STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365849	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Toledo	4293 Monroe St Toledo, OH 43606

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, resident interview, staff interview, interview with the local health department, and review of facility policy the facility failed to assist dependent residents with activities of daily living (ADL) care. This affected three (#26, #78, and #94) of four residents reviewed for ADL care. The facility census was 86. Findings include: 1. Review of the medical record revealed Resident #26 was admitted on [DATE]. Diagnoses included nontraumatic subarachnoid hemorrhage, dementia in other diseases, hyperlipidemia, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 02/21/25, revealed the resident was severely cognitively impaired and required partial/moderate assistance with personal hygiene. Review of the care plan, dated 09/09/22, revealed Resident #26 required one person assist with bathing/showers and supervision to one person assist with dressing. Review of progress note, dated 02/20/25, revealed the nurse was informed by Certified Nursing Assistant (CNA) that Resident #26 asked for help stating something was biting her. The CNA assisted the resident in getting ready for bed and as the staff was taking off the resident's shirt stated there were bites all over the resident as the resident started itching herself. The CNA continued to assist the resident by taking off her bra and saw multiple small bugs in the resident's bra. Resident #26 was assessed and observed multiple bug bites on the resident's arms, chest, underneath her breast, back, legs, and feet. Redness and bite marks were observed to bilateral hips. The marks appeared reddened and discolored and some appeared healed over. Resident #26 was showered and all linen was bagged. The physician was notified. Resident #26 was placed in a new room for isolation as the bugs appeared to be body lice. Review of progress note, dated 02/20/25, revealed notification to the resident's Power of Attorney (POA) of the room move for isolation due to signs and symptoms of body lice. Review of Skin Alteration Assessment, dated 02/20/25, revealed Resident #26 had multiple bug bites, and scattered scratches from the resident itching on her chest, arms, legs, back, and underneath breast. Areas appeared reddened and some scabbed over. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note, dated 02/23/25, revealed Resident #26 had dead nets in her hair. Review of progress note, dated 02/24/24, revealed Resident #26's skin is noted to have some red marks and areas noted to be in different stages of healing that have scabbed over. Review of Weekly Wound Round Assessment, dated 02/25/25, revealed a rash due to lice infestation on the chest and upper-mid vertebrae. Interview on 03/26/25 at 10:43 A.M. with CNA #224 revealed she had assisted Resident #26 when the lice was discovered. CNA #224 stated Resident #26 had her bra in her hand, stated something was biting her, and asked for help. CNA #226 stated she picked up the bra and saw a whole lot of bugs in the bra and also on the floor. CNA #224 stated once the bedding was removed there were dead bugs in a perimeter around the bed. CNA #224 confirmed there were bites on the resident's ankles, back, and under the breast. Interview on 03/26/25 at 12:30 P.M. with Registered Nurse (RN) Unit Manager #262 verified Resident #26 would often refuse showers and the CNA's would accept the first no. RN Unit Manager #262 verified prior to finding the lice it had been a while since Resident #26 received a bath or a shower. The timeframe was unknown and stated again that it had been a while. Interview on 03/27/25 at 4:48 P.M. with Health Department Epidemiologist #500 verified it would take six to nine days for lice eggs to hatch and if there were nits on the hair and bites on the body it was most likely combination of head and body lice that affected the resident. 2. Review of the medical record revealed Resident #78 was admitted on [DATE]. Diagnoses included diffuse traumatic brain injury without loss of consciousness, major depressive disorder recurrent, essential hypertension, quadriplegia, and bipolar disorder. Review of the MDS assessment, dated 02/16/25, was cognitively intact and required partial/moderate assistance with eating. Review of the care plan, dated 12/10/24, revealed Resident #78 required assistance with ADL care due to weakness, non-ambulatory, contractures, and limited range of motion. Resident #78 required one person assistance with eating. Observation on 03/26/25 at 12:42 P.M. revealed the lunch meal served in the dining room with thirteen residents present. Resident #78 was observed to have two hot dogs in a bun on the lunch tray. CNA #206 passed trays and assisted other residents. While walking by Resident #78, CNA #206 would offer him a bite of the hotdog. Resident #78 was observed to watch CNA #206 deliver trays and assist other residents while waiting for his next bite of food. Resident #78's tablemate, Resident #50 was observed to take approximately one-third of a hotdog in a bun from Resident #78's plate and lob it in the Resident #78's mouth. Resident #78 leaned his head back to take in the food and was observed chewing with with a full mouth of food. Resident #50 was observed to continue to feed Resident #78 when