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	03/20/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on medical record review and staff interview, the facility failed to ensure the licensed nursing staff notified the physician of a resident's readmission to the facility and to obtain medication and/or treatment orders to direct staff how to care for one (#61) of 19 sampled residents in a facility census of 91. Findings included: Review of an admission record revealed the facility admitted Resident #61 on 01/30/25. The resident had a diagnosis of critical illness myopathy. Per the admission record, the resident was their own responsible party. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/07/25, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Review of a discharge MDS assessment, with an ARD of 02/15/25, revealed Resident #61 discharged to a short-term general hospital on 02/15/25. Review of Resident #61's progress notes dated 02/15/25 at 7:02 A.M. revealed the resident's family requested the resident be sent to the hospital as the resident did not feel well. Review of Resident #61's progress notes dated 03/06/25 at 5:29 P.M. revealed the resident arrived back in the facility from the hospital. Review of Resident #61's medical record revealed no evidence to indicate physician orders were in place for medications and/or treatments to direct staff how to care for the resident on the date of readmission to the facility, 03/06/25. During an interview on 03/18/25 at 9:14 A.M., Licensed Practical Nurse (LPN) #56 stated she worked on the unit Resident #61 returned to on 03/06/25. LPN #56 stated she did not have any orders for the resident, so she was not able to properly care for Resident #61 on the day they readmitted to the facility (03/06/25). LPN #56 stated she was really concerned that she had a resident and did not have any orders to properly care for the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 3:23 P.M., the Medical Director (MD) stated he was not notified on 03/06/25 that Resident #61 had been readmitted to the facility. During an interview on 03/19/25 at 3:24 P.M., Nurse Practitioner (NP) #57 stated the provider (MD) was not notified of Resident #61's return to the facility on [DATE] to review medications and reconcile physician orders. During an interview on 03/19/25 at 3:34 P.M., the Director of Nursing (DON) stated there was no reason Resident #61's medication and treatment orders were not transcribed on the date of readmission to the facility (03/06/25). The DON stated both the day shift and night shift nurses should have entered the resident's orders into the electronic medical record and contacted the provider (MD) to reconcile any orders from the hospital. During an interview on 03/19/25 at 4:50 P.M., the Administrator stated he expected all orders to be entered on admission (readmission) and for the staff to notify the provider (MD) immediately upon a resident's admission (readmission) to the facility so that orders could be reconciled for medications and treatments. During a follow-up interview on 03/20025 at 8:44 A.M., LPN #56 stated she did not notify the NP or the MD on 03/06/25 that Resident #61 had arrived back in the facility from the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37935 Based on medical record review, staff interview, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual, the facility failed to ensure Minimum Data Set assessments were coded accurately for two (#38 and #65) of three residents reviewed for resident assessments in a facility census of 91. Findings included: 1. Review of an admission record revealed the facility admitted Resident #38 on 01/19/18. The resident had diagnoses of anxiety disorder, dementia, schizoaffective disorder, and major depressive disorder. Review of an annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/06/24, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the resident was not currently considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability or a related condition. The MDS indicated the resident had active diagnoses to include anxiety disorder, depression, and schizophrenia. Review of an annual MDS assessment, with an ARD of 01/06/25, revealed Resident #38 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the resident was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS indicated the resident had active diagnoses to include anxiety disorder, depression, and schizophrenia. Review of Resident #38's care plan report document included a focus area initiated 01/14/25, and revised 02/04/25, revealed the resident had a positive Level II PASRR due to serious mental illnesses. 2. Review of an admission record indicated the facility admitted Resident #65 on 08/11/23. The resident had a medical history to include diagnoses of schizoaffective disorder, anxiety disorder, and adjustment disorder with mixed anxiety and depressed mood. Review of the significant change in status MDS assessment, with an ARD of 11/12/24, revealed Resident #65 had a BIMS score of nine (9), which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS assessment indicated the resident had active diagnoses to include anxiety disorder and schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 9:37 A.M., the MDS Coordinator stated the MDS assessments for Resident #38 and Resident #65 were coded incorrectly. Per the MDS Coordinator, both Resident #38 and Resident #65 should have indicated yes, the residents had serious mental illnesses. The MDS Coordinator stated she just missed coding the MDS assessment correctly. According the MDS Coordinator, it was important for the MDS assessment to be accurate as it gave a picture of the residents and for reimbursement purposes. During an interview on 03/19/25 at 10:16 A.M., the Director of Nursing (DON) stated he had nothing to do with the MDS assessment process but would expect all MDS assessments to be coded accurately for proper reimbursement. During an interview on 03/19/2025 at 10:40 AM, the Administrator stated he was not involved in the MDS assessment process but would expect the MDS assessments to be coded as accurately. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual, dated October 2024, revealed, to code yes if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD (intellectual disability/developmental disability) or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review Conditions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51682 Based on observation, medical record review, staff and resident interview, and facility policy review, the facility failed to ensure residents who were assessed by the facility to require supervision while smoking were supervised by staff when they went out to smoke, failed to ensure residents did not keep their smoking materials in their possession, failed to ensure residents smoked in the designated smoking area of the facility, and failed to ensure resident smoking evaluations were accurate. This affected four (#79, #70, #39, and #244) of six sampled residents reviewed for accidents in a facility census of 91. Findings included: 1. Review of a admission record revealed the facility admitted Resident #79 on 09/08/23. The resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/13/25, revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Review of Resident #79's care plan revealed a focus area initiated 01/13/25, that revealed the resident smoked. Interventions directed staff to inform the resident about smoking risks and hazards and about smoking cessation (initiated 01/13/25); inform the resident about the facility policy on smoking, including locations, times, and safety concerns (initiated 01/13/25); notify the charge nurse immediately if it was suspected the resident violated the facility smoking policy (initiated 01/13/25); observe the resident's clothing and skin for cigarette burns (initiated 01/13/25); and indicated the resident required supervision while smoking (initiated 01/13/25). Review of Resident #79's quarterly smoking safety evaluation, dated 01/02/25, revealed the resident did smoke and required supervision when smoking. Per the smoking safety evaluation, the facility staff stored the resident's smoking materials. During a concurrent observation and interview on 03/10/25 at 11:41 A.M., Resident #79 stated the resident smoked twice daily. Resident #79 stated the facility maintained most residents' smoking material in the activity room but stated they kept their own because when staff locked the smoking materials together, they tended to disappear and were given to other residents who may have been out of cigarettes. Observation revealed the resident had two cigarettes and a lighter in a cigarette package in their possession. According to Resident #79, residents who wished to smoke had to go outside to the designated patio or out to the front of the building and discard the cigarette butts in a bucket. During a concurrent observation and interview on 03/11/25 at 12:16 P.M., Resident #79 obtained a different package of cigarettes from their nightstand drawer and stated that a friend supplied them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/11/25 at 12:35 P.M., Resident #79 sat alone, in a motorized wheelchair in the circular area adjacent to the facility parking lot. Resident #79 held a lit cigarette with the left hand and then discarded the cigarette butt in a bucket on the ground near the chair. The Receptionist/Transport Scheduler opened the front door, and look out towards the direction of Resident #79, then returned to her desk. During an interview on 03/11/25 at 12:40 P.M., the Receptionist/Transport Scheduler stated she observed Resident #79 smoking when she looked outside the facility. The Receptionist/Transport Scheduler stated she did not interfere with Resident #79 smoking because she had worked for the facility long enough to know which residents were safe smokers and could go outside by themselves. During an interview on 03/19/25 at 4:34 P.M., the Director of Nursing (DON) stated he was not aware Resident #79 was going out to smoke by themselves. 