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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foundation Park Care Center	1621 S Byrne Rd Toledo, OH 43614

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, and facility policy review the facility failed to implement the facility policy regarding the requirement to report a resident to resident altercation to the state agency. This affected one resident (#15) reviewed for abuse. The facility census was 92. Findings include: Review of Resident #15's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease and atrial fibrillation. Review of Resident #15's quarterly Minimum Data Set (MDS) dated [DATE] revealed she had an impaired cognition and behaviors included wandering and rejection of care. Review of Resident #15's nurses note dated 02/20/25 revealed the resident was in the dining room sitting at the table eating lunch. An altercation between two other residents happened and in the process Resident #15 was hit in the face with a plate receiving a cut to her forehead. The nurse separated residents. Resident #15 was assessed by staff and received wound care. Neurological checks were begun. Review of Resident #15's health status note dated 02/20/25 revealed the resident had a small laceration to the forehead. The resident removed the dressing which resulted in bleeding. The site was cleaned and antibiotic ointment applied with a clean dressing. Review of Resident #15's nurses note dated 02/21/25 revealed the resident had a large hematoma to the forehead. Observation on 03/04/25 at 10:25 A.M. revealed Resident #15 was ambulating through the facility with the assistance of a walker. Observation of her forehead revealed a healing bruise the size of a coffee saucer along with an approximate 1 1/2 inch healing cut in the center of the bruising. Interview with the Director of Nursing (DON) on 03/04/25 at 11:01 A.M. verified Resident #15 was hit with a dinner plate on accident. The DON stated it really was not an altercation involving Resident #15. The altercation was between two other residents when one resident attempted to leave the dining room holding the plate in the air and when a second resident attempted to pull the plate away, the plate hit Resident #15 in the forehead. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse #120 on 03/05/25 at 7:25 A.M. verified Resident #15 did get hit in the face with a dinner plate and suffered a laceration to her forehead. The nurse stated that Resident #31 was upset with another resident in the dining room and when Resident #31 was asked to leave the dining room she became upset and swung the plate and accidentally hit Resident #15 in the forehead. Resident #15 suffered a laceration and large bruise to the forehead. Interview with the Administrator on 03/05/25 at 1:10 P.M. verified the facility did not implement its policy regarding the abuse and mistreatment of Resident #15 when Resident #15 was hit in the forehead with a plate. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property dated 2017 revealed the Administrator or his/her designee will notify the Ohio Department of Health (ODH) of all alleged violations involving mistreatment, neglect, abuse, exploitation, misappropriation of resident property and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, and facility policy review the facility failed to report a resident to resident altercation. This affected one resident (#15) reviewed for abuse. The facility census was 92. Findings include: Review of Resident #15's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease and atrial fibrillation. Review of Resident #15's quarterly Minimum Data Set (MDS) dated [DATE] revealed she had an impaired cognition and behaviors included wandering and rejection of care. Review of Resident #15's nurses note dated 02/20/25 revealed the resident was in the dining room sitting at the table eating lunch. An altercation between two other residents happened and in the process Resident #15 was hit in the face with a plate receiving a cut to her forehead. The nurse separated residents. Resident #15 was assessed by staff and received wound care. Neurological checks were begun. Review of Resident #15's health status note dated 02/20/25 revealed the resident had a small laceration to the forehead. The resident removed the dressing which resulted in bleeding. The site was cleaned and antibiotic ointment applied with a clean dressing. Review of Resident #15's nurses note dated 02/21/25 revealed the resident had a large hematoma to the forehead. Observation on 03/04/25 at 10:25 A.M. revealed Resident #15 was ambulating through the facility with the assistance of a walker. Observation of her forehead revealed a healing bruise the size of a coffee saucer along with an approximate 1 1/2 inch healing cut in the center of the bruising. Interview with the Director of Nursing (DON) on 03/04/25 at 11:01 A.M. verified Resident #15 was hit with a dinner plate on accident. The DON stated it really was not an altercation involving Resident #15. The altercation was between two other residents when one resident attempted to leave the dining room holding the plate in the air and when a second resident attempted to pull the plate away, the plate hit Resident #15 in the forehead. Interview with Registered Nurse #120 on 03/05/25 at 7:25 A.M. verified Resident #15 did get hit in the face with a dinner plate and suffered a laceration to her forehead. The nurse stated that Resident #31 was upset with another resident in the dining room and when Resident #31 was asked to leave the dining room she became upset and swung the plate and accidentally hit Resident #15 in the forehead. Resident #14 suffered a laceration and large bruise to the forehead. Interview with the Administrator on 03/05/25 at 1:10 P.M. verified Resident #15's injury nor the resident to resident altercation was reported to the state agency as required. (continued on next page)

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