

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 05/16/2024
NAME OF PROVIDER OR SUPPLIER Foundation Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742</p> <p>Based on medical record review, staff interview and review of facility policy, the facility failed to ensure a copy of the advanced directives were in the resident's medical record. This affected two (#59 and #236) of three residents reviewed for advanced directives. The facility census was 83.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #59 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, dementia, iron deficiency anemia, long term use of insulin, hypomagnesemia, atrial fibrillation, personal history of other diseases of the musculoskeletal system and connective tissue, stage III chronic kidney disease, heart disease, and cellulitis of face.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #59 was severely cognitively impaired.</p> <p>Review of a physician order, dated [DATE], revealed Resident #59's advanced directives were Do Not Resuscitate Comfort Care - Arrest (DNRCC-Arrest).</p> <p>Review of the care plan, dated [DATE], revealed Resident #59 had chosen advanced directive of DNRCC-Arrest. The medical record did not include a signed copy of the Advanced Directive.</p> <p>Interview on [DATE] at 12:50 P.M. with Registered Nurse (RN) #522 verified Resident #59's medical record did not include a signed copy of the resident's Advanced Directives.</p> <p>44815</p> <p>2. Review of the medical record revealed Resident #236 was admitted on [DATE] with a diagnoses of dementia.</p> <p>Review of the MDS assessment for Resident #236, dated [DATE], revealed it was in progress at the time of review.</p> <p>Review of the Nursing Admission Screening, dated [DATE], revealed Resident #236 was alert and oriented to herself.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician orders on [DATE] for Resident #236 revealed no order for code status or advance directives.</p> <p>Interview on [DATE] at 3:10 P.M. with Licensed Practical Nurse (LPN) #534 confirmed no advance directive order was entered in Resident #236's electronic medical record. LPN #534 further confirmed no paper copy of an advance directive or code status was available for Resident #236.</p> <p>Review of an undated facility policy titled Policy and Procedure: CPR/Advance Directives, revealed each resident will have an advance directive in place at admission and resident (or resident representative) wishes (advanced directives) are to be honored and documented in the medical record.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation, staff interview, review of a hospital referral and medical record review, the facility failed to ensure accurate skin assessments were completed upon admission. This affected one (#236) of two residents reviewed for skin conditions. The facility census was 83.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #236 was admitted on [DATE] with a diagnosis of dementia.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #236, dated 05/09/24, revealed it was in progress at the time of review.</p> <p>Review of the hospital Community Referral Form, scanned to the facility on [DATE], revealed a traumatic face superior wound was first assessed on 04/27/24. A wound assessment dated [DATE] indicated the area had edema, ecchymosis (bruising), was red, dry, and intact.</p> <p>Review of the Nursing Admission Screening, dated 05/09/24, revealed Resident #236 was alert and oriented to herself. Further review revealed Resident #236 had no identified skin concerns.</p> <p>Review of a Shower/Skin Assessment, dated 05/14/24, revealed Resident #236 was noted to have a discolored area with a description of old bruising on face and arm from when the resident arrived.</p> <p>Review of a progress note dated 5/13/2024 at 9:06 P.M. by Licensed Practical Nurse (LPN) #534 revealed Resident #236 had old yellow bruising on/around her face and the resident denied any pain.</p> <p>Observation and concurrent interview on 05/13/24 at approximately 11:00 A.M. with Resident #236 revealed bruising to her forehead and around her right eye. The bruising was yellowish in color. Resident #236 stated she was not aware she had a bruise to her face.</p> <p>Interview on 05/13/24 at 11:47 A.M. with LPN #536 verified Resident #236 had bruising to her face and forehead. LPN #536 stated Resident #236 had to have arrived with the bruises to her face based on the color and condition of her skin.