2. Review of an admission record revealed the facility admitted Resident #70 on 11/14/24. The resident had a medical history that included diagnoses of nicotine dependence and dementia. Review of a quarterly MDS assessment, with an ARD of 01/10/25, revealed Resident #70 had a BIMS score of 15, which indicated the resident had intact cognition. Review of Resident #70's care plan included a focus area revised 01/13/25, that revealed Resident #70 smoked. Interventions directed staff to inform the resident about smoking risks and hazards, and smoking cessation (initiated 01/13/25); inform the resident about the facility policy on smoking, including locations, times, and safety concerns (initiated 01/13/25); notify the charge nurse immediately if it was suspected the resident violated the facility smoking policy (01/13/25); observe the resident's clothing and skin for cigarette burns (initiated 01/13/25); and indicated the resident required supervision while smoking (initiated 01/13/25). Resident #70's admission smoking safety evaluation dated 01/04/25 revealed the resident did smoke and required supervision when smoking. Per the smoking safety evaluation, the facility staff stored the resident's smoking materials. During a concurrent observation and interview on 03/11/25 at 1:58 P.M., Resident #70 stood to the left of the front door with a lit cigarette in their possession. The Receptionist/Transport Scheduler approached the resident and instructed Resident #70 to move further away from the front door to smoke to where there was a cigarette butt container located towards the end of the circular driveway. Resident #70 ambulated with the use of a walker further down a paved walkway towards the end of the driveway on the left side of the building and continued to smoke. Resident #70 stated they smoked at least five to six times per day in that location without supervision. Resident #70 stated their smoking materials were kept in their possession. During an interview on 03/19/25 at 4:34 P.M., the DON stated he was not aware Resident #70 smoked until that week. The DON stated he thought the resident should be supervised when they smoked and should return their cigarettes. 3. Review of an admission record the facility admitted Resident #39 on 07/20/23. The resident had a diagnosis of chronic obstructive pulmonary disease. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review a quarterly MDS assessment, with an ARD of 02/17/25, revealed Resident #39 had a BIMS score of 15, which indicated the resident had intact cognition. Review of Resident #39's care plan revealed a focus area revised 08/08/23, that revealed the resident smoked. Interventions directed staff to educate the resident on facility smoking policies and protocols (initiated 07/31/23) and indicated the resident would sign in and out to smoke outside the facility (revised 05/28/24). Review of Resident #39's smoking safety evaluation dated 02/15/25 revealed the resident did smoke and required supervision when smoking. Per the smoking safety evaluation, the facility staff stored the resident's smoking materials. During a concurrent observation and interview on 03/11/25 at 2:33 P.M., Resident #39 exited the front door of the facility on a motorized wheelchair to an area on the left side of the facility where there was a bucket that contained cigarette butts. Resident #39 then lit a cigarette and smoked. Resident #39 stated they smoked several times before they received their dialysis treatments and again in the afternoon. Resident #39 stated they always went out the front door to smoke and did not sign out to smoke. Resident #39 stated they did not require supervision and kept their cigarettes and lighter in their possession. During an observation on 03/11/25 at 4:44 P.M., Resident #39 was observed outside the facility directly to the left of the front door. Resident #39 retrieved a lighter from their pocket and lit a cigarette. After a couple puffs on the cigarette, Resident #39 began to dispose of ashes on the ground. There were no staff members present at the time of the observation. During an interview on 03/19/25 at 4:34 P.M., the DON stated he was aware Resident #39 was going out to smoke, but was not aware the resident was not an independent smoker. The DON stated he would expect the resident to turn in their smoking materials, for the resident's assessment should match their abilities, and for staff to supervise the resident until a re-evaluation was conducted. 4. Review of an admission record revealed the facility admitted Resident #244 on 03/05/25. The resident had diagnoses of acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. Review of an admission MDS assessment, with an ARD of 03/12/25, revealed Resident #244 had a BIMS score of seven (7), which indicated the resident had severe cognitive impairment. The MDS assessment revealed the resident used tobacco. Review of Resident #244's care plan included a focus area initiated 03/13/25, that indicated the resident smoked. Interventions directed staff to educate the resident on facility smoking policies and protocols (initiated 03/13/25); inform the resident about smoking risks and hazards and about smoking cessation (initiated 03/13/25); and to monitor, document, and report and instances of noncompliance (initiated 03/13/25). Review of Resident #244's admission smoking safety evaluation dated 03/06/25 revealed the resident did not smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 03/11/25 at 1:58 P.M., Resident #244 sat in a wheelchair directly outside the front door of the facility and smoked a cigarette with another resident. The Receptionist/Transport Scheduler approached the resident and instructed the resident to move further away from the front door to smoke to where there was a cigarette butt container located towards the end of the circular driveway. Resident #244 stated they only had a little bit of the cigarette left, so they were not going further away from the building. Resident #244 took additional puffs of the cigarette, dropped ashes on the ground near their wheelchair, then flung the lit cigarette butt towards the nearby bucket. During an interview on 03/12/25 at 8:39 A.M., Licensed Practical Nurse (LPN) #10 stated residents who smoke were required to smoke in the area outside of the activity department; however, several residents continued to smoke outside the front of the facility, despite knowing they were not supposed to and staff did not stop them. During an interview on 03/12/25 at 9:35 A.M., Activity Aide (AA) #2 revealed she was routinely assigned to the secure units; however, since the Activity Director (AD) was not available during the early morning, she monitored smoking at that time. AA #2 stated some residents went out front of the facility to smoke, but the activity department staff were not assigned to monitor those areas. AA #2 stated staff who saw the residents smoking out front should stop them. Per AA #2, the activities staff maintained the smoking material during the day and then provided a small box with limited smoking material for each resident at the nurses' station for evening smoke times. AA #2 stated some residents kept their own lighter and could light their own cigarettes, and the activities staff lit the remaining residents' cigarettes. AA #2 stated there had been residents who did not follow the smoking policy, and the AD was notified. During an interview on 03/12/25 at 9:50 A.M., the AD stated when an activity aide was available, they monitored smoking during the day. The AD stated the only designated smoking area was outside of the activity room, and all residents who smoked must be supervised during smoke times. The AD stated when residents were not smoking, their cigarettes were kept in a locked box in the activity room. The AD revealed none of the residents wanted to be supervised, and there had been residents who did not follow the smoking policy. The AD stated that if a resident was caught not following the policy, including being caught with cigarettes or a lighter, then the staff member who caught them was to fill out a document. According to the AD, if the resident signed the document four times, the resident would be issued a 30-day discharge notice. During an interview on 03/19/25 at 4:34 P.M., the DON stated he was not aware Resident #244 smoked until that week. The DON stated the resident needed to be supervised when they smoked and needed to turn in their smoking materials after use. The DON stated after learning the resident smoked, the resident should have been immediately reassessed, their smoking materials secured, and their family notified to not bring them to the resident. Per the DON, he expected all residents who smoked to return their smoking material after use, not to go out unsupervised, and the smoking assessments to match the true expectation. During an interview on 03/19/25 at 4:50 P.M., the Administrator stated he was aware residents were going out to smoke and the facility policy allowed residents to do so, although he was not aware who required supervision or who was allowed to smoke independently. The Administrator stated he expected all residents to return their smoking materials after use and only smoke under supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled, Resident Smoking, with a copyright date of 2024, revealed, it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Smoking is prohibited in all areas except designated smoking area. A 'Designated Smoking Area' sign will be prominently posted. Safety measures for the designated smoking area will include, but not limited to: a. Protection from weather conditions (i.e. [id est, that is] covered). b. Provision of ashtrays made of noncombustible material and safe design. c. Accessible metal containers with self-closing covers into which ashtrays can be emptied. All residents and family members will be notified of this policy during the admission process, and as needed. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. If a resident or family does not abide by the smoking policy or care plan (e.g. [exempli gratia, for example] smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.

