plan, and review of facility policy, the facility failed to provide care and services to residents in accordance with professional standards of practice, the comprehensive assessment of each resident, and physician orders. This failure resulted in multiple residents not receiving prescribed medications, treatments, or care interventions, thereby potentially placing all residents residing in the facility at risk. The facility census was 89.Findings include: Interview on 03/10/26 at 7:48 A.M. with Resident #40 revealed that on 02/22/26 she observed Licensed Practical Nurse (LPN) #100 working and appearing to be under the influence of an unknown substance. Resident #40 stated that LPN #100 administered her medications late.Interview on 03/10/26 at 8:03 A.M. with Resident #22 revealed that on 02/22/26 she observed LPN #100 working and appearing to be under the influence of an unknown substance. Resident #22 stated that LPN #100 told her she had been up for three days. Resident #22 further stated she observed LPN #100 administer medication to Resident #81 after dropping the medications on the floor. Resident #22 stated that LPN #223 and Certified Nursing Assistant (CNA) #101 telephoned the on-call manager, LPN #105, from the facility to notify her of LPN #100's erratic behaviors.Interview on 03/10/26 at 10:13 A.M. with the Director of Nursing (DON) revealed that neither she nor the Administrator were made aware of LPN #100's erratic behavior on 02/22/26. The DON stated that calls placed by CNA #101 and LPN #223 were directed to LPN #105 and not to herself or the Administrator. The DON stated that LPN #105 notified her that facility staff reported LPN #100 was acting strange but did not notify her of the extent of the erratic behavior. The DON stated that LPN #100 completed her scheduled shift on 02/22/26 and returned to work on 02/23/26, working part of her shift. The DON stated that LPN #105 told her LPN #100 reported being tired due to not sleeping well in the days immediately prior.Review of time punches for LPN #100 revealed she worked on 02/22/26 from 6:17 A.M. through 6:18 P.M., with a lunch break from 10:30 A.M. through 11:00 A.M. Further review of time punches revealed that on 02/23/26 LPN #100 worked from 6:20 A.M. through 12:38 P.M.Interview on 03/10/26 at 10:59 A.M. with LPN #105 verified she received calls from CNA #101 and LPN #223 on 02/22/26 regarding LPN #100's behavior. LPN #105 stated she notified the DON of the staff's concerns and was directed to call the facility and speak with LPN #100. LPN #105 stated that when she spoke with LPN #100 she appeared coherent and reported she was tired due to not sleeping well in the days immediately prior. LPN #105 stated she received no additional direction from the DON on 02/22/26. LPN #105 further stated that on 02/23/26 facility residents began complaining about LPN #100 and it was at that time the facility made the decision to drug test LPN #100. LPN #100 tested positive for cocaine.Interview on 03/10/26 at 11:35 A.M. with the DON revealed she asked LPN #223 why she did not contact herself or the Administrator regarding the concerns on 02/22/26. The DON stated that LPN #223 reported that LPN #105 told her she was going to contact the Administrator.Interview on 03/10/26 at 11:41 A.M. with Resident #81 revealed that on 02/22/26 LPN #100 appeared to be under the influence of an unknown substance. Resident #81 stated that LPN #100 administered his pain medication after dropping it on the floor. Resident #81 stated he reported his concerns to the DON and Administrator on 02/23/26 at approximately 10:00 A.M.Interview on 03/10/26 at 11:58 A.M. with Resident #9 revealed he did not receive his medications on 02/22/26.Interview on 03/10/26 at 12:27 P.M. with LPN #223 revealed that on 02/22/26 she observed LPN #100 appearing to be under the influence of an unknown substance. LPN #223 stated that Resident #81 informed her that LPN #100 dropped his medications and was slamming items. LPN #223 stated that LPN #100 appeared disheveled and very tired. LPN #223 stated she contacted LPN #105 to report her concerns and was told by LPN #105 she would investigate the situation and notify the Administrator.Interview on 03/11/26 at 9:52 A.M. with CNA (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	#101 revealed she contacted LPN #105 three times on 02/22/26 at approximately 11:30 A.M., 12:41 P.M., and 2:52 P.M. CNA #101 stated she informed LPN #105 that LPN #100 was acting weird, appeared to be under the influence of an unknown substance, was falling asleep while standing up, and dozing off mid-conversation. CNA #101 further stated she informed LPN #105 that LPN #100 entered Resident #40's room and fell asleep on the resident's