</p> <p>Interview on 05/14/24 at 4:13 P.M. with Registered Nurse (RN) #514 revealed she completed the Nursing Admission Screening for Resident #236 upon admission on 05/09/24. RN #514 stated she completed a head-to-toe assessment of Resident #236 and did not observe any bruising to her face. Concurrent observation of Resident #236 with RN #514 confirmed Resident #236 had bruising with a yellow hue between her eyebrows, around the bridge of her nose, along the right eye and on her left upper cheek. RN #514 confirmed she did not observe or document the discoloration on Resident #236 upon admission.</p> <p>Interview on 05/16/24 at 8:10 A.M. with LPN #526 confirmed she worked with Resident #236 the morning after her admission. LPN #526 stated she noted the bruising on Resident #236's face the morning after her admission and stated she interviewed Resident #236 who stated she had previously fallen.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy titled Assessment, revealed a nursing assessment will be completed upon admission by the admitting nurse and abnormalities should be reflected and placed into the medical record.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to maintain appropriate physician orders, failed to accurately assess a dialysis access sites and further failed to ensure a dialysis catheter site was covered. This affected one (#17) of one resident reviewed for dialysis. The facility identified one resident on dialysis. The facility census was 83.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included dementia, end stage renal disease, and dependence on renal dialysis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/20/24, revealed Resident #17 was rarely/never understood and received dialysis.</p> <p>Review of the physician orders for Resident #17 revealed an order dated 02/15/23 to check thrill and bruit every shift, an order dated 02/15/23 to 05/15/24 to assess and document in progress notes the upper right chest central line catheter site for dressing condition, redness, pain, drainage and swelling. An order dated 09/29/23 stated to use a sterile dressing kit for dialysis port site if dressing becomes wet of comes off as needed and on order on 10/02/23 stated dialysis was on Tuesday, Thursday, and Saturday at 11:00 A.M., with pick up at 10:00 A.M.</p> <p>Further review revealed an order dated 05/15/24 to assess and document in progress notes the upper left chest central line catheter site for dressing condition, redness, pain, drainage and swelling.</p> <p>Review of the medication administration record (MAR) from 03/01/24 through 03/15/24 revealed Resident #17's right upper chest central line catheter site was assessed each day on the evening and night shifts.</p> <p>Review of the treatment administration record (TAR) from 03/01/24 to 05/15/24 revealed Resident #17's fistula was checked for a thrill and bruit each day, evening, and night shift.</p> <p>Further review of both the medication and treatment records from 03/10/24 to 05/15/24 revealed no documentation of a sterile dressing change for Resident #17's dialysis catheter site.</p> <p>Review of the progress notes dated 04/01/24, 04/11/24, and 04/26/24 revealed thrill and bruit was present and the fistula site was within normal limits.</p> <p>Review of the care plan dated 02/15/23 revealed Resident #17 had renal failure related to end stage renal disease. Interventions included dialysis every Tuesday, Thursday, and Saturday; to give blood pressure medications before dialysis; and to monitor, document and report signs and symptoms of acute failure, edema, and weight gain over two pounds. An update to the care plan dated 05/16/24 included the left upper chest central line catheter to be assessed and documentation placed in the progress notes regarding the dressing condition, redness, pain, drainage and swelling every shift.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 05/15/24 at 4:36 P.M. of Resident #17 with State tested Nurse Aide (STNA) #588 and Certified Occupational Therapy Assistant (COTA) #615 confirmed Resident #17's chest catheter was on his upper left chest, the catheter was uncovered, and his fistula was to his left upper arm. Further interview with STNA #588 revealed Resident #17's chest catheter was frequently uncovered because Resident #17 would pick off the bandage. Further observation at that time by Registered Nurse (RN) Surveyor revealed no thrill or bruit in Resident #17's fistula.