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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. 45555 Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure a resident received their tube feeding as ordered by the physician for one (#68) of three sampled residents reviewed for tube feeding in a facility census of 91. Findings included: Review of an admission record revealed the facility admitted Resident #68 on 10/25/23. The resident had diagnoses of cerebral infarction, chronic respiratory failure with hypoxia, tracheostomy status, dependence on respiratory (ventilator) status, protein-calorie malnutrition, and gastrostomy status. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 03/11/25, revealed Resident #68 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired with cognitive skills for daily decision-making and had short-term and long-term memory problems. The MDS assessment indicated the resident had a feeding tube and received 51 percent (%) or more of their total calories through the feeding tube and 501 cubic centimeters (cc) a day or more of fluids through the feeding tube. Review of Resident #68's care plan included a focus area initiated 10/31/23, and revised 02/21/25, that indicated the resident required a tube feeding related to oropharyngeal dysphagia (impairment in the ability to swallow). Interventions indicated the resident was dependent with tube feeding and water flushes (initiated 10/31/23). Review of Resident #68's order summary report revealed an order dated 02/08/25, for Vital AF 1.2 continuous enteral feed by way of a gastrostomy tube at 75 milliliters (ml) per hour and 150 ml water flushes every six hours every shift for nutritional supplements. There was also an order dated 02/11/25, for a nothing by mouth (NPO) texture diet, continuous tube feed by way of a gastrostomy tube. During an observation on 03/13/25 at 11:19 P.M., Resident #68's tube feeding pump was off and the bottle, which was dated 03/13/25 at 9:00 A.M., was empty. During an interview on 03/19/25 at 12:22 P.M., Unit Manager (UM) #74 stated the date and time on the tube feeding bottle indicated the time the bottle of feeding was hung. UM #74 stated a resident should not have their feeding off if it was supposed to be a continuous feeding unless there was residual, and then the physician should be notified. UM #74 stated it should be documented if the feeding was not able to be started timely. During an interview on 03/19/25 at 12:46 P.M., Licensed Practical Nurse (LPN) #10 stated if a resident was supposed to receive a continuous tube feeding, then it should not be off for more than 20 minutes. LPN #10 stated the date and time on the bottle label was the time it was hung. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 1:59 P.M., the Director of Nursing (DON) stated if a resident received a continuous tube feeding, then the feeding should only be paused long enough to perform a certain task, such as a shower or perineal care or if the head of the bed needed to be lowered, the feeding needed to be paused to prevent aspiration. The DON stated the date and time on the tube feeding bottle should be completed when it was hung. Per the DON, once a bottle was empty, it should be changed immediately. The DON stated it was not appropriate to leave the resident for that long time without a feeding and would expect it to be documented if the resident's feeding tube was left off for any amount of time. During an interview on 03/19/25 at 3:06 P.M., the Administrator stated there was no excuse for the tube feeding to not be hung as soon as it was required. The Administrator stated that if the order was for continuous, it needed to be continuous. Review of a facility policy titled, Flushing a Feeding Tube, with a copyright date of 2024, revealed it is the policy of this facility to ensure that staff providing care and services to the resident via [by way of, through] a feeding tube are aware of, competent in and utilize facility protocols regarding feeding nutrition and care. Feeding tube care and services will be provided in accordance with resident needs and professional standards of practice.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45555 Based on medical record review, resident and staff interview, and facility policy review, the facility failed to provide physician-ordered respiratory care and services for three (#4, #78, and #291) of four residents reviewed for respiratory care in a facility census of 91. Findings included: 1. Review of an admission record revealed the facility admitted Resident #4 on 04/26/24. The resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, obstructive sleep apnea, and tracheostomy status with dependence on respirator (ventilator). Review of an annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/18/24, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the resident received oxygen therapy, suctioning, and tracheostomy care and used an invasive mechanical ventilator. Review of Resident #4's care plan included a focus area, initiated 05/17/24, that indicated the resident had a tracheostomy. Interventions directed staff to ensure tracheostomy ties were secured at all times (initiated 05/17/24); provide oxygen as ordered (initiated 05/17/24); monitor and document for restlessness, agitation, confusion, and increased or decreased heart rate (initiated 05/17/24); monitor and document level of consciousness, mental status, and lethargy as needed (initiated 05/17/24); monitor respiratory rate, depth, and quality and check and document every shift as ordered (initiated 05/17/24); and an keep extra tracheostomy tube and obturator at the resident's bedside (initiated 05/17/24). Review of Resident #4's care plan included a focus area, initiated 05/17/24, that indicated the resident was using prolonged mechanical ventilation around the clock. Interventions directed staff to administer aerosol treatments as ordered (revised 06/28/24), monitor for tube misplacement at least every two hours and as needed (initiated 05/17/24), observe for indications of tube obstruction and suction as needed (initiated 05/17/24), and provide routine tracheostomy change by respiratory care staff (initiated 05/17/24). During an interview on 03/12/25 at 2:10 P.M., Resident #4 stated if there was not a respiratory therapist at the facility during the night, a nurse would assist with their ventilator. The resident stated they were not sure if they received all their breathing treatments and stated they had to wait at times when they needed suctioning. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's order summary report included orders to place artificial nose (AFN) at night and remove Passy Muir Valve (PMV). Document if the resident wears the AFN or if the resident refused, ordered on 12/04/24; provide 28 percent (%) continuous automatic tube compression (CATC) every night shift, ordered on 02/18/25; administer oxygen at one (1) to 10 liters per minute (L/min) via PMV/AFN around the clock with the Respiratory Therapist (RT) to titrate as needed to maintain oxygen saturation greater or equal to 90% every shift, ordered on 08/22/24; change inner cannula daily every shift and as needed (PRN), ordered on 09/17/24; oral care every shift and PRN, ordered on 08/22/24; oxygen saturation check every shift and PRN, keep greater or equal to 90%, ordered on 08/22/24; suction tracheostomy every shift as needed and PRN, ordered on 08/22/24; tracheostomy care every shift and PRN, ordered on 08/22/24; tracheostomy check every six hours and to verify if the tracheostomy was patent, midline, and secure and ties are intact, ordered on 08/22/24; and budesonide inhalation suspension (an inhaled corticosteroid) 0.5 milligrams (mg)/2 milliliters (ml), one unit inhaled orally every 12 hours for shortness of breath related to COPD, ordered on 08/21/24. Review of Resident #4's respiratory administration record for the timeframe from 02/01/25 through 02/28/25 revealed staff did not document completion of placing AFN at night and remove PMV at 9:00 P.M. on 02/12/25, 02/15/25 through 02/19/25, 02/22/25, and 02/26/25; maintaining 28% CATC on night shift on 02/18/25, 02/19/25, and 02/26/25; providing budesonide inhalation suspension 0.5 mg/2 ml at 8:00 A.M. on 02/20/25 and 8:00 P.M. on 02/12/25, 02/13/25, 02/15/25 through 