STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365752	A. Building B. Wing	08/04/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on open and closed medical record review, staff interview, review of a facility incident report, review of the Enhanced Information Dissemination and Collection (EIDC) system (system for reporting information) and review of the facility policy, the facility failed to report incidents of potential abuse and/or neglect to the State Survey Agency (SSA). This affected two (#100 and #68) of five residents reviewed for abuse. The facility census was 86. Findings include:1. Review of the closed medical record for Resident #100 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included dementia with behaviors, diabetes mellitus (DM), peripheral vascular disease (PVD), chronic heart failure, chronic kidney disease (CKD) stage four, atrial fibrillation (A-fib) (abnormal heart rhythm), and atherosclerotic heart disease. Review of the plan of care, initiated on [DATE], revealed Resident #100 was care planned for advanced directives of Full Code (full life-saving measures to be taken in the event of cardiac/respiratory arrest) status. Interventions included: if resident was found unresponsive, staff were to call a stat (immediate assistance) to the room, initiate cardiopulmonary resuscitation (CPR) and call 911, and notify family of changes in condition. Review of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #100 was cognitively impaired.Review of the physician orders for [DATE] revealed Resident #100 had an order for a Full Code status. Review of a nursing progress note dated [DATE] at 7:26 A.M. and authored by LPN #400, revealed LPN #400 went to obtain Resident #100's morning blood sugar and found him to be absent of vital signs.Further review of Resident #100's medical record revealed no additional information related to an assessment or action taken by facility staff when the resident was found unresponsive. Review of the EIDC system from [DATE] through [DATE] revealed no evidence the facility submitted a Self-Reported Incident (SRI) to the SSA related to Resident #100's death. An interview on [DATE] at 9:06 A.M. with the Director of Nursing (DON) revealed Resident #100 was a Full Code status and staff failed to initiate CPR or call 911 when the resident was found without vital signs on [DATE]. Further interview with the DON verified the facility did not submit an SRI to the SSA to report potential neglect of Resident #100 when staff failed to initiate life-saving measures.2. Review of the medical record for Resident #68 revealed an admission date of [DATE] with diagnoses of dementia, congestive heart failure (CHF), anxiety, and CKD stage three.Review of the significant change MDS assessment, dated [DATE], revealed Resident #68 was cognitively intact and was (staff) dependent for transfers and utilized a wheelchair.Review of the care plan, initiated [DATE], revealed Resident #68 had an activities of daily living (ADLs) self-care performance deficit related to cognitive impairment, mobility deficits, weak gait and required staff assistance. Resident #68 was also care planned to be at risk for falls due to decreased safety awareness, cognitive impairment, required assistive device for balance and mobility, and weak gait with an invention to use the stand up lift (lift used to assist residents with standing when they are experiencing weakness) for transfers due to weakness and unsteadiness, every shift. Review of the Kardex (information sheet specific to the resident's direct care for the Certified Nursing Assistance [CNA] to provide daily care, this will include things such has how a resident transfers) for Resident #68 revealed he may use a stand up lift for transfers due to weakness/unsteadiness every shift. Review of a nursing progress note, dated [DATE] and authored by Licensed Practical Nurse (LPN) #435, revealed Resident #68 complained of pain to his left foot. Resident #68 stated that the CNA that put him to bed didn't take her time and tossed him into bed. LPN #435 assessed Resident #68's foot and found his left foot was painful to touch and did not have any swelling or discoloration noted. The physician was notified and an order for an X-ray of the left foot was obtained.Review of a nursing progress note, dated [DATE], revealed Resident #68's left foot X-ray was obtained the evening prior and resulted as unremarkable plain radiograph of the left foot.Review of a facility incident report dated [DATE] and titled alleged abuse, and filed by LPN #435, revealed she received report from CNA #510 that Resident #68 complained of pain to his left foot from being transferred to rough by the staff the night before. Resident #68 stated they hurt his foot due to the rough transfer. The incident report further stated that LPN #435 reported the incident to the supervisor as well as the DON. The DON stated she would advise the Administrator. LPN #435 indicated in the incident report the physician was notified and an order was obtained for an X-ray to the left foot for Resident #68 to rule out any injury, and as needed (PRN) pain medication was administered to Resident #68.Review of the EIDC system from [DATE] through [DATE] revealed no evidence the facility submitted an SRI to the SSA related to the allegation of physical abuse for Resident #68.Interview on [DATE] at 11:34 A.M. with the DON

