STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365488	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Toledo	4420 South Avenue Toledo, OH 43615

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and facility policy, the facility failed to ensure residents were provided with interventions to prevent skin breakdown in accordance with physician orders and nursing plans of care. This affected three (#1, #2, #3) of three sampled residents reviewed for skin integrity. Facility census was 69. Findings include: 1. Resident #1 admitted to the facility on [DATE] with diagnoses including, polyosteoarthritis, anemia, chronic fatigue, polyneuropathy, congestive heart failure, peripheral vascular disease, spondylosis, absence right leg above knee, and covid-19. According to the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had severe cognitive impairment, was dependent on staff for the completion of activities of daily living including bed mobility, always incontinent of bowel and bladder, and was at risk for pressure ulcer development with no skin breakdown. Review of nursing plans of care noted on 07/07/23 a care plan was developed to address Resident #1's potential/actual impairment to skin integrity related to fragile skin. Interventions included, follow facility protocols for treatment of injury, the resident needs low air loss mattress to protect the skin while in bed, and offloading boots to foot while in bed. Further review of the medical record discovered an additional plan of care dated 01/24/23 addressing Resident #1's bowel incontinence related to immobility with interventions including, check resident every two hours and assist with toileting as needed. On 08/30/24 a Braden scale for predicting pressure sore risk scored Resident #1 at risk for pressure sore development. According to weekly wound evaluation documentation dated 10/30/24 Resident #1 was assessed with a healed stage two pressure ulcer to the sacrum that was acquired on 10/09/24. Instructions included continued application of zinc. On 11/04/24 weekly skin observation documentation noted the resident with intact skin. Risk factors for impaired skin integrity were incontinence and limited mobility with interventions including check and change and low air loss mattress. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/05/24 at 7:34 A.M. with Certified Nurse Aide (CNA) #201 discovered Resident #1 in bed with two incontinence briefs applied. Resident #1 was unable to indicate when last checked for incontinence or repositioning. CNA #201 stated she assumed care of Resident #1 at 7:00 A.M. and this was her first observation of the resident. CNA #201 went on to state CNA #202 provided care for the resident on the previous shift and had left the facility before CNA #201 received a report regarding the last incontinence check or repositioning for Resident #1. Resident #1 was also discovered without the offloading boot in place and Resident #1 left foot resting on the mattress surface. CNA #201 was unaware the offloading boot was to be applied and was unable to locate the boot in Resident #1's room. According to task, bowel and bladder monitoring documentation, Resident #1 was documented as incontinent on 11/04/24 at 9:23 P.M. with repositioning documented as taking place at 9:24 P.M. No further bowel and bladder tracking was documented in the medical record. On 11/05/24 at 7:45 A.M. interview with the Director of Nursing (DON) revealed residents are not to be double briefed due to creating an increased potential for skin breakdown and infections. CNA's are to document incontinence checks and repositioning in the medical record under tasks. The DON also stated resident skin breakdown interventions are contained in the nursing plan of care and also included incontinence frequency checks for the specific resident. 2. Resident #2 admitted to the facility on [DATE] with diagnoses including, rheumatoid arthritis, major depressive disorder, dysphagia, congestive heart failure, muscle wasting and atrophy, protein calorie malnutrition, anxiety disorder, hypertension, atrial fibrillation, type 2 diabetes mellitus, right eye blindness and atrioventricular septal defect. According to the most current MDS assessment dated [DATE] revealed Resident #2 had severe cognitive impairment, was dependent on staff for the completion of activities of daily living including bed mobility, always incontinent of bowel and bladder, and was at risk for pressure ulcer development with no current skin breakdown. On 09/19/24 Braden scale for predicting pressure sore risk scored Resident #2 at moderate risk for pressure sore development. On 09/21/24 a Bladder Incontinence Data Collection Tool was completed and Resident #2 was assessed as incontinent of bladder requiring staff to complete incontinence care. Resident does not verbalize the need to use toilet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing plan of care was developed on 09/30/24 to address Resident #2's Activity of Daily Living (ADL) self-care performance deficit related to fatigue, impaired balance, limited mobility, vision loss, osteoarthritis, and episodes of pain. Resident transfers extensive assist of one but Hoyer lift with assist of two is often needed. Interventions included, the resident is totally dependent on one to two staff to provide bath/shower as necessary, for bed mobility, the resident requires extensive to dependent assistance by two staff, the resident is bedfast all or most of the time, the resident requires skin