02/19/25, and 02/26/25; administered oxygen at 1 to 10 L/min for night shift (6:00 P.M. to 6:00 A.M.) on 02/12/25, 02/15/25 through 02/19/25, and 02/26/25; change inner cannula from 7:00 A.M. to 7:00 P.M. on 02/20/25 and from 7:00 P.M. to 11:00 P.M. on 02/12/25, 02/15/25 through 02/19/25, 02/26/25, and 02/27/25; oral care during day shift (6:00 A.M. to 6:00 P.M.) on 02/20/25 and 02/23/25 and night shift (6:00 P.M. to 6:00 A.M.) on 02/12/25, 02/15/25 through 02/19/25, and 02/26/25; check oxygen saturation during day shift on 02/20/25 and night shift on 02/12/25, 02/15/25 through 02/19/25, and 02/26/25; suction tracheostomy during day shift on 02/19/25 and 02/20/25, and night shift on 02/12/25, 02/15/25 through 02/19/25, and 02/26/25; tracheostomy care during day shift on 02/20/25 and night shift on 02/12/25, 02/15/25 through 02/19/25, and 02/26/25; tracheostomy check at 2:00 A.M. on 02/10/25, 02/13/25, 02/16/25 through 02/20/25, 02/22/25, 02/23/25, and 02/27/25; at 8:00 A.M. and 2:00 P.M. on 02/20/25; and at 8:00 P.M. on 02/12/25, 02/15/25 through 02/19/25, and 02/26/25. Review of Resident #4's progress notes revealed electronic medication administration record progress notes, dated 02/23/25, indicated there was no staff to administer the budesonide (11:50 P.M.), complete a tracheostomy check (11:50 P.M.), and to place the AFN (11:51 P.M.). (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's March 2025 respiratory administration record for the timeframe from 03/01/25 through 03/11/25 revealed staff did not document completion of placing AFN at night and remove PMV at 9:00 P.M. on 03/04/25, 03/05/25, 03/08/25, and 03/09/25 maintaining 28% CATC on night shift on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; budesonide inhalation suspension 0.5 mg/2 ml at 8:00 P.M. on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; administering oxygen at 1 to 10 L/min for night shift on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; change inner cannula from 7:00 A.M. to 7:00 P.M. on 03/06/25 and from 7:00 P.M. to 11:00 P.M. on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; oral care during day shift (6:00 A.M. to 6:00 P. M.) on 03/04/25 and 03/06/25 and night shift (6:00 P.M. to 6:00 A.M.) on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; check oxygen saturation during night shift on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; suction tracheostomy during day shift on 03/06/25 and night shift on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; tracheostomy care during day shift on 03/06/25 and night shift on 03/04/25, 03/05/25, 03/08/25, and 03/09/25; tracheostomy check at 2:00 A.M. on 03/05/25, 03/06/25, 03/09/25, and 03/10/25, at 8:00 A.M. and 2:00 P.M. on 03/06/25, and at 8:00 P.M. on 03/04/25, 03/05/25, 03/08/25, and 03/09/25. Review of Resident #4's progress notes revealed a respiratory therapy note, dated 03/08/25, that indicated the resident would be placed on the CATC by the night nurse. Review of Resident #4's respiratory therapy progress note dated 03/09/25 at 6:26 P.M. indicated report was to be given to the night shift nurse to place the resident on their CATC 28% at bedtime. During an interview on 03/19/25 at 1:59 P.M., the Director of Nursing (DON) stated he was told that the staff did not feel competent or comfortable with the tasks related to respiratory care. He stated there was nothing that the nurse should not be able to do if there was not an RT available. He stated that they should be able to do all the tasks to provide care to residents with a ventilator or tracheostomy. He reviewed the respiratory documentation for Resident #4 and confirmed there were blanks in the documentation and stated that if it was not documented, then it was not completed. During an interview on 03/19/25 at 3:06 P.M., the Administrator stated respiratory services should be completed according to the physician orders. He stated there was not a reason for services to not be provided. 2. Review of Resident #78's admission record revealed the facility admitted the resident on 11/01/23. The resident had a medical history that included diagnoses of quadriplegia, chronic respiratory failure with hypoxia, and tracheostomy status with dependence on respirator (ventilator). The admission record indicated the facility discharged the resident on 02/18/25. Review of a quarterly MDS assessment, with an ARD of 02/04/25, revealed Resident #78 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the resident was dependent on staff for all activities of daily living (ADLs). Per the MDS assessment, the resident required an invasive mechanical ventilator, tracheostomy care, oxygen therapy, and suctioning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #78's care plan included a focus area, initiated 11/21/23, that indicated the resident had a tracheostomy related to respiratory failure. Interventions directed staff to ensure tracheostomy ties were secured at all times (initiated 11/21/23); monitor and document respiratory rate, depth, and quality every shift or as ordered (initiated 11/21/23); provide tracheostomy care as ordered (initiated 02/28/24); suction as necessary (initiated 11/21/23); and keep an extra tracheostomy tube and obturator at the resident's bedside (initiated 02/28/24). Review of Resident #78's care plan included another focus area, initiated 11/21/23, that indicated the resident was ventilator-dependent related to respiratory failure. Interventions directed staff to administer aerosol treatments using an in-line nebulizer (initiated 11/21/23), maintain the ventilator settings as ordered (initiated 02/28/24), observe for indications of tube obstruction and suction as needed (initiated 11/21/23), obtain and monitor laboratory/diagnostic work as ordered by the physician and report results to the physician and follow up as indicated (initiated 11/21/23), provide routine tracheostomy change by respiratory care (initiated 11/21/23), provide tracheostomy care twice in a 24-hour period, and change the inner cannula one time in a 24-hour period or more as necessary (initiated 02/28/24). Review of Resident #78's care plan included a focus area, initiated 11/13/23, that indicated the resident was resistive to care/medications/treatments including having their tracheostomy collar changed and respiratory care. Interventions directed staff to allow the resident to make self-determination and have freedom of choice (initiated 03/05/24), educate the resident about the importance of adhering to treatment regimen (initiated 11/13/23), give clear explanation of all care activities (initiated 11/13/23), and try to determine the reason for non-compliance with care/treatment (initiated 11/13/23). Review of Resident #78's order summary report for active orders as of 02/18/2025, included obtain pulse oximetry every shift and record, maintain oxygen saturation at greater than 90%, ordered on 09/07/24; change inner cannula twice daily and PRN, ordered on 09/17/24; oral care every shift and PRN, ordered on 09/07/24; oxygen at 1 to five (5) L/min via ventilator with RT to titrate to keep oxygen saturation greater than or equal to 90%, ordered on 09/09/24; suction tracheostomy every shift and PRN, ordered on 09/07/24; tracheostomy care every shift and PRN, ordered on 09/07/24; tracheostomy check every shift, verify tracheostomy was patent, midline, secure, and that the ties are intact, ordered on 09/07/24; verify ventilator settings every shift, ordered on 09/07/24; provide manual respirations, lavage (wash out) and suction the tracheostomy every six hours, ordered on 01/22/25; ventilator check every four hours, ordered on 09/07/24; and check diaphragmatic pacer every six hours, must remain on at all times with respirations set at 17, ordered on 09/07/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #78's February 2025 respiratory administration record revealed staff did not document completion of pulse oximetry for night shift on 02/12/25 and 02/15/25 through 02/17/25; changing inner cannula at 7:00 P.M. to 11:00 P.M. on 02/12/25 and 02/15/25 through 02/17/25; oral care for night shift on 02/12/25 and 02/15/25 through 02/17/25; oxygen at 1 to 5 L/min at 7:00 P.M. to 11:00 P.M. on 02/12/25 and 02/15/25 through 02/17/25; suction tracheostomy on night shift on 02/12/25 and 02/15/25 through 02/17/25; tracheostomy