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on open and closed medical record review, staff interview, review of a facility investigation and review of facility policy, the facility failed to initiate and thoroughly investigate potential neglect and physical abuse. This affected two (#100 and #68) of five residents reviewed for abuse. The facility census was 86.Findings include: 1. Review of the closed medical record for Resident #100 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included dementia with behaviors, diabetes mellitus (DM), peripheral vascular disease (PVD), chronic heart failure, chronic kidney disease (CKD) stage four, atrial fibrillation (A-fib) (abnormal heart rhythm), and atherosclerotic heart disease. Review of the plan of care, initiated on [DATE], revealed Resident #100 was care planned for advanced directives of Full Code (full life-saving measures to be taken in the event of cardiac/respiratory arrest) status. Interventions included: if resident was found unresponsive, staff were to call a stat (immediate assistance) to the room, initiate cardiopulmonary resuscitation (CPR) and call 911, and notify family of changes in condition.Review of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #100 was cognitively impaired.Review of the physician orders for [DATE] revealed Resident #100 had an order for a Full Code status. Review of a nursing progress note dated [DATE] at 7:26 A.M. and authored by LPN #400, revealed LPN #400 went to obtain Resident #100's morning blood sugar and found him to be absent of vital signs.Further review of Resident #100's medical record revealed no additional information related to an assessment or action taken by facility staff when the resident was found unresponsive. Interview on [DATE] at 9:06 A.M. with the Director of Nursing (DON) verified the facility did not complete an investigation related to staff failing to initiate CPR for Resident #100 when he was found without vital signs and had a Full Code status. 2. Review of the medical record for Resident #68 revealed an admission date of [DATE] with diagnoses of dementia, congestive heart failure (CHF), anxiety, and CKD stage three.Review of the significant change MDS assessment, dated [DATE], revealed Resident #68 was cognitively intact and was (staff) dependent for transfers and utilized a wheelchair.Review of the care plan, initiated [DATE], revealed Resident #68 had an activities of daily living (ADLs) self-care performance deficit related to cognitive impairment, mobility deficits, weak gait and required staff assistance. Resident #68 was also care planned to be at risk for falls due to decreased safety awareness, cognitive impairment, required assistive device for balance and mobility, and weak gait with an invention to use the stand up lift (lift used to assist residents with standing when they are experiencing weakness) for transfers due to weakness and unsteadiness, every shift.Review of the Kardex (information sheet specific to the resident's direct care for the Certified Nursing Assistance [CNA] to provide daily care, this will include things such has how a resident transfers) for Resident #68 revealed he may use a stand up lift for transfers due to weakness/unsteadiness every shift.Review of a nursing progress note, dated [DATE] and authored by Licensed Practical Nurse (LPN) #435, revealed Resident #68 complained of pain to his left foot. Resident #68 stated that the CNA that put him to bed didn't take her time and tossed him into bed. LPN #435 assessed Resident #68's foot and found his left foot was painful to touch and did not have any swelling or discoloration noted. The physician was notified and an order for an X-ray of the left foot was obtained. Review of a facility incident report dated [DATE] and titled alleged abuse, and filed by LPN #435, revealed she received report from CNA #510 that Resident #68 complained of pain to his left foot from being transferred to rough by the staff the night before. Resident #68 stated they hurt his foot due to the rough transfer. The incident report further stated that LPN #435 reported the incident to the supervisor as well as the DON. The DON stated she would advise the Administrator. LPN #435 indicated in the incident report the physician was notified and an order was obtained for an X-ray to the left foot for Resident #68 to rule out any injury, and as needed (PRN) pain medication was administered to Resident #68.Review of the facility's investigation for alleged abuse for Resident #68 revealed a statement from LPN #435, dated [DATE], stating that she was notified by Certified Nursing Assistant (CNA) #510 that Resident #68 complained of pain from being roughly transferred by the night shift. Further review of the facility investigation revealed an undated written statement from CNA #510 that stated she went to give a shower to Resident #68, and he complained of a broken foot after he was transferred roughly the evening prior. Additionally, a telephone statement from CNA #520, dated [DATE], revealed she transferred Resident #68 per the usual transfer method with her hands around his waist and her leg between his knees, asked Resident #68 to stand, and he was pivoted into bed. CNA #520 stated Resident #68 then told her she hurt his leg once he was in bed. Further review of