inspection with care, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse, the resident is totally dependent on two staff for toilet use, and the resident is totally dependent on two staff for transferring. On 09/23/24 to address Resident #2's potential alteration in elimination frequently incontinent of bowel and bladder, interventions included the following: monitor for skin redness and irritation and provide incontinent care as needed (PRN). No frequency was indicated related to providing turning or repositioning or checking the resident for incontinence episodes. On 11/04/24 weekly skin observation documentation noted the resident with intact skin. Risk factors for impaired skin integrity were incontinence and limited mobility with interventions including check and change and low air loss mattress. According to task, bowel and bladder monitoring and repositioning documentation, Resident #2 was documented as incontinent on 11/04/24 at 11:48 P.M. No further bowel and bladder tracking or reposition was documented in the medical record. Observation on 11/05/24 at 7:02 A.M. noted Resident #2 in bed. Certified Nurse Aide (CNA) #203 entered the room and proceeded to complete an incontinence check. CNA #203 discovered Resident #2 had two adult incontinence briefs applied and the resident was soiled of a moderate amount of urine. CNA #203 indicated she had just assumed the shift at 7:00 A.M. and was unaware when the resident was last provided with an incontinence care. CNA #203 stated CNA's were informed by nurses not to place two briefs on residents. On 11/05/24 at 7:08 A.M. interview with Licensed Practical Nurse (LPN) #301 revealed she was unaware Resident #2 was placed in two incontinence briefs and was unaware when the resident was last provided repositioning or observed for incontinence episodes. On 11/05/24 at 8:40 A.M., telephone interview with CNA #204 confirmed providing care to Resident #2 between 11/04/24 at 10:30 P.M. and 11/05/24 at approximately 12:30 A.M. CNA #204 stated she turned care over to CNA #205 at that time. CNA #204 also confirmed oncoming staff was not at the facility at the end of the shift and no report was provided. CNA #204 ended the shift on 11/05/24 at 6:30 A.M. On 11/05/24 at 8:46 A.M., telephone interview with CNA #205 denied assuming care of Resident #2 during the shift on 11/05/24. CNA #205 verified she did not check Resident #2 for incontinence or provide turning with repositioning during her shift on 11/05/24 between 12:30 A.M. and 6:30 A.M. On 11/05/24 at 7:45 A.M., interview with the Director of Nursing (DON) revealed residents are not to be double briefed due to creating a increased potential for skin breakdown and infections. CNA's are to document incontinence checks and repositioning in the medical record under task. The DON also stated resident skin breakdown interventions are contained in the nursing plan of care and also included incontinence frequency checks for the specific resident. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #3 admitted to the facility on [DATE] with diagnoses including, cerebral infarction, type 2 diabetes mellitus, protein calorie malnutrition, hypertension, anemia, dysphagia, acute kidney failure, and muscle disorder. According to the most current MDS assessment dated [DATE] revealed Resident #3 with the inability to make needs known, severe cognitive impairment, dependent on staff for the completion of ADLs including bed mobility, always incontinent of bowel and bladder, and at risk for pressure ulcer development with no current skin breakdown. Review of nursing plans of care revealed on 05/18/24 a plan of care was developed to address Resident #3's ADL self-care performance deficit related to disease process. Interventions included the following; for bed mobility, the resident is able to complete task with limited to extensive assist of one to two staff members, for toilet use, the resident is able to complete task with extensive to total assist of one to two staff members, for transfers, the resident is able to complete task with extensive to total assist of one to two staff members, monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. No turning or repositioning frequency was indicated in the nursing plans of care. On 09/03/24 a Braden scale for predicting pressure sore risk scored Resident #3 at high risk for pressure sore development. On 09/03/24 a Bladder Incontinence Data Collection Tool was completed and noted resident is incontinent of bladder all or most of the time. A physician order was initiated on 10/10/24 to provide additional ADL assistance related to diagnosis of Hemiplegia and Cerebral Infarction. Please refer to plan of care. On 11/04/24, weekly skin observation documentation noted risk factors for impaired skin integrity were due to impaired mobility and incontinence of bowel and bladder. Interventions to preserve skin integrity included weekly skin assessment and two hour turns per facility protocol. Observation on 11/05/24 at 7:13 A.M with Certified Nurse Aide (CNA) #201 discovered Resident #3 in bed with two incontinence briefs applied. Resident #3 was unable to indicate when last checked for incontinence and was observed to require total dependence of care from CNA #201. CNA #201 stated she assumed care of Resident #3 at 7:00 A.M. and the observation was her first observation of the resident. CNA #201 went on to state the previous CNA identified to provide care to Resident #3 left the facility before giving report regarding the last turning and repositioning or incontinence check for Resident #3. CNA #201 stated Resident #3 required two hour incontinence episode checks with repositioning. According to task bowel and bladder monitoring documentation Resident #3 was documented to be checked and found incontinent on 11/04/24 at 8:22 A.M. No further bowel and bladder tracking or documentation of incontinence monitoring was documented in the medical record. Review of repositioning documentation noted on 11/04/24 at 11:57 P.M. Resident #3 was provided with repositioning. No further repositioning was noted in the medical record. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/24 at 7:45 A.M. interview with the Director of Nursing (DON) revealed residents are not to be double briefed due to creating a increased potential for skin breakdown and infections. CNA's are to document incontinence checks and repositioning in the medical record under task. The DON also stated resident skin breakdown interventions are contained in the nursing plan of care and also included incontinence frequency checks for the specific resident. Review of facility undated Pressure Injury Prevention and Management policy revealed the facility shall establish and utilize a systematic approach for pressure injury prevention and management. The approach will include prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors: monitoring the impact of the interventions; modifying the interventions as appropriate. Interventions for prevention and to promote healing included the development of a care plan to include measurable goals with appropriate interventions. Basic or routine care interventions include redistribution of pressure, minimize exposure to moisture. Review of facility undated Turing and Repositioning policy instructed that all residents at risk of or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to a medical condition. Turning and repositioning is a primary responsibility of nursing assistants. The frequency of turning and repositioning will be documented in the residents plan of care. Repositioning while in the chair directed every one hour repositioning for a resident unable to reposition or make position changes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure incontinence interventions were implemented in a timely manner and in accordance with nursing plans of care. This affected three (#1, #2, #3) of three sampled residents reviewed for incontinence care and treatment. Facility census was 69. Findings include: 1. Resident #1 admitted to the facility on [DATE] with diagnoses including, polyosteoarthritis, anemia, chronic fatigue, polyneuropathy, congestive heart failure, peripheral vascular disease, spondylosis, absence right leg above knee, and covid-19. According to the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 with severe cognitive impairment, dependent on staff for the completion of activities of daily living including bed mobility, always incontinent of bowel and bladder, and at risk for pressure ulcer development with no skin breakdown. On 09/20/24, a Bladder Incontinence Data Collection Tool was completed and noted resident was incontinent of bladder requiring staff to complete incontinence care. Resident does wet through brief and pants when urinating. Resident does not verbalize the need to use the toilet. Review of Resident #1's nursing plan of care dated 01/24/23 revealed Resident #1 had bladder incontinence. Interventions included, clean peri-area with each incontinence episode. No documentation indicated a frequency to monitor Resident #1 for urinary incontinence. On 01/24/23 a plan of care was implemented to address Resident #1 bowel incontinence related to immobility with interventions including; check resident every two hours and assist with toileting as needed. Observation on 11/05/24 at 7:34 A.M. with Certified Nurse Aide (CNA) #201 discovered Resident #1 in bed with two incontinence briefs applied. Resident #1 was unable to indicate when last checked for incontinence. CNA #201 stated she assumed care of Resident #1 at 7:00 A.M. and this was her first observation of the resident. CNA #201 went on to state CNA #202 provided care for the resident on the previous shift and had left the facility before CNA #201 received a report regarding the last incontinence check for Resident #1. According to task bowel and bladder monitoring documentation Resident #1 was documented as incontinent on 11/04/24 at 9:23 P.M. with repositioning documented as taking place at 9:24 P.M. No further bowel and bladder tracking was documented in the medical record. On 11/05/24 at 7:45 A.M. interview with the Director of Nursing (DON) revealed residents are not to be double briefed due to creating a increased potential for skin breakdown and infections. CNAs are to document incontinence checks in the medical record under task and resident incontinence frequency checks are indicated in the nursing plan of care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #2 admitted to the facility on [DATE] with diagnoses including, rheumatoid arthritis, major depressive disorder, dysphagia, congestive heart failure, muscle wasting and atrophy, protein calorie malnutrition, anxiety disorder, hypertension, atrial fibrillation, type 2 diabetes mellitus, right eye blindness and atrioventricular septal defect. According to the most current MDS assessment dated [DATE] assessed Resident #2 with severe cognitive impairment, dependent on staff for the completion of activities of daily living including bed mobility, always