care on night shift on 02/12/25 and 02/15/25 through 02/17/25; tracheostomy check on night shift on 02/12/25 and 02/15/25 through 02/17/25; verify ventilator settings on night shift on 02/12/25 and 02/15/25 through 02/17/25; manual respirations, lavage, and suction at 2:00 A.M. on 02/13/25, 02/14/25, 02/16/25 through 02/18/25; and at 8:00 P.M. on 02/12/25 and 02/15/25 through 02/17/25; check pacer at 2:00 A.M. on 02/10/25, 02/13/25, 02/14/25, 02/16/25, and 02/17/25; and at 8:00 P.M. on 02/12/25 and 02/15/25 through 02/17/25; ventilator check at 12:00 A.M. on 02/13/25, 02/14/25, and 02/16/25 through 02/17/25; at 4:00 A.M. on 02/10/25, 02/13/25, 02/14/25, and 02/16/25 through 02/17/25; and at 8:00 P.M. on 03/12/25 and 03/15/25 through 03/17/25. During an interview on 03/13/25 at 11:16 P.M., Registered Nurse (RN) #31 stated it was impossible to do the regular nursing and medication duties and the respiratory/ventilator/tracheostomy care at the same time for all the residents. She stated if there were blanks in the respiratory documentation, then that meant there was not a RT in the building, and she stated she did not provide any respiratory care unless it was needed immediately, such as suctioning, including for Resident #78. During an interview on 03/19/25 at 1:59 P.M., the DON stated he was told that the staff did not feel competent or comfortable with the respiratory tasks. He stated there was nothing that a nurse should not be able to do if there was not an RT available. He stated that the nurses should be able to do all the tasks to provide care to residents with a ventilator or tracheostomy. The DON reviewed the respiratory documentation for Resident #78 and confirmed there were blanks in the documentation and stated that if it was not documented, then it was not completed. During an interview on 03/19/25 at 3:06 P.M., the Administrator stated respiratory services should be completed according to the physician orders. He stated there was not a reason for services to not be provided. 52520 3. Review of a medical record revealed the facility admitted Resident #291 on 02/11/25. The resident had a medical history that included diagnoses of acute respiratory failure and tracheostomy status. Re view of an admission MDS assessment, with an ARD of 02/17/25, revealed Resident #291 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident was dependent on staff for all ADLs. Review of Resident #291's care plan included a focus area initiated 02/20/25, that indicated the resident had a tracheostomy related to impaired breathing mechanics. Interventions directed staff to ensure that tracheostomy ties were secured at all times (initiated 02/20/25); suction as necessary (initiated 02/20/25); oxygen settings by way of a tracheostomy as ordered (initiated 02/20/25); monitor/document respiratory rate, depth and quality, check and document every shift as ordered (initiated 02/20/25); and provide good oral care daily and as needed (initiated 02/20/25). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #291's respiratory treatment administration record for the timeframe 02/01/25 through 02/28/25, revealed no evidence to indicate the resident's suction equipment was changed on 02/18/25; no evidence to indicate the resident's tracheostomy ties were changed on 02/27/25; no evidence to indicate the resident's inner cannula was changed on 02/12/25 at 10:00 P.M., 02/15/25 through 02/19/25 at 10:00 P.M., and 02/26/25 at 10:00 P.M.; no evidence to indicate oral care was provided on 02/12/25 at 6:00 P.M., 02/15/25 through 02/19/25 at 6:00 P.M., 02/20/25 at 6:00 A.M., and 02/26/25 at 6:00 P.M.; and no evidence to indicate tracheostomy care was provided on 02/12/25 at 6:00 P.M., 02/15/25 through 02/19/25 at 6:00 P.M. , 02/20/25 at 6:00 A.M., and 02/26/25 at 6:00 P.M. During a telephone interview on 03/17/25 at 1:58 P.M., Agency Licensed Practical Nurse (LPN) #48 said she was the 6:00 P.M. to 6:00 A.M. shift nurse on the tracheostomy/ventilator unit on 02/18/25. Agency LPN #48 stated she did not change Resident #291's suction equipment or inner cannula on 02/18/25. During a telephone interview on 03/17/25 at 2:44 P.M., LPN #49 said she was the 6:00 P.M. to 6:00 A.M. shift nurse on the tracheostomy/ventilator unit on 02/19/25. LPN #49 stated she did not change Resident #291's inner cannula or provide suction or tracheostomy care to the resident on 02/19/25. During a telephone interview on 03/18/25 at 10:47 A.M., Agency LPN #50 said she was the 6:00 P.M. to 6:00 A.M. shift nurse on the tracheostomy/ventilator unit on 02/17/25. Agency LPN #50 stated she did not change Resident #291's inner cannula during her shift. on 02/17/25. During an interview on 03/19/25 at 3:04 P.M., the DON stated his expectation was that physician orders were to be followed completely, and care and treatment should be provided as ordered. During an interview on 03/19/25 at 1:13 P.M., the Administrator stated the expectation was that physician orders be followed and care provided to residents as ordered by the physician. Review of a facility policy titled, Mechanical Ventilation, copyright 2024, revealed residents who require mechanical ventilation will be cared for in accordance to [sic] Federal, State and local guidance and with current standards of practice. The facility will ensure that there are sufficient numbers of trained, competent, qualified staff, consistent with State practice acts/laws when providing mechanical ventilation. The facility will identify who is responsible for the following: a. Monitoring, oversight, and supervision of a resident on mechanical ventilation; b. Tracheostomy care and suctioning; c. Setting of the ventilator; d. Monitoring of the ventilator; e. Response to ventilator alarms; f. Emergency care. The policy specified, appropriate staff will be trained and maintain competency in the use of mechanical ventilation to include, which included a. Use and maintenance of the ventilator system according to manufacturer's instructions, and f. Tracheostomy care and suctioning. The policy specified, 11. Documentation, based on current professional standards of practice, should reflect the assessment and monitoring of the resident's respiratory condition, dependent upon the type of respiratory services received, physician's orders and the resident's individualized respiratory care plan. Review of a facility policy titled, Tracheostomy Care, with a copyright date of 2024, indicated the facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. The policy indicated, 3. Tracheostomy care will be provided according to the physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Tracheostomy Care-Suctioning, copyright 2024, indicated, the facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the airway. This deficiency represents non-compliance investigated under Complaint Numbers OH00162930 and OH00162121.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on staff interview, record review, and policy review, the facility failed to provide coordination of treatment to ensure medications were administered as ordered for a dialysis resident. This affected one (#61) of two sampled residents reviewed for dialysis. The facility census was 91. Findings included: Review of the admission record indicated Resident #61 was admitted on [DATE]. According to the Admission Record, the resident had a medical history that included a diagnosis of critical illness myopathy. Per the Admission Record, the resident was their own responsible party. Review of Resident #61's Progress Notes, dated 03/06/25 at 5:29 P.M., revealed the resident arrived back in the facility from the hospital. Review of Resident #61's hospital discharge summary dated 03/06/25, revealed Discharge Orders, that specified an order Cefazolin (an antibiotic used to treat many different kinds of bacterial infections) 2 grams (gm) intravenously piggyback every Monday and Wednesday after hemodialysis and 3 gm every Friday after hemodialysis until 03/30/25. Review of Resident #61's Order Summary Report, revealed an order dated 03/09/25, for dialysis on Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays. The resident also had an order dated 03/07/25, for Cefazolin sodium injection solution reconstituted 2 gm intravenously in the afternoon after hemodialysis every Monday and Wednesday for internal