</p> <p>Interview on 05/15/24 at 5:09 P.M. with the Director of Nursing (DON) confirmed, after checking herself, Resident #17's fistula did not have a thrill or bruit. The DON also confirmed the left chest catheter did not have a dressing in place to cover the insertion site. Additionally, the DON confirmed no knowledge of what staff were assessing and documenting when checking Resident #17's thrill and bruit. Further, the DON confirmed the MAR and physician order reflected Resident #17 had a right upper chest catheter.</p> <p>Interview on 05/16/24 at 8:47 A.M. with Registered Nurse (RN) #483 confirmed Resident #17's order dated 09/29/23 to use a sterile dressing kit for dialysis port site if dressing becomes wet or comes off as needed did not populate on the MAR/TAR and it should populate somewhere for the nurse to address.</p> <p>Review of the facility policy titled Non-Sterile, Clean Dressing Change, dated 10/18/23, stated dressing changes are completed per physician order. Documentation of the dressing change is noted in the medical record.</p> <p>Review of the undated facility policy titled Physician Orders, revealed it is the responsibility of the charge nurse to obtain, process and transcribe all physician orders. Physician orders are completed in the electronic medical record.</p> <p>Review of the undated facility policy titled Intravenous Catheters, stated all intravenous catheters are evaluated and documented daily for signs and symptoms of infection. All dressing changes are to be dated with dressing changes performed every two days for gauze dressings and every seven days for transparent dressings. Dressings will be replaced if damp, lose or visibly soiled.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</p> <p>Based on observation, medical record review and staff interview, the facility failed to ensure non-pharmacological behavioral interventions were assessed or implemented to address resistance to care resulting in lack of timely care and/or treatment. This affected one (#46) of four residents reviewed for behavioral services. The facility census was 83.</p> <p>Findings include:</p> <p>Resident #46 admitted to the facility on [DATE] with diagnoses including dementia, type II diabetes mellitus, hypertension, dysphagia, depression, and anxiety.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 04/17/24, Resident #46 was moderately cognitively impaired, sometimes understood/understands, rejected care daily, required partial to moderate assistance with activities of daily living (ADLs), was frequently incontinent of bowel and bladder, was at risk for pressure ulcer development with no skin breakdown and received antianxiety, antidepressant and antibiotic medications.</p> <p>Review of the plan of care (POC) revealed the following: on 10/05/23 the POC was revised to to address Resident #46 had dementia with behavioral symptoms related to cognitive impairment/poor decision making, refused medications/treatments/laboratory work, yelled at times and talked sexually to care workers during care. Interventions included the following: when the resident was speaking sexually during care, educate him on the importance of working with staff appropriately to get ADLs completed, administer medications as ordered by the physician, notify physician of any adverse reactions, consult behavioral care for daily mood symptoms and/or behavioral symptoms, allow the resident to make decisions about treatment regime and to provide sense of control. If the resident refused medications, treatments, labs, and/or ADL assistance, educate the resident on how completing the task helps well being and health. Minimize potential for the resident's disruptive behaviors by offering activities and tasks which divert attention. On 08/14/23, a POC area identified Resident #46 had potential to be verbally and/or physically aggressive related to cognitive impairment/poor decision making, impaired safety awareness/judgement, poor impulse control and anger. Interventions included: when the resident becomes agitated, intervene before agitation escalates, guide away from source of distress and engage calmly in conversation. If the resident's response was aggressive, staff to walk calmly away and approach later, assist resident to an area with reduced noise and dim lights to help calm resident, administer medications as ordered and monitor/document for side effects and effectiveness, provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, give the resident as many choices as possible about care and activities.