incontinent of bowel and bladder, at risk for pressure ulcer development with no current skin breakdown. On 09/21/24 a Bladder Incontinence Data Collection Tool was completed and Resident #2 was assessed as incontinent of bladder requiring staff to complete incontinence care. Resident does not verbalize the need to use toilet. A nursing plan of care was developed on 09/23/24 to address Resident #2's potential alteration in elimination frequently incontinent of bowel and bladder. Interventions included the following: monitor for skin redness and irritation and provide incontinent care as needed (PRN). No frequency was indicating related to checking the resident for incontinence episodes. According to task bowel and bladder monitoring documentation Resident #2 was documented as incontinent on 11/04/24 at 11:48 P.M. No further bowel and bladder tracking was documented in the medical record. Observation on 11/05/24 at 7:02 A.M. noted Resident #2 in bed. Certified Nurse Aide (CNA) #203 entered the room and proceeded to complete an incontinence check. CNA #203 discovered Resident #2 had two adult incontinence briefs applied and the resident was soiled of a moderate amount of urine. CNA #203 indicated she had just assumed the shift at 7:00 A.M. and was unaware when the resident was last provided with an incontinence observation. CNA #203 stated CNA's were informed by nurses not to place two briefs on residents. On 11/05/24 at 7:08 A.M. interview with Licensed Practical Nurse #301 revealed she was unaware Resident #2 was placed into two incontinence briefs and was unaware when the resident was last observed for incontinence episode. On 11/05/24 at 8:40 A.M. telephone interview with CNA #204 confirmed providing care to Resident #2 between 11/04/24 at 10:30 P.M. and 11/05/24 at approximately 12:30 A.M. CNA #204 stated she turned care over to CNA #205 at that time. CNA #204 also confirmed oncoming staff was not at the facility at the end of the shift and no report was provided. CNA #204 ended the shift on 11/05/24 at 6:30 A.M. On 11/05/24 at 8:46 A.M. telephone interview with CNA #205 denied assuming care of Resident #2 during the shift on 11/05/24. CNA #205 verified she did not check Resident #2 for incontinence or provide turning with repositioning during her shift between 11/05/24 at 12:30 A.M. and 6:30 A.M. According to task bowel and bladder monitoring documentation Resident #2 was documented to be checked and found incontinent on 11/04/24 at 11:48 P.M. No further bowel and bladder tracking or documentation of incontinence monitoring was documented in the medical record. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/24 at 7:45 A.M. interview with the Director of Nursing (DON) revealed residents are not to be double brief due to creating a increased potential for skin breakdown and infections. CNAs are to document incontinence checks in the medical record under task and resident incontinence frequency checks are indicated in the nursing plan of care. 3. Resident #3 admitted to the facility on [DATE] with diagnoses including, cerebral infarction, type 2 diabetes mellitus, protein calorie malnutrition, hypertension, anemia, dysphagia, acute kidney failure, and muscle disorder. According to the most current MDS assessment dated [DATE] revealed Resident #3 with the inability to make needs known, severe cognitive impairment, dependent on staff for the completion of activities of daily living (ADL) including bed mobility, always incontinent of bowel and bladder, at risk for pressure ulcer development with no current skin breakdown. Review of nursing plans of care revealed on 05/18/24 a plan of care was developed to address Resident #3's ADL self-care performance deficit related to disease process. Interventions included for toilet use, the resident is able to complete task with extensive to total assist of one to two staff members. On 09/03/24 a Bladder Incontinence Data Collection Tool was completed and noted resident is incontinent of bladder all or most of the time. A physician order was initiated on 10/10/24 to provide additional ADL assistance related to diagnoses of Hemiplegia and Cerebral Infarction. Please refer to plan of care. Observation on 11/05/24 at 7:13 A.M. with Certified Nurse Aide (CNA) #201 discovered Resident #3 in bed with two incontinence briefs applied. Resident #3 was unable to indicate when last checked for incontinence and was observed to require total dependence of care from CNA #201. CNA #201 stated she assumed care of Resident #3 at 7:00 A.M. and the observation was her first observation of the resident. CNA #201 went on to state the previous CNA identified to provide care to Resident #3 left the facility before giving report regarding the last incontinence check for Resident #3. CNA #201 stated Resident #3 required two hour incontinence episode checks with repositioning. According to task bowel and bladder monitoring documentation Resident #3 was documented to be checked and found incontinent on 11/04/24 at 8:22 A.M. No further bowel and bladder tracking or documentation of incontinence monitoring was documented in the medical record. On 11/05/24 at 7:45 A.M. interview with the Director of Nursing (DON) revealed residents are not to be double brief due to creating a increased potential for skin breakdown and infections. CNAs are to document incontinence checks in the medical record under task and resident incontinence frequency checks are indicated in the nursing plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00159047.