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview, review of a written staff statement and review of the facility policy, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) or call nine-one-one (911) for Emergency Medical Services (EMS) assistance for Resident #100, who was found unresponsive, absent of breaths, without a pulse/heartbeat and was identified to have advance directives reflecting the resident was a Full Code (full life-saving measures to be taken in the event of cardiac/respiratory arrest) status. This resulted in Immediate Jeopardy and serious life-threatening harm/death on [DATE] when Licensed Practical Nurse (LPN) #400 went to Resident #100's room to check his blood sugar levels and found the resident to be unresponsive and absent of vital signs. LPN #400 called for the shift supervisor, LPN #410, who confirmed Resident #100 was absent of vital signs and neither nurse initiated CPR, called 911 for EMS assistance, or contacted the physician for direction. Resident #100 subsequently passed away in the facility, without life-saving measures being implemented, without 911 being called, and without the physician being contacted. This affected one (#100) of five residents reviewed for death in the facility. The facility census was 86. On [DATE] at 2:13 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at 5:35 A.M. when LPN #400 entered Resident #100's room to obtain his morning blood sugar level and found the resident was absent of vital signs. LPN #400 called for LPN #410 to confirm Resident #100, who was a Full Code status, was not breathing and did not have a pulse/heartbeat. LPN #400 and LPN #410 failed to initiate life-saving measures, including CPR, did not contact 911 for assistance, and further failed to seek direction from a physician. Resident #100 passed away in the facility. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], the Unit Manager LPN #445, provided verbal educational counseling to LPN #400 and LPN #410 on how to respond to a Full Code status. On [DATE], the DON reviewed all resident code statuses to verify physician orders for residents with a Full Code status were up to date. On [DATE], the DON or designee educated all licensed nursing staff on reviewing code status and initiating CPR for residents who required such care prior to the arrival of EMS. The education was provided via in-person, text message, and phone. On [DATE], the DON completed an audit of all in-facility deaths for the past 60 days, with no negative findings. On [DATE], the DON placed a list of all residents who have a Full Code status at the nurses' stations. The DON will ensure the list is updated as needed. On [DATE], an Ad-hoc Quality Assurance Performance Improvement (QAPI) meeting was held to identify issues and help prevent this incident from recurring. Members present included the Administrator, DON, Registered Nurse (RN) #460, Business Office Manager (BOM) #500, Activities Director (AD) #501, Dietary Manager (DM) #502, Maintenance Director (MD) #503, Therapy Director (TD) #504, Medical Records Clerk (MRC) #505, Social Service Director (SSD) #420, RN #506, LPN #450, LPN #507, and LPN #508. On [DATE], as identified by the Ad Hoc QAPI meeting, RN #460 performed an audit of CPR certifications for all licensed nurses. Any nurse identified to not have current CPR certification will be offered CPR certification by the facility. Beginning on [DATE], the DON will ensure all licensed nurses sign a staff education confirming receipt and understanding of education prior to their next scheduled shift related to identifying code status, verifying vital signs, initiating CPR and calling 911 for residents with a Full Code status, and continuing CPR until EMS arrives and assumes care of the resident. Beginning on [DATE], Human Resources (HR) #700 will verify CPR verification for all licensed nurses upon hire and a yearly CPR course will be offered to maintain certification. Beginning on [DATE], the DON or designee will audit all full code statuses three times a week for four weeks, then weekly for eight weeks to ensure resident code statuses are accurate. Beginning on [DATE], the DON or designee will provide education two times weekly on each shift for four weeks to ensure nursing staff understand how to verify resident code status and that residents with a Full Code must have CPR initiated and EMS called. Beginning on [DATE], the Administrator or designee will audit, upon occurrence for four months, all Full Code residents who experience an event in the facility that requires CPR to ensure advanced directives are followed, CPR was performed, and EMS was notified. Any identified issues will be corrected immediately and reported to the QAPI committee monthly for further review. Telephone interviews on [DATE] with LPN #400 and LPN #410 verified education was received on Full Code status, initiation of CPR, and notifying EMS when a resident with a Full Code status experienced cardiac or respiratory arrest. On [DATE] at 7:35 A.M., the DON reported LPN #400 and LPN #410 to the Ohio Board of Nursing for failing to initiate CPR for