</p> <p>Review of behavioral health service progress notes dated 01/22/24 and 03/25/24 revealed the administration of medications Zoloft 25 milligrams (mg) once daily for depression and buspirone 5 mg twice daily for anxiety continued to be administered with no dosage adjustments or non-pharmacological interventions recommended.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a quarterly activity progress note dated 04/16/24 revealed Resident #46 could not answer the activity assessment questions appropriately. The resident was verbal during the interview. Resident #46 was alert to name, had facial expressions with some eye contact, utilized a wheelchair and his speech was clear but sometimes hard to understand due to his accent. Resident #46 liked to stay in his room, listen to music and watch television. The resident would propell himself short distances from his room and watch what was going on. Staff invited the resident to activities and provided one on one visits. Resident #46 liked to reminisce about his home country and how he helped people there. The resident's family visited often.</p> <p>Review of nursing progress notes revealed Resident #46 refused the following care and treatment: 04/17/24 at 8:42 P.M. refused medications three times this evening, explained the need for them and continued to refuse; 04/18/24 at 7:31 P.M. resident threatening to throw urinal with urine in it at State tested Nurse Aide (STNA) because she took the Hoyer lift in the room to assist roommate in bed, yelling at staff and swearing for staff to the leave room; 04/21/24 at 9:22 A.M. refused care three times; 04/23/24 at 12:46 P.M. refused three times, agitated with other staff lead to refusal of medications; 4/26/24 at 12:44 P.M. Zolof 25 mg, Omeprazole 40 mg and Buspirone 5 mg refused; 04/28/24 at 1:27 P.M. and 04/30/24 at 1:27 P.M. medications refused; 05/05/24 7:26 P.M. medications refused; 05/09/24 at 7:08 P.M. refused medication this evening and insisted he was not taking it; 05/11/24 8:35 P.M. refused shower and skin assessment; and 05/13/24 at 10:19 A.M. combative with care. The nursing progress notes did not indicate any non-pharmacological interventions were attempted to assist with providing care to Resident #46.</p> <p>Further review of Resident #46's medical record revealed no resident specific interventions were included and no indication of staff success with care, treatment compliance or assessment to determine underlying cause of resistance.</p> <p>Observation on 05/13/24 at 9:59 A.M. revealed Resident #46 in bed refusing care. The room was noted with a strong urine odor. Concurrent interview with Registered Nurse (RN) #512 revealed Resident #46 resisted care and confirmed the resident was heavily soiled with urine.</p> <p>Further observation on 05/13/24 at 4:56 P.M. revealed Resident #46 was seated at bedside in a wheelchair. Resident #46 proceeded to expose his left posterior thigh and revealed approximately one inch of blistered tissue. The room continued with a strong urine odor.</p> <p>Interview on 05/14/24 at 5:55 A.M. with STNA #584 revealed she was assigned to provide care for Resident #46 from 10:00 P.M. on 05/13/24 until 6:30 A.M. on 05/14/24. STNA #584 stated she assisted the resident to bed at 2:00 A.M. and returned to check him at approximately 5:00 A.M. STNA #584 stated Resident #46 was soiled and refused care. STNA #584 informed the nurse; however, she did not return to attempt to provide care for Resident #46.</p> <p>Observation 05/14/24 at 6:05 A.M. with STNA #583 revealed Resident #46 was sitting on his bed. Concurrent interview with STNA #583 confirmed the resident was sitting on heavily soiled, yellow/brown stained bed linen.</p> <p>Interview on 05/14/24 at 6:19 A.M. with STNA #583 revealed Resident #46 frequently refused care and treatment. STNA #583 verified the resident's room had a strong urine odor for two days. STNA #583 stated some staff were able to get the resident to accept care and treatment; however, STNA #583 stated she had not been provided any specific interventions for Resident #46.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/14/24 at 11:25 A.M. with STNA #586 revealed she had traded an assignment with STNA #583 due to STNA #586 being successful in providing care for Resident #46 without resistance. STNA #586 confirmed successful interventions utilized to provide care for the resident had not be made available to other caregivers.</p> <p>Observation on 05/14/24 at 12:08 P.M. revealed Resident #46 was out of his room. The resident's room had a strong urine odor.