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	04/29/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, and review of facility policy, the facility failed to notify residents' representatives when they experienced a change in condition. This affected two (Residents #54 and #58) of three residents reviewed for notifications. The facility census was 60.Findings include:1. Review of the medical record for Resident #54 revealed she was admitted on [DATE] with diagnoses including acute kidney failure, asthma, cataracts, difficulty walking, obesity, unspecified psychosis, depression, fatty liver, symptomatic epilepsy, cognitive communication deficit, heart failure, stage three chronic kidney disease, hypertension, gastrointestinal hemorrhage, and obstructive sleep apnea.Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #54 experienced mild cognitive impairment and did not display any behaviors at the time of the assessment. She utilized a walker and a manual wheelchair and required maximal assistance with transfers. Resident #54 required moderate assistance with activities of daily living. This assessment indicated she utilized dialysis services.Review of a progress note dated 02/02/26 for Resident #54 revealed she experienced chest pain and was sent to a local emergency room for treatment. There was no indication Resident #54's power of attorney (POA) had been notified of this change in condition.Interview on 04/29/26 at 3:15 P.M. with the Administrator revealed Resident #54's (POA) had not been notified of the change in condition SR #54 experienced on 02/02/26.2. Review of the medical record for Resident #58 revealed she was admitted on [DATE] with diagnoses including depression, anxiety, rheumatoid arthritis, osteoarthritis, hyperlipidemia and chronic obstructive pulmonary disease (COPD).Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #58 experienced mild cognitive impairment and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a manual wheelchair, was dependent for transfers, and was independently mobile. Resident #58 required moderate assistance with activities of daily living.Review of a progress note dated 03/11/26 for Resident #58 revealed she was experiencing abdominal pains and spasms, and audible wheezing. Imaging, labs, and medications were ordered. There was no indication Resident #58's POA had been notified of this change in condition.Interview on 04/29/26 at 3:43 P.M. with the Administrator revealed Resident #58's POA had not been notified of the change in condition Resident #58 experienced on 03/11/26.Review of facility policy titled, Change in a Resident's Condition or Status, dated 02/26/25, revealed the facility would notify a resident's representative if they experienced a significant change in condition.This deficiency represents non-compliance investigated under Complaint Number 2985811.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, observations, staff interviews, and review of facility policy, the facility failed to ensure respiratory equipment was maintained and stored in a sanitary manner. This affected two (Residents #54 and #58) of two residents reviewed for respiratory equipment. The facility census was 60.Findings include:1. Review of the medical record for Resident #54 revealed she was admitted on [DATE] with diagnoses including acute kidney failure, asthma, cataracts, difficulty walking, obesity, unspecified psychosis, depression, fatty liver, symptomatic epilepsy, cognitive communication deficit, heart failure, stage three chronic kidney disease, hypertension, gastrointestinal hemorrhage, and obstructive sleep apnea.Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #54 experienced mild cognitive impairment and did not display any behaviors at the time of the assessment. She utilized a walker and a manual wheelchair and required maximal assistance with transfers. Resident #54 required moderate assistance with activities of daily living. This assessment indicated she utilized dialysis services.Observation on 04/29/26 at 9:40 A.M. of Resident #54's private room revealed a nasal cannula on the floor next to an oxygen concentrator and the cannula was not labeled with the date it was initiated. Continued observation revealed a Continuous Positive Airway Pressure (CPAP) machine on the nightstand next to the bed. The tubing was not labeled with the date it was initiated and the mask was not covered to protect it from dust and germs. Additionally, there was a portable oxygen tank next to the dresser with a nasal cannula on the floor that was not labeled with date it was initiated.Interview on 04/29/26 at 11:55 A.M. with Licensed Practical Nurse (LPN) #101 confirmed the above observations of the respiratory equipment in Resident #54's room. LPN #101 stated oxygen and CPAP tubing should be dated, nasal cannulas should not be on the floor, and CPAP masks should be cleaned and bagged daily after use.Interview on 04/29/26 at 12:30 P.M. with the Director of Nursing revealed the facility did not have a policy or procedure regarding the maintenance of oxygen nasal cannulas and nebulizer tubing. Continued interview confirmed oxygen nasal cannulas should not be on the floor and tubing should be changed and labeled with the date of initiation once weekly.Review of facility policy titled, CPAP/BiPAP Cleaning, dated 2025, revealed CPAP masks should be cleaned and dried daily after use then stored in a plastic bag.2. Review of the medical record for Resident #58 revealed she was admitted on [DATE] with diagnoses including depression, anxiety, rheumatoid arthritis, osteoarthritis, hyperlipidemia and chronic obstructive pulmonary disease (COPD).Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #58 experienced mild cognitive impairment and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a manual wheelchair, was dependent for transfers, and was independently mobile. Resident #58 required moderate assistance with activities of daily living.Observation on 04/29/26 at 11:35 A.M. of Resident #58's room revealed a nebulizer machine on her nightstand with tubing that was not labeled with the date it was initiated.Interview on 04/29/26 at 11:40 A.M. with Certified Nurse Assistant #102 confirmed the tubing connected to the nebulizer machine on Resident #58's nightstand was not dated.Interview on 04/29/26 at 12:30 P.M. with the Director of Nursing revealed the facility did not have a policy or procedure regarding the maintenance of nebulizer tubing. Continued interview confirmed nebulizer tubing should be changed and labeled with the date of initiation once weekly.This was an incidental finding found during the course of the complaint investigation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews, and review of facility policy, the facility failed to ensure medication was administered and stored in a secure manner. This affected one (Resident #58) of one resident reviewed for medication administration and storage. The facility census was 60.Findings include:Review of the medical record for Resident #58 revealed she was admitted on [DATE] with diagnoses including depression, anxiety, rheumatoid arthritis, osteoarthritis, hyperlipidemia and chronic obstructive pulmonary disease (COPD).Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #58 experienced mild cognitive impairment and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a manual wheelchair, was dependent for transfers, and was independently mobile. Resident #58 required moderate assistance with activities of daily living.Observation on 04/29/26 at 11:35 A.M. of the bedside table in Resident #58's room revealed a medication cup with one green oblong pill, one white oblong pill, and four white round pills. Additionally, an inhaler was next to the medication cup. The nurse was not present in Resident #58's room.Interview on 04/29/26 at 11:40 A.M. with Certified Nurse Assistant #102 confirmed the above noted medications on Resident #58's bedside table.Interview on 04/29/26 at 11:50 A.M. with Licensed Practical Nurse #101 confirmed she was the nurse responsible for the above noted medication on Resident #58's bedside table. Continued interview confirmed residents should be observed consuming their medications when they are administered.Review of facility policy titled, Medication Administration, dated 2025, revealed nursing staff administering medications should observe the resident consuming their medications.Review of facility policy titled, Medication Storage, dated 2026, revealed medications would be under the direct observation of the person administering medications, or locked in a medication cart.This was an incidental finding found during the course of the complaint investigation.