abdominal abscess until 03/30/25 and 3 gm intravenously in the afternoon after hemodialysis every Friday for internal abdominal abscess until 03/30/25. Review of Resident #61's electronic medication administration record (EMAR) for the timeframe 03/01/25 - 03/21/25, revealed for the administration of the Cefazolin on 03/10/25 (Monday), 03/12/25 (Wednesday), and 03/14/25 (Friday), staff documented 11 which indicated dialysis staff to administer. Review of Resident #61's dialysis notes for the timeframe 03/01/25 - 03/31/25, revealed no evidence to indicate the dialysis staff administered Cefazolin to the resident on 03/10/25, 03/12/25, or 03/14/25. Interview on 03/17/25 at 3:30 P.M., with the dialysis Registered Nurse (RN) stated he was only responsible to administer Mircera (a synthetic drug used to treat anemia caused by chronic kidney disease) and Venofer (an iron replacement product used to treat iron deficiency anemia in people with kidney disease) to Resident #61; however, if he was asked to administer a medication by the nursing staff, he could do so at his discretion if he had the time. The dialysis RN stated the nursing staff would sometimes ask him to administer a medication for them, but he had no way to document that the medication was administered and this was communicated to the nursing and administrative staff. According to the dialysis RN, it was up to nursing to order the medication and document its administration. The dialysis RN stated on 03/17/25, nursing asked him to administer Resident #61's intravenous Cefazolin, which he stated he would administer after the resident's dialysis treatment. The dialysis RN stated he had no way to view the EMAR to verify the medication order and he went off what the nurse brought him. (continued on next page)

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Park Terrace Rehabilitation Center	2735 Darlington Rd Toledo, OH 43606

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Hemodialysis, with a copyright date of 2024, indicated This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The policy specified, 3. The facility will coordinate and collaborate with the dialysis facility to assure that: a. The resident's needs related to dialysis treatments are met; b. The provision of the dialysis treatments and care of the residents meets current standards of practice for the safe administration of the dialysis treatments; c. Documentation requirements are met to assure that treatments are provided as ordered by the nephrologist, attending practitioner and dialysis team.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 52520 Based on staff interview and facility document review, the facility failed to ensure there was Registered Nurse (RN) coverage eight consecutive hours, seven days a week for 17 days during the timeframe from 02/01/25 through 03/13/25. This had the potential to affect all 91 residents. The census was 91. Findings included: Review of the Daily Timecard, for the timeframe from 02/01/25 through 03/13/25, revealed there was not consecutive eight hours of RN coverage on 02/01/25, 02/02/25, 02/07/25, 02/11/25, 02/15/25, 02/16/25, 02/19/25, 02/20/25, 02/21/25, 02/24/25, 02/25/25, 02/28/25, 03/01/25, 03/02/25,03/03/25, 03/05/25, and 03/07/25. Interview on 03/18/25 at 1:10 P.M., with Human Resources (HR) Coordinator #1 stated she had been working at the facility for three years, and for the previous three years she was responsible for scheduling prior to the Staffing and Scheduling Coordinator being hired. The HR Coordinator reviewed and confirmed there was no consecutive eight hours of RN coverage on the dates listed above. Interview on 03/18/25 at 2:23 P.M., with the Staffing and Scheduling Coordinator (SSC) stated there should be eight consecutive RN hours per day. The SSC stated the night shift always had RN coverage since he took over staffing. He said his expectation was there should be proper RN coverage. Interview on 03/18/25 at 3:06 P.M., with the Director of Nursing (DON) stated the facility did not have a policy for RN staffing coverage. Interview on 03/19/25 at 3:04 P.M., with the DON stated he had been the DON since 02/14/25 and had been the Assistant Director of Nursing (ADON) for two weeks prior to becoming the DON. He stated the facility had been deficient in maintaining RN nursing coverage for eight consecutive hours per day. He said the facility had just found out they were deficient in the RN nursing coverage and would put systems in place to ensure it did not continue to happen. Interview on 03/19/25 at 1:13 P.M., with the Administrator stated he had been the Administrator of the facility for the past five weeks. He said he found it hard to believe the facility had not been staffing RNs for eight consecutive hours per day. The Administrator said his expectation was there would have to be an RN scheduled for eight consecutive hours every day. This deficiency represents non-compliance investigated under Complaint Numbers OH00162930 and OH00163294.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on staff interview, record review, and policy review, the facility failed to ensure pharmacy recommendations were implemented timely for one (#65) of five sampled residents reviewed for unnecessary medications. The facility census was 91. Findings included: Review of the admission record indicated Resident #65 admitted on [DATE]. According to the admission record, the resident had a medical history that included diagnoses of paranoid personality disorder, schizoaffective disorder, adjustment disorder with mixed anxiety and depressed mood, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/25, revealed Resident #65 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident took antipsychotic, antidepressant, hypoglycemic, and anticonvulsant medication during the seven-day look-back period. Review of Resident #65's Care Plan Report, included a focus area initiated 11/06/24, that indicated the resident used anti-anxiety medications related to an anxiety disorder. Interventions directed staff to administer anti-anxiety medications as ordered by physician and monitor for side effects and effectiveness every shift (initiated 11/06/24). Review of Resident #65's Note to Attending Physician/Prescriber, from the pharmacy consultant, dated 11/18/24 revealed a recommendation to discontinue as needed (pro re nata, PRN) use of lorazepam 0.5 milligram (mg) every four hours as needed for anxiety or reorder for a specific number of days per federal guideline. The physician/prescriber response section was blank. Review of Resident #65's Note to Attending Physician/Prescriber, from the pharmacy consultant, dated 12/13/2024 revealed a recommendation to discontinue PRN use of lorazepam 0.5 mg every four hours as needed for anxiety or reorder for a specific number of days per federal guideline. The physician/prescriber response section was blank. Review of Resident #65's Note to Attending Physician/Prescriber, from the pharmacy consultant, dated 01/14/25 revealed a recommendation to discontinue PRN use of lorazepam 0.5 mg every four hours as needed for anxiety or reorder for a specific number of days per federal guideline. The physician/prescriber response section was blank. Review of Resident #65's Note to Attending Physician/Prescriber, from the pharmacy consultant, dated 02/07/25 revealed a recommendation to discontinue PRN use of lorazepam 0.5 mg every four hours as needed for anxiety or reorder for a specific number of days per federal guideline. The physician/prescriber response section was blank. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #65's Physician Order Recap Report for orders dated from 09/01/24 through 03/31/25, revealed an order entry dated 11/02/24, for Ativan (lorazepam) 0.5 mg, give one tablet by mouth every four hours as needed for anxiety. The Physician Order Recap Report indicated an end date for the Ativan of 02/18/25 with the reason listed as following pharmacy recommendation. Review of Resident #65's November 2024 EMAR [electronic medication administration record] revealed documentation the resident received Ativan 0.5 mg 1 tablet on 11/13/24 at 9:10 P.M. Resident #65's December 2024, January 2025, and February 2025, EMAR revealed no documentation to indicate the Ativan was given. Telephone interview on 03/18/25 at 12:30 P.M., with the Pharmacy Consultant stated any PRN psychotropic medication should have a 14-day stop date, then be reevaluated and either discontinued, continued PRN with rationale documented by the physician, or the medication should be scheduled. The Pharmacy Consultant stated she came into the facility monthly and made recommendations that she expected the facility to address by the time she returned the next month. The Pharmacy Consultant stated she had put in the recommendations for Resident #65 month after month with no response. The Pharmacy Consultant stated that since the new administration started it had gotten better. Interview on 03/19/25 at 12:22 P.M., with Unit Manager (UM) #74 stated that when she got pharmacy recommendations, she gave them to the physician then followed up on the recommendations in the electronic health record; notified the pharmacy, the resident, and responsible party; and documented. She stated she expected the recommendations to be followed up on in a few days. UM #74 stated psychotropic medications needed to have a 14-day stop date and then be reevaluated. Interview on 03/19/25 at 1:59 P.M., with the Director of Nursing (DON) stated that when he started at the facility there were several pharmacy recommendations that were not completed. The DON stated he had the pharmacy print out the February 25 recommendations and he reviewed them with the Nurse Practitioner (NP). The DON stated the pharmacy recommendations should be completed within 48 to 72 hours, especially since the NP was in the building daily. The DON stated the UM and he were responsible to ensure they were completed. The DON stated PRN psychotropic drugs needed a stop date. The DON stated that after the timeframe, the medication needed to be discontinued or made routine with the appropriate diagnosis. Interview on 03/19/25 at 3:06 P.M., with the Administrator stated he expected pharmacy recommendations to be followed up on immediately. The Administrator stated the previous DON and other managers did not complete those duties. Review of an undated policy titled, Medication Regimen Review, indicated, 7. Timelines and responsibilities for Medication Regimen Review: a. The consultant pharmacist shall schedule at least one monthly visit to the facility and shall allow for sufficient time to complete all required activities. b. The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. The policy continued, f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45555 Based on observation, staff interview, record review, and policy review, the facility failed to ensure there was a medication error rate of five percent (%) or less. There were 10 errors out of 26 opportunities observed, which yielded a medication error rate of 38.5%, This affected two (#68 and #57) of two residents observed for medication administration. Findings included: 1. Review of Resident #68's Physician Order Summary Report included the following orders: - an order dated 02/08/25, for docusate sodium oral liquid 50 milligrams (mg)/ 5 milliliters (ml), give 5 ml by way of gastrostomy tube in the morning for bowel regimen. - an order dated 02/08/25, for potassium chloride oral packet 20 milliequivalents, give one packet by way of gastrostomy tube in the morning for prevention of hypokalemia (low potassium). - an order dated 02/08/25, for sertraline hydrochloride (HCL) oral tablet 25 mg, give one tablet by way of gastrostomy tube in the morning for depression. - an order dated 02/08/25, for alprazolam oral tablet 0.25 mg, give one tablet by way of gastrostomy tube two times a day for anxiety. - an order dated 02/08/25, for Baclofen oral tablet 20 mg, give one tablet by way of gastrostomy tube two times a day for muscle spasm pain. - an order dated 02/08/25, for buspirone HCL oral tablet 15 mg, give one tablet by way of gastrostomy tube two times a day for anxiety. - an order dated 02/08/25, for Robinul oral tablet 1 mg, give one tablet by way of gastrostomy tube tow times a day for secretions. -an order dated 02/08/25, for Senna-Time S oral tablet 8.6-50 mg, give two tablets by way of gastrostomy tube two times a day to aid elimination. - an order dated 02/08/25, for simethicone oral tablet chewable 125 mg, give one tablet by way of gastrostomy tube two times a day for gas. - an order dated 02/11/25, that directed staff to flush the resident's gastrostomy tube with 30 ml of water before and after each medication administration every shift to maintain patency. -an order dated 02/11/25, that directed staff to flush the resident's gastrotomy tube with 5 ml of water between each medication administration every shift to maintain patency. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the medication administration on 03/17/25 at 8:34 A.M., with Registered Nurse (RN) #42 prepared medications to administer to Resident #68. RN #42 crushed all the medication together, mixed them in a cup of water that contained potassium chloride and docusate sodium, and administered them through the resident's gastrostomy tube. Interview on 03/17/25 at 4:24 P.M., with RN #42 reviewed Resident #68's medication orders and stated that he did not give the medications according to the orders. RN #42 stated it took so much time to do each medication individually and in order to spend enough time and get everything done for all the residents, he combined all the resident's medications. RN #42 stated he should have followed the physician orders and gave each medication individually. Interview on 03/19/25 at 1:59 P.M., with the Director of Nursing stated Resident #68 did not have an order to cocktail their medications, so the nurse should have crushed and administered each medication individually. Interview on 03/19/25 at 3:06 P.M., the Administrator stated medications should be given according to the physician orders. 2. Review of Resident #57's Physician Order Summary Report for active orders as of 03/10/25, revealed an order dated 02/28/25, for Spiriva Respimat 2.5 micrograms/ actuation aerosol solution, inhale two puffs orally in the morning for chronic obstructive pulmonary disease. Observation of the medication administration on 03/17/25 at 9:17 A.M., Licensed Practical Nurse (LPN) #43 prepared medications to administer to Resident #57, to include a Spiriva inhaler. LPN #43 handed the Spiriva inhaler to Resident #57, and the resident inhaled one puff of the medication then handed the inhaler back to LPN #43. LPN #43 did not ensure Resident #57 inhaled two puffs of the Spiriva. Interview on 03/17/25 at 11:31 A.M., with LPN #43 stated she did not realize Resident #57 was supposed to inhale two puffs of the Spiriva. LPN #43 stated she should have had the resident take another puff after waiting a minute. Interview on 03/19/25 at 3:06 P.M., with the Administrator stated medications should be given according to the physician orders. Review of the policy titled, Medication Administration via Enteral Tube, with a date of 2024, indicated, 6. Each medication will be administered separately, not combined or added to an enteral feeding formula. Review of the policy titled, Medication Administration, with a date of 2024, indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy specified, 10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right Time f. Right documentation. This deficiency represents the noncomplaince investigated under Complaint Number OH00163446.