</p> <p>Observation on 05/14/24 at 1:56 P.M. revealed Resident #46 in the corridor outside his room, seated in a wheelchair. Resident #46 had blisters to the left posterior thigh. No treatment application was observed on the blisters.</p> <p>Interview on 05/15/24 at 5:50 A.M. with STNA #584 revealed she was assigned to Resident #46 from 10:00 P.M. on 05/14/24 to 6:30 A.M. on 05/15/24. STNA #584 stated Resident #46 had behaviors and refused care. STNA #584 discovered blisters to his left thigh during the night and when she reported to work, she found Resident #46 with a puddle of urine on the floor next to his bed. STNA #584 stated the staff reported the resident had been resistant to care. STNA #584 confirmed no resident specific interventions or strategies had been established to address Resident #46 behaviors or refusals.</p> <p>Interview on 05/15/24 at 6:11 A.M. with Licensed Practical Nurse (LPN) #538 revealed she was unaware Resident #46 had blisters to the posterior left thigh. LPN #538 also confirmed no specific interventions established to maintain continuity when the resistant resisted care. Observation at 6:29 A.M. with LPN #538 confirmed the blisters to the resident's left thigh and proceeded to apply barrier cream. LPN #538 also verified the resident's room had a strong urine odor.</p> <p>Observation on 05/15/24 at 2:05 P.M. revealed Resident #46 was in his room, seated in a wheelchair with a large amount of urine puddling to the floor under his feet and wheelchair.</p> <p>Interview on 05/15/24 at 2:07 P.M. with the Director of Nursing (DON) verified Resident #46 was heavily soiled with a puddle of urine on the floor under the resident.</p> <p>Interview on 05/16/24 at 7:02 A.M. with Licensed Social Worker (LSW) #482 verified Resident #46's plan of care lacked specific and individualized interventions to promote acceptance of care and the medical record contained no specific non-pharmacological interventions for direct care staff to be successful in providing care to Resident #46 and de-escalating behaviors.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on observation, resident interview, staff interview, medical record review and review of facility policy, the facility failed to ensure medications were secure at all times and further failed to ensure medications were stored in approved and labeled containers. This affected thirteen (#5, #8, #12, #13, #23, #24, #36, #38, #52, #58, #61, #69 and #71) residents of thirteen residents observed for the storage of medication. The facility census was 83.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included neurocognitive disorder with Lewy bodies, emphysema, lymphedema, depression, epilepsy and insomnia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/17/24, revealed Resident #69 was cognitively intact, with no behavioral symptoms, was independent with activities of daily living (ADLs) and mobility and used antidepressant medication.</p> <p>Review of the care plan dated 06/01/23 revealed Resident #69 had dementia with behavioral symptoms related to cognitive impairment evidenced by poor decision making. Interventions included for medications to be administered as ordered by the physician, and, if medications were refused, the resident was to be educated on the importance of the medication for health and well being.</p> <p>Review of the physician orders for Resident #69 revealed an order written on 01/10/24 for amitriptyline hydrochloride 100 milligrams (mg) by mouth at bedtime for depression.</p> <p>Review of the May 2024 medication administration record (MAR) for Resident #69 revealed amitriptyline hydrochloride 100 mg was administered daily at 8:00 P.M.</p> <p>Observation on 05/13/24 at 10:09 A.M. of Resident #69's room revealed a red pill sitting in the center of plastic cup lid on the night stand next to Resident #69's bed. Concurrent interview with Resident #69 revealed the red pill was a sleeping pill from the previous night.</p> <p>Interview on 05/13/24 at 10:15 A.M. with Licensed Practical Nurse (LPN) #512 verified the red pill sitting on the plastic lid on the night stand next to Resident #69's bed. LPN #512 stated residents were to be observed taking medications.</p> <p>Observation on 05/13/24 at 10:20 A.M. of Resident #69's medications in the medication cart with LPN #512 verified the medication found at the bedside of Resident #69 was amitriptyline hydrochloride 100 mg.