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	09/30/2025

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 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** Based on record review, observation, resident interview, staff interview, and facility policy review, the facility failed to ensure residents received timely incontinence care. This affected one resident (#62) of three residents reviewed for incontinence. This had the potential to affect 39 residents who the facility identified as incontinent. The facility census was 70. Findings include: Review of Resident #62's medical record revealed an admission date of 12/12/24. Diagnoses included metabolic encephalopathy, unspecified protein-calorie malnutrition, insomnia, hypertensive heart disease with heart failure, and hypertension. Review of Resident #62's care plan dated 09/22/25 revealed Resident #62 had functional bladder incontinence and required peri-care to be completed with each incontinence episode. Review of Resident #62's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had severe cognitive impairment and was dependent for toileting and showers. Furthermore, Resident #62 was always incontinent of bowel and bladder. Observation on 09/29/25 at 9:27 A.M. of the hallway outside of Resident #62's room revealed an extremely strong odor of urine and stool coming from Resident #62's room. Interview on 09/29/25 at 9:45 A. M. with Resident #62 revealed her incontinence brief had been changed at approximately 8:45 A.M. on 09/29/25 but stated the staff did not wake her in the night to change her incontinence brief.Interview on 09/29/25 at 9:15 A.M. it with Certified Nurse Aide (CNA) #182 revealed she had changed Resident #62's brief in the morning when she began her shift and Resident #62's incontinent care products were saturated with urine and stool from the overnight shift. CNA #182 stated the stool was stuck to the resident's skin. CNA #182 confirmed incontinent care was not timely completed for Resident #62. Interview and observation on 09/29/25 at 9:49 A.M. with CNA #182 verified the strong smell of urine and stool in the hallway by Resident #62's room. CNA #182 stated when she had changed Resident #62's brief in the morning she did not have the chance to change the resident's bed sheets. Concurrent observation of Resident #62 revealed her mattress sheets were saturated in urine with stool present on the sheets. A strong odor of urine was present, and Resident #62 had an incontinent brief with the securement tabs removed from the brief inside the brief she was wearing as an additional incontinent pad inside her brief. CNA #182 confirmed Resident #62's sheets remained soiled and wet, and confirmed the resident had multiple incontinent care products in use stating she was told by the facility to use an additional incontinence brief with the securement straps torn off as a pad inside resident's incontinent briefs. Interview on 09/30/25 at 2:56 P.M. with the Director of Nursing (DON) revealed possible adverse outcomes of incontinence care not being provided every two hours may include skin breakdown and Urinary Tract Infections (UTI). The DON stated they use liners in incontinence briefs for residents who are heavily incontinent and the briefs should be checked and changed every two hours. Review of the undated facility policy titled Perineal Care revealed perineal care would be provided to incontinent residents as needed to promote cleanliness and comfort, prevent infection, and prevent skin breakdown. This violation represents non-compliance investigated under Complaint #2624787.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure resident water cups were clean and free from mold. The facility also failed to ensure there were no strong odors of urine in the facility. This affected one resident (#62) of four residents reviewed for a safe, clean environment. The facility census was 70. Findings include: Review of Resident #62's medical record revealed an admission date of 12/12/24. Diagnoses included metabolic encephalopathy, unspecified protein-calorie malnutrition, insomnia, hypertensive heart disease with heart failure, and hypertension. Review of Resident #62's care plan dated 09/22/25 revealed Resident #62 had functional bladder incontinence and required peri-care to be completed with each incontinence episode. Review of Resident #62's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had severe cognitive impairment and was dependent for toileting and showers. Furthermore, Resident #62 was always incontinent of bowel and bladder. 1. Interview on 09/29/25 at 9:45 A.M. with Resident #62 revealed she would like to use her water cup but she did not know where her water cup was.Observation on 09/29/25 at 10:34 A.M. of Resident #62's water cup that was sitting on her dresser revealed a black substance to be on the bottom of the inside of the cup where there was approximately 60 milliliters of water. Floating on the top of the water was a small film and multiple areas in the water contained floating substances.Interview on 09/29/25 at 10:36 A.M. with Certified Nursing Assistant (CNA) #176 verified Resident #62's water cup contained a black substance that CNA #176 identified as mold.Interview on 09/29/25 at 3:04 P.M. with Dietary Manager (DM) #193 revealed the dietary staff were responsible for cleaning all the residents' water cups. Furthermore, DM #193 stated they did not have any documentation regarding the cleaning of resident water cups. DM #193 stated as a corrective action, the facility would be switching to disposable cups instead of regular cups.2. Observation on 09/29/25 at 9:27 A.M. of the hallway outside of Resident #62's room revealed an extremely strong odor of urine and stool coming from Resident #62's room. Interview on 09/29/25 at 9:45 A.M. with Resident #62 revealed her incontinence brief had been changed at approximately 8:45 A.M. on 09/29/25 but stated the staff did not wake her in the night to change her incontinence brief. Interview and observation on 09/29/25 at 9:49 A.M. with CNA #182 verified the strong smell of urine and stool in the hallway by Resident #62 ' s room. CNA #182 stated when she had changed Resident #62 ' s brief in the morning she did not have the chance to change the resident's bed sheets. Concurrent observation of Resident #62 revealed her mattress sheets were saturated in urine with stool present on the sheets. A strong odor of urine was present. CNA #182 confirmed Resident #62's sheets remained soiled and wet. Review of the facility policy titled Homelike Environment with a last revision date of February 2021 revealed residents should be provided with a safe, clean, sanitary, comfortable, and homelike environment that includes a clean bed and bath linens that are in good condition and pleasant, neutral scents.This violation represents non-compliance investigated under Complaint #2624787 and Complaint #2626557.