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observation, record review, staff interview, and policy review, the facility failed to ensure staff donned recommended personal protective equipment (PPE) in a room labeled as requiring enhanced barrier precautions (EPB) for one (Resident #6) of five residents reviewed for transmission-based precautions or EBP. The facility further failed to ensure staff performed proper hand hygiene and glove changes during the provision of incontinence care for one (Resident #190) of two residents reviewed for bladder and bowel incontinence. The facility census was 91. Findings included: 1. Review of the admission record indicated Resident #6 admitted on [DATE]. According to the admission record, the resident had a medical history that included diagnoses of peripheral vascular disease, osteomyelitis (bone infection), and non-pressure chronic ulcer of other part of right foot with unspecified severity. Review of Resident #6's Physician Order Summary Report contained an active order dated 06/11/24 for EBP for a chronic wound and history of MDRO. Review of Resident #6's Care Plan Report included a focus area, initiated 09/04/24, that indicated the resident required EBP related to a surgical wound and ulcer on their right foot. An intervention dated 09/04/24 directed staff to implement EBP. Observation on 03/10/25 at 12:25 P.M., revealed Resident #6's room was labeled with signage that indicated the resident required EBP. Certified Nurse Aide (CNA) #4 provided incontinence care to Resident #6 while wearing gloves but no gown. Interview on 03/10/25 at 12:35 P.M., with CNA #4 stated she provided incontinence care and transferred Resident #6 to a wheelchair while in the resident's room. CNA #4 stated she did not notice the posted signage that indicated Resident #6 required EBP prior to entering the resident's room, so therefore did not don a gown to provide care to the resident. CNA #4 stated she should have worn gloves and a gown while providing care to Resident #6. Interview on 03/19/25 at 4:34 P.M.,with the Director of Nursing stated he expected staff to don a gown before providing high-contact care to a resident requiring EBP, including before incontinence care and before transferring a resident. Interview on 03/19/25 at 4:50 P.M., with the Administrator stated he expected all staff to don the recommended PPE according to the posted signage when a resident required EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Enhanced Barrier Precautions, dated August 2022, revealed, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). The policy further specified, 3. Examples of high contact resident care activities requiring the use of gowns and gloves for EBPs include: a. dressing; b. bathing showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting. 37935 2. Review of the admission record indicated Resident #190 admitted on [DATE]. According to the admission record, the resident had a medical history that included diagnoses of acute and chronic respiratory failure with hypercapnia (elevated carbon dioxide levels in bloodstream). Review of Resident #190's Care Plan Report included a focus area, initiated 07/05/25, that indicated the resident had functional bladder incontinence. The Care Plan Report also included a focus area, initiated 05/16/24, that indicated the resident had bowel incontinence. An intervention dated 10/25/23 directed staff to provide perineal care after each incontinent episode. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/25/25, revealed Resident #190 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. According to the MDS, the resident was always incontinent of urine, frequently incontinent of bowel, and was dependent on staff for toileting hygiene and toilet transfers. 45555 Observation on 03/17/25 at 2:58 P.M., Agency Certified Nurse Aide (CNA) #44 and Agency CNA #45 entered Resident #190's room and put on gowns, gloves, and surgical masks. The CNAs introduced themselves to the resident and explained that they were going to provide incontinence care. CNA #44 removed the brief from the front and, using wipes, cleaned from front to back on each side and down the middle, using a different part of the cloth or a new cloth with each wipe. The resident was turned onto their right side, and the resident's buttocks were cleaned using clean wipes. Barrier cream was applied to the buttocks and then two clean briefs were placed under the resident (per the resident's request). Resident #190 was turned back onto their back, and the brief was pulled up in the front and attached. CNA #44 pulled the sheet and the blanket up over the resident, pulled the over-the-bed table in front of the resident, moved the non-invasive mechanical ventilator tubing to the side, pulled the fan over by the resident, and then grabbed the trash can and walked over to the door. The CNAs took off their gowns, gloves, and masks at the doorway of the resident's room and used hand sanitizer. They did not change gloves or perform hand hygiene until incontinence care was complete and they were ready to leave the resident's room. Interview on 03/17/25 at 3:13 P.M., with CNA #44 stated they were to do hand hygiene before and after providing care, when entering the room and before exiting the room. She stated she had not been taught to change gloves from a dirty area to a clean area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 12:22 P.M., with Unit Manager #74 stated hand hygiene and glove changes should occur before and after perineal care. She stated staff should not touch other items in the room with the same gloves used to provide perineal care. Interview on 03/19/25 at 12:46 P.M., with Licensed Practical Nurse (LPN) #10 stated hand hygiene and glove changes should occur before providing perineal care and after completing perineal care, then staff should take off their gloves, perform hand hygiene, and put on new gloves to finish applying a clean brief and adjusting the resident and their covers. Interview on 03/19/25 at 1:59 P.M., with the Director of Nursing (DON) stated that during perineal care, staff should perform hand hygiene when entering the room prior to the procedure, complete the dirty portion of perineal care, such as touching any bodily fluids, then change gloves when going to the clean portion of the process. The DON stated hand hygiene should occur with all glove changes. Review of the policy titled, Perineal Care, copyright 2024, revealed the policy directed staff to, 6. Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate, and 16. Remove gloves and discard. Perform hand hygiene. Review of the policy titled, Hand Hygiene, copyright 2024, revealed section, 6. Additional considerations specified, a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The policy included a table titled, Hand Hygiene Table that specified, When, during resident care, moving from a contaminated body site to a clean body site, staff should use either soap and water or an alcohol-based hand rub.

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 35314 Based on personnel file review, staff interview, and policy review, the facility failed to provide dementia management and resident abuse prevention education for five Certified Nurse Aides (CNAs) (#9, #24, #27, #34, and #35 of five staff reviewed for training. This had the potential to affect all 91 residents in the facility. Findings included: Review of personnel files provided by the facility revealed the following: CNA #9's personnel file revealed a hire date of 08/16/2023. The personnel file contained no evidence of training or competency for abuse or dementia. CNA #24's personnel file revealed a hire date of 08/03/2022. The personnel file contained no evidence of training or competency for abuse or dementia. CNA #27's personnel file revealed a hire date of 05/29/2014. The personnel file contained no evidence of training or competency for abuse or dementia. CNA #34's personnel file revealed a hire date of 10/08/2017. The personnel file contained no evidence of training or competency for abuse or dementia. CNA #35's personnel file revealed a hire date of 03/08/2011. The personnel file contained no evidence of training or competency for abuse or dementia. Interview on 03/19/25 at 12:37 P.M., with the Director of Nursing (DON) stated the training for staff was not sufficient and did not occur as it should at the facility. The DON stated he expected the facility staff to have evidence of abuse and neglect training. The DON stated that as the DON, it had been challenging to ensure all the staff received the required training while completing other tasks in the facility. The DON confirmed there were no records of training for staff abuse and neglect or dementia management. Review of the undated policy titled, Required Training, Certification and Continuing Education or Nurse Aides, revealed, 6. In-service training will be provided by qualified personnel and will be based on the needs of the residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews, and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention. Review of the undated policy titled, Abuse, Neglect and Exploitation, revealed, A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-serves and as needed.