</p> <p>49742</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of the medical record revealed Resident #36 was admitted on [DATE]. Diagnoses included Alzheimer's disease, hypertension (HTN), hypothyroidism, generalized anxiety disorder, major depressive disorder, dementia, stage III chronic kidney disease, abnormal weight loss, restlessness and agitation, iron deficiency anemia, atrial fibrillation (a. fib), bilateral osteoarthritis of the knee, bilateral age-related cataracts and hearing loss (unspecified ear).</p> <p>Review of the MDS assessment, dated 02/28/24, revealed Resident #36 was severely cognitively impaired.</p> <p>Review of the physician orders revealed Resident #36 was ordered Levothyroxine (used to treat hypothyroidism) 112 micrograms (mcg) by mouth one time daily.</p> <p>Observation on 05/13/24 at 9:01 A.M. of Resident #36's room revealed a pink, oblong pill laying on the floor.</p> <p>Interview on 05/13/24 at 9:01 A.M. with LPN #533 verified the pill laying on the floor of Resident #36's room was Levothyroxine.</p> <p>15816</p> <p>3. Observation on 05/14/24 at 7:58 A.M. revealed Registered Nurse (RN) #522 administering medications to residents from the A hall cart. A clear plastic medication cup was observed in the upper drawer of the cart. The cup contained several oval white tablets. No pharmaceutical labeling was applied to the clear plastic 30 cubic centimeter (cc) medication cup.</p> <p>Interview on 05/14/24 at 8:02 A.M. with RN #522 verified the cup of white oval tablets in the medication cart. RN #522 indicated the cup was in place prior to assuming her shift at 6:30 A.M. RN #522 verified the medications were not in an approved pharmaceutical container with appropriate identification. RN #522 proceeded to obtain a large house stock bottle of acetaminophen and indicated she would place the tablets into the container. RN #522 began to return the tablets to the house stock bottle of acetaminophen. Upon Surveyor intervention, RN #522 proceeded to discard the tablets.</p> <p>Interview on 05/14/24 at 8:54 A.M. with the Director of Nursing (DON) verified facility policy indicated medications were not to be removed from original, approved pharmacy containers until administered.</p> <p>According to the facility policy titled Administration Procedures for all Medications, reviewed 01/03/23, revealed once medications are removed from the package or container, unused medications should be disposed of in accordance with facility policy.</p> <p>Review of the facility policy titled Administration Procedures for All Medications, dated 01/02/23, revealed medications shall be administered in a safe and effective manner, after medication administration, documentation of the administration should occur on the medication administration record and if a resident refuses medication the refusal should be documented on the medication administration record.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on staff interview and record review, the facility failed to ensure an accurate Nutritional Assessment was completed. This affected one (#50) of four residents reviewed for nutrition. The facility census was 83.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses of dementia and congestive heart failure.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had intact cognition and was on a therapeutic diet.</p> <p>Review of a diet order dated 04/09/24 revealed Resident #50 should receive a no added salt (NAS) diet, with regular textures and thin liquid consistency. The order additionally noted low fat, 2000 milligram (mg) sodium and low cholesterol.</p> <p>Review of a diet order dated 04/09/24 through 05/01/24 revealed Resident #50 was on a 1500 milliliter (ml) fluid restriction and should receive 800 ml on first shift, 500 ml on second shift, and 200 ml on third shift.</p> <p>Review of a diet order dated 04/10/24 revealed Resident #50 should receive a custom diet with regular textures and thin liquid consistency. Notes included to give one small cup of water and milk and a half cup of coffee at breakfast, one small cup of water and juice at lunch, and one small cup of water and juice at dinner. Additionally, no ice should be given and no extra fluids from the kitchen, unless approved by the nurse.</p> <p>Review of the Nutritional Assessment, completed 04/12/24, revealed Resident #50 was not on a fluid restriction and fluid was encouraged with meals, a hydration cart three times per day and ad lib (as much and as often as desired). Further review revealed Resident #50's estimated fluid needs were more than 1800 ml per day.