bed. CNA #101 stated that throughout her shift residents voiced concerns to her about not receiving medications, tube feedings, treatments, and other interventions. CNA #101 stated she observed LPN #100 drop Resident #81's medications on the floor prior to administering them.Review of the facility's substantiated Self-Reported Incident #271289 revealed residents reported to another nurse that LPN #100 was dropping pills and appeared to be under the influence of an unknown substance. The report indicated that LPN #223 contacted LPN #105; however, LPN #105 did not report the incident to the Administrator. When the Administrator was notified of the events of 02/22/26, LPN #100 was drug tested on [DATE] and tested positive for cocaine, (a highly addictive and powerful central nervous system stimulant derived from the leaves of the South American coca plant). Upon receiving the positive test result, LPN #100 was immediately suspended pending the facility investigation.Further review of this SRI revealed all facility residents were not assessed for possible negative effects related to this incident. Further review of this SRI revealed the facility did not obtain statements from all affected residents. Interview on 03/10/26 at 3:27 P.M. with Registered Nurse (RN) #281 verified the facility did not assess all facility residents nor did they obtain resident statements. Interview on 03/11/26 at 12:54 P.M. with the DON verified the investigation was not completed thoroughly. Review of SRI #271289 revealed the incident occurred on 02/22/26 and the investigation was concluded on 03/03/26. The facility could provide no documentation of obtaining resident statements, or of completing resident assessments demonstrating the incident was investigated thoroughly. There was no evidence of a Quality Assurance Performance Improvement (QAPI) meeting, or of the Medical Director being notified timely of the incident. Additionally, the facility staff education was not completed until 03/11/26. Interview on 03/10/25 at 3:27 P.M. with the DON verified the facility had not yet held a Quality Assurance Performance Improvement (QAPI) meeting to evaluate this incident. Follow up interview on 03/11/26 at 12:54 P.M. with the DON verified the facility had no additional documentation regarding this SRI, the corrective action for this SRI was not completed timely, the Medical Director was not notified of the incident until 02/25/26, and the facilities investigation was not completed thoroughly. Review of the facility Resident Agreement, dated 11/24/24, reveled the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that will compromise necessary and appropriate care consistent with the program for which the resident is contracted.Review of the Administrator Job Description revealed that major duties and responsibilities of this position include planning, developing, organizing, evaluating, and directing the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations. Managing and minimizing facility risk through a team approach to achieve desired outcomes in customer services, key performance indicators, employee retention, and other areas as identified, ensures resident incidents and concerns that arise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etc. are reported to the correct entity with in the stated regulatory requirement, establish a culture of compliance by adhering to all facility policies and procedures, and complies with standards of business conduct, and state/federal regulations and guidelines.Review of the undated facility policy titled, Illegal Drug Use, revealed the facility is an illegal-drug free facility. No one is allowed to possess, be under the influence of, or use any of said illegal drugs on the premises of this facility. Review of the undated facility policy titled, Abuse, Neglect and Exploitation, it is the policy of this facility to provide protections for health, (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies and procedures are implemented as written. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include:a. Identifying staff responsible for the investigation.b. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence.c. Investigating different types of alleged violations.d. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.e. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause.f. Providing complete and thorough documentation of the investigation.Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies within specified time frames. Not later than 24 hours if the events that cause the allegation do not involve abuse and not result in serious bodily injury. This deficiency represents non-compliance investigated under Complaint Number 2793023.