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview, review of facility job descriptions, review of staff cardiopulmonary resuscitation (CPR) certifications and review of facility policy, the facility failed to ensure staff were competent and compliant with with implementing CPR per the physician orders and further failed to ensure nurse supervisors were qualified per the facility job description qualifications. This affected one (#100) of three residents reviewed for Advanced Directives. The facility census was 86.Findings include:Review of the closed medical record for Resident #100 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included dementia with behaviors, diabetes mellitus (DM), peripheral vascular disease (PVD), chronic heart failure, chronic kidney disease (CKD) stage four, atrial fibrillation (A-fib) (abnormal heart rhythm), and atherosclerotic heart disease. Review of the plan of care plan, initiated on [DATE], revealed Resident #100 was care planned for advanced directives of Full Code (full life-saving measures to be taken in the event of cardiac/respiratory arrest) status. Interventions included: if resident was found unresponsive, staff were to call a stat (immediate assistance) to the room, initiate CPR and call 911, and notify family of changes in condition.Review of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #100 was cognitively impaired. Review of the physician orders for [DATE] revealed Resident #100 had an order for Full Code status. Review of a nursing progress note dated [DATE] at 7:26 A.M. revealed Licensed Practical Nurse (LPN) #400 went to obtain the morning blood sugar for Resident #100 and found him to be absent of vital signs.Further review of Resident #100's medical record revealed no additional information related to an assessment or action taken by facility staff when the resident was found unresponsive. A telephone interview on [DATE] at 9:36 A.M. with LPN #400 confirmed she was responsible for Resident #100's care on the morning of [DATE] and found the resident in bed without vital signs. LPN #400 revealed this was the first time she had found a resident, who was a Full Code status, unresponsive and she was uncertain of what to do and requested assistance from LPN #410, the shift nursing supervisor. LPN #400 verified she did not initiate CPR or call 911 for Resident #100. A telephone interview on [DATE] at 10:21 A.M. with LPN #410 revealed she was the nursing supervisor for the night shift on [DATE], into the morning of [DATE]. LPN #410 stated LPN #400 called her to Resident #100's room on the morning of [DATE] due to the resident not having vital signs. LPN #410 verified she did not initiate CPR or call 911 for Resident #100 and the protocol for a resident with a Full Code status would have been to initiate CPR and call 911. LPN #410 confirmed a Registered Nurse (RN) was in the facility at the time Resident #100 was found; however, the nursing supervisor's decisions superseded the RN, even when the nursing supervisor was an LPN.A telephone interview on [DATE] at 9:49 A.M. with RN #415 revealed she worked night shift on [DATE] into [DATE]. RN #415 stated she did not have knowledge of Resident #100 being found unresponsive at the time he was discovered by LPN #400. RN #415 stated if she had known of the situation, she would have initiated CPR and called 911. RN #415 stated LPN #410 was the nursing supervisor on that shift and the nursing supervisor's decisions superseded an RN, even when the nursing supervisor was and LPN.Review of LPN #400's CPR certification revealed a valid certification, with an expiration date of [DATE]. Review of LPN #410's CPR certification revealed a valid certification, with an expiration date off [DATE]. Review of the facility policy titled, Policy and Procedure: CPR/Advanced Directives, undated, revealed it was the policy of the facility that each resident would have an advanced directive in place at admission and the staff would provide basic life support, including CPR, to him/her in an emergency prior to the arrival of emergency medical personnel according to the physician's order and the resident's advanced directives. The facility would ensure and maintain records that licensed staff were trained and certified/recertified in CPR and were available immediately, 24 hours per day, to provide basic life support, including CPR. All licensed staff must be aware of a resident's code status and immediately act accordingly.Review of the facility job description titled, Treatment Nurse, dated 2003 and used for all staff nurses, revealed the purpose of the charge nurse was to provide direct nursing care to the residents under the medical direction and supervision of the residents' attending physician, the (DON), or the Medical Director of the facility. Additionally, the charge nurse would assist in the modification of treatment regimen to meet the physical and psychosocial needs of the resident in accordance with established medical practices and the requirements of the policies and goals of the facility. Specific requirements included the ability to make independent decisions when circumstances warranted such action; knowledgeable of nursing and