</p> <p>Review of the physician order dated 05/01/24 revealed Resident #50 had an order for 1800 ml fluid restriction with 900 ml provided on first shift, 600 ml on second shift, and 300 on ml third shift. The order further noted Resident #50 could have one eight ounce cup of coffee every morning.</p> <p>Interview on 05/15/24 at 8:20 A.M. with Registered Nurse (RN) #512 confirmed Resident #50 was on an 1800 ml fluid restriction beginning 05/01/24. RN #512 stated Resident #50 had an order from 04/09/24 to 05/01/24 for a 1500 ml fluid restriction. Further interview confirmed Resident #50 was on a fluid restriction due to his diagnosis of congestive heart failure and his risk for weight gain due to fluid intake.</p> <p>Interview on 05/15/24 at 11:17 A.M. with the Director of Nursing (DON) confirmed Resident #50 had two diet orders, one dated 04/09/24 and another dated 04/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/16/24 at 9:48 A.M. with Registered Dietitian (RD) #501 confirmed the Nutritional Assessment she completed on 04/12/24 did not accurately reflect Resident #50's order for a fluid restriction and did not reflect Resident #50 had two diet orders, one of which included parameters for fluid restriction. RD #501 could provide no explanation why she was not aware of Resident #50's fluid restriction.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>44815</p> <p>Based on observation, staff interview and review of the facility's recipes, the facility failed to ensure portion sizes were followed when serving all diet textures. This affected 83 residents identified by the facility as receiving food from the kitchen. Additionally, the facility failed to ensure recipes were followed during preparation of pureed foods. This affected five (#18, #20, #21, #38, and #287) of five residents identified by the facility as having a physician ordered pureed diet. The facility census was 83.</p> <p>Findings include:</p> <p>Interview on 05/14/24 at 10:57 A.M. with Cook #506 revealed the facility had 14 residents who received mechanical soft diets and five residents who received a pureed diet.</p> <p>Observations on 05/14/24, beginning at 10:57 A.M., revealed Cook #506 used a utensil to portion 15 scoops of baked turkey crunch to process for residents on a mechanical soft diet. Continued observation revealed Cook #506 used a utensil to portion six scoops of baked turkey crunch to process for residents on a pureed diet. While processing the pureed turkey, Cook #506 added five slices of white bread to the mixer and pureed the bread along with the turkey. Cook #506 also added an unmeasured amount of water to the mixer while pureeing the turkey and bread.</p> <p>Interview on 05/14/24 at 11:12 A.M. with Cook #506 revealed she always added one extra scoop of food to the mixer when preparing altered-texture foods to ensure enough food was available for residents. Further interview and concurrent observation revealed Cook #506 used a size 16 scoop for the baked turkey crunch.</p> <p>Follow-up interview on 05/14/24 at 11:27 A.M. with Cook #506 confirmed she added five slices of bread to the mixer while pureeing the baked turkey crunch. Additionally, Cook #506 confirmed she added an unmeasured amount of hot water to the pureed turkey and bread to ensure it was the appropriate texture.</p> <p>Observations of meal service on 05/14/24, beginning at 11:29 A.M., revealed Dietary Manager (DM) #501 used a size 16 scoop to serve one scoop of the baked turkey crunch for residents on a regular diet. Additionally, DM #501 also used a size 16 scoop to serve one scoop of the mechanical soft baked turkey crunch.</p> <p>Interview on 05/14/24 at approximately 12:00 P.M. with DM #501 revealed she used a two ounce scoop to serve the pureed baked turkey crunch.</p> <p>Interview and observation on 05/14/24 at approximately 12:00 P.M. with Cook #506 confirmed the size 16 scoop was two ounces.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the recipe for baked turkey crunch revealed a portion size serving was 5 1/3 ounces. Review of the recipe for ground (mechanical soft) baked turkey crunch revealed a portion size serving was four ounces. Review of the recipe for pureed baked turkey crunch revealed a portion size serving was four ounces. Further review of the pureed baked turkey crunch recipe revealed instructions for pureeing included mixing baked turkey crunch with chicken broth only. Additionally, the instructions stated if product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth pudding or soft mashed potato consistency.</p> <p>Interview on 05/14/24 at 3:40 P.M. with DM #501 confirmed the appropriate serving sizes were not provided during the lunch meal. DM #501 verified the scoop size used to serve baked turkey crunch to residents on a regular diet was two ounces rather than the required 5 1/3 ounces, the scoop used to serve the mechanical soft baked turkey crunch was two ounces rather than the required four ounces, and the scoop used to portion the pureed baked turkey crunch was two ounces rather than the required four ounces. Additionally, DM #501 confirmed bread and water should not have been used during the preparation of pureed baked turkey crunch.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742</p> <p>Based on observation, staff interview, review of the medical record and review of the facility policy, the facility failed to ensure floors were adequately maintained. This had the potential to affect all 83 residents of the facility. Additionally, the facility failed to ensure resident rooms were free from odors. This affected one (#43) one one resident reviewed for room odors. The facility census was 83.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 05/13/24 at approximately 7:30 A.M. of the Bayview Dining Room revealed a sticky substance covering the floor throughout the dining room, which caused shoes to stick to the floor, become tacky, and make a squeaking noise while walking. Shoes remained tacky after leaving the dining room. Interview on 05/13/24 at approximately 7:30 A.M. with State tested Nursing Assistant (STNA) #569 verified the floors were sticky in Bayview Dining Room and this occurred yearly when the air conditioning was turned off in the facility. 2. Observation on 05/13/24 from 8:57 A.M. to 9:07 A.M. of the B Hall revealed floors covered in a sticky substance, causing shoes to become tacky and adhere to the floor when walking in resident rooms. Interview on 05/14/24 at 6:37 A.M. with STNA #568 verified the floors were sticky. 3. Observation on 05/13/24 at 10:00 A.M. of the C Hall revealed a sticky substance, causing shoes to become tacky and adhere to the floor when walking. Additional observation on 05/13/24 at 2:00 P.M. of the C Hall revealed the floors appeared to be clean; however, they remained tacky with shoes sticking to the floor when walking. Concurrent interview with Monitor #492 verified the floors were sticky. Interview on 05/14/24 at 2:09 P.M. with Registered Nurse (RN) #484 verified the sticky floors throughout the facility. RN #484 stated housekeeping staff had been re-educated regarding the correct dilution for the chemicals used to clean the floors. Interview on 05/15/24 at 7:00 A.M. with the Administrator verified the floors were not cleaned with the walk behind auto floor scrubber on 05/13/24 as the staff member called off on Monday, 05/13/24. <p>44815</p> <ol style="list-style-type: none"> 4. Review of the medical record for Resident #43 revealed an admitted [DATE], with a readmitted [DATE] and a diagnosis of dementia with behavioral disturbance. <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had severely impaired cognition. Further review revealed Resident #43 was frequently incontinent of urine and always incontinent of bowel.</p> <p>Review of the current care plan revealed Resident #43 had an activities of daily living (ADLs) self-care performance deficit related to incontinence. Resident #43 required staff assistance for toilet use and personal hygiene.</p> <p>Observation on 05/13/24 at 3:07 P.M. of Resident #43's room revealed a strong urine odor. Resident #43 was not in the room a the time of the observation. Concurrent interview with State tested Nurse Aide (STNA) #561 confirmed Resident #43's room smelled of urine.</p> <p>Interview on 05/13/24 at 3:10 P.M. with Licensed Practical Nurse (LPN) #534 confirmed Resident #43's room smelled of urine. LPN #534 stated, at times, Resident #43 urinated in bed.</p> <p>Observation on 05/14/24 at approximately 3:00 P.M. revealed Resident #43 was not in his room. The resident's room had a strong urine odor.</p> <p>Observation on 05/15/24 at 8:55 A.M. revealed Resident #43 seated in his wheelchair in his room. The resident's room had a strong urine odor. Concurrent interview with Monitor #492 verified the room smelled of urine.</p> <p>Review of facility policy entitled Foundation Park Care Center (FPCC) Policy for Daily Cleaning of Care Areas, dated 10/2023, revealed housekeeping, laundry, and maintenance staff had the primary responsibility for maintaining the facility in a safe, functional, sanitary, and comfortable condition on a daily basis.</p>