CNA #206 was assisting other residents in the dining room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/26/25 at 12:50 P.M. with Resident #50 stated she assists Resident #78 with his meals at lunch and dinner when they are in the dining room. Resident #50 and Resident #78 stated they have never been informed another resident cannot not feed him. Resident #50 stated aides will often ask if she plans to feed him and count on her to do it. Interview on 03/26/25 at 12:56 P.M. with CNA #206 verified Resident #50 fed Resident #78 when she was assisting other residents. CNA #206 stated she has never told Resident #50 to not assist Resident #78 with eating and has never been told Resident #50 could not assist Resident #78. Interview on 03/26/25 at 2:15 P.M. with the Administrator and Director of Nursing (DON) verified no residents are approved or trained to feed other residents. 3. Review of the medical record revealed Resident #94 was admitted on [DATE]. Diagnoses included acquired fibrokeratoma, cellulitis of the right lower leg, opioid use, cerebral infarction, asthma, and epilepsy. Review of the MDS assessment, dated 12/27/24, revealed the resident was cognitively intact. Resident #94 required substantial/maximal assistance with bathing/showering. Review of the care plan, dated 12/23/24, revealed Resident #94 was at risk for ADL self-performance deficit due to weakness, difficulty ambulating, spasticity, cognitive deficits, asthma, pain, fall risks, anxiety, and history of stroke. The resident required one person assistance with bathing/showering and personal hygiene. Interview on 03/25/25 at 9:15 A.M. with Resident #94 revealed she is not always receiving showers. Resident #94 states she stinks. Resident #94 stated she did receive a shower on Saturday (3 days ago) however they did not use any shampoo on her hair or deodorant on her body. Interview on 03/25/25 at 9:21 A.M. with CNA #206 revealed Resident #94's hair does appear greasy. CNA #206 began to assist Resident #94 and stated that she does have a body odor. CNA #206 stated aides do not use soap and shampoo even though it is available. Observation on 03/25/24 at 9:25 A.M. revealed Resident #94 did have body odor under her armpits and her hair appeared greasy and unkempt. Review of policy, Support Activities of Daily Living, dated March 2018, revealed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADL's. Residents who are unable to carry out ADL care independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Review of policy titled Food and Nutrition Services, dated October 2017, verified food and nutrition staff will be available and adequately staffed to assist residents with eating as needed. Nurse aides and feeding assistants will provide support to enhance the resident experience, but not as a critical component to the functioning of the department. This deficiency represents non-compliance investigated under Complaint Number OH00163959, Complaint Number OH00163167, Complaint Number OH00162850, and Complaint Number OH00163858.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, resident interview, staff interview, and review of policy the facility failed to provide treatment for pressure ulcers. This affected two (Resident #43 and Former Resident #9) of three residents reviewed for pressure ulcers. The facility census was 86. Findings include: 1. Review of the medical record revealed Resident #43 was admitted on [DATE]. Diagnoses included paraplegia, chronic osteomyelitis, pressure ulcer right buttock stage 4, pressure ulcer sacral region stage 4. Review of the Minimum data Set (MDS) assessment, dated 03/18/25, revealed the resident was cognitively intact, always incontinent of urine and stool, and two stage four pressure ulcers. Review of wound care notes, dated 03/14/25, revealed Resident #43 has a stage four sacral decubitus ulcer and right buttock ulcer with bone exposure, no necrotic tissue or purulent drainage. Review of physician order, dated 03/11/25, revealed an order for wound care to the right thigh with instructions to cleanse with liquid antibacterial soap and water rinse well, apply collagen then silver alginate cover with tape, assess for pain prior to wound treatment and medicate per order as indicated. Observation on 03/25/25 at 11:26 A.M. revealed the wound care treatment cart outside Resident #43's resident room. Interview on 03/25/25 at 12:03 P.M. with Resident #43 revealed since approximately 3:30 A.M. that morning he did not have a wound dressing on his thigh wound and there was fecal matter in his wound. Resident #43 stated the dressing came off during incontinence care, the aide reportedly informed the nurse, however the dressing was not reapplied. Resident #43 stated the wound care nurse just applied a new dressing. Interview on 03/25/25 at 12:20 P.M. with Licensed Practical Nurse (LPN) #205 verified when completing wound care rounds today Resident #43 did not have dressing to his right thigh and there was fecal matter in the wound. 31638 2. Review of Former Resident (FR) #9 revealed an admitted [DATE]. Diagnoses included paraplegia, alcohol use with withdraw, and myocardial infarction. Review of FR # 9's admission MDS dated [DATE] revealed the resident had impairment on both upper and lower extremities. He was dependent on staff for all activities of daily living. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of FR #9's care plan revealed the resident was at risk for impaired skin integrity related to weakness, paraplegia, alcoholism, numbness, urinary catheter, incontinence, dermatitis, cognitive deficits, behaviors, and smoking. Interventions included inspecting skin daily during routine care, apply barrier cream/ointment after each incontinent episode as needed, dietary evaluation, explain all procedures prior to care, and to provide a pressure reducing mattress. Review of FR #9's facility wound care note dated 03/04/25 revealed the note was absent regarding wounds of the heel and foot. Review of FR #9's progress note revealed on 03/05/25 the resident went out to a physician's appointment and demanded to be sent to the emergency room instead of back to the facility. The record was absent regarding the reason for the hospital admission. Review of FR #9's Wound Ostomy Continence Nursing Consult Note from the local hospital dated 03/05/25 revealed the resident was admitted with a pressure injury to the left lateral heel. The wound measured 3.8 centimeters (cm) long by 3.1 cm wide by 0.3 cm deep and had serosanguinous drainage. The wound was described as subcutaneous, pink/red in color with devitalized tissue, dusky in color and with slough. The peri-wound was hypopigmented. The patient also had a pressure injury to the right ankle. The wound measured 0.9 cm long by 0.5 cm wide by 0.3 cm deep. The wound was pink/red with serosanguinous drainage. The peri-wound was hyperpigmented and edematous. Both wounds were described as painful. Review of FR #9's hospital physician's note dated 03/13/25 revealed he developed a stage three pressure ulcer to the left lateral heel. The wound was present on admission to the hospital. Review of FR #9's after visit summary dated 03/13/25 revealed treatment to the left lateral heel and right ankle which were stage 3 pressure ulcers. Treatment included applying a foam dressing. Review of FR # 9's facility physician assistant note dated 03/13/25 revealed the resident was readmitted from the hospital. The resident had a left heel and right ankle pressure wound. Continue local wound care. Review of FR #9's medical record dated 03/13/25 revealed the Physician Assistant ordered wound care for the resident's left heel and right ankle wounds per hospital after visit summary (AVS). The order was incomplete as to treatment. Review of FR # 9's physician note dated 03/18/25 revealed the resident was disoriented and being sent out to the hospital. The resident had chronic pressure ulcers. Review of FR # 9's treatment administration record dated March 2025 revealed the record was absent of wound care to the left lateral heel and the right ankle. Telephone interview with the Corporate Nurse #400 and the DON on 03/26/25 at 11:07 A.M. verified the facility failed to obtain orders for FR #9's wounds to the left lateral heel and right ankle after his return from the hospital on 03/13/25. Corporate Nurse #400 stated she knew the staff completed wound care on the resident even though there were no orders nor documentation regarding care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Skin Management Program undated revealed initial admission assessment included review of hospital records, transfer documents, etc., to understand the resident's history of or risk factors for pressure injuries. Assess resident for other skin conditions. If an alteration in skin integrity is identified the charge nurse will do the following: notify/document the physician and obtain order for treatment. This deficiency represents non-compliance investigated under Master Complaint Number OH00164030, Complaint Number OH00163959 and Complaint Number OH00162616.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure adequate toenail care. This affected two (#15 and #94) of four residents reviewed for activities of daily living. The facility census was 86. Findings include: 1. Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included lymphedema, venous insufficiency, myiasis, essential hypertension, personal history of transient ischemic attack and cerebral infarction without residual deficits, paroxysmal atrial fibrillation, heart failure, non-pressure chronic ulcer of other part of right and left lower leg with necrosis of muscle. Review of the Minimum Data Set (MDS) Assessment, dated 01/28/25, revealed the resident was cognitively intact and required set-up/clean up assistance with personal hygiene and partial/moderate assistance with footwear. Review of the care plan, dated 10/25/24, verified Resident #15 was at risk for activities of daily living (ADLs) self-performance due to weakness, difficulty ambulating, fall risk, and wounds. Resident #15 required one person assist with bathing/showering, dressing, and personal hygiene. Review of request for services documentation, signed 03/24/25, revealed signed consent for eye care and podiatry care. The checkbox for the reason for a podiatry visit was listed as thickened, dystrophic, and/or painful nails with increased risk of infection. Observation on 03/25/25 at 2:40 P.M. of Resident #15 revealed resident was in her resident room and her toes were exposed. The toe nails were observed to be long, thick, and discolored. Interview on 03/25/25 at 2:42 P.M. with Licensed Practical Nurse (LPN) #221 verified Resident #15's toe nails were too long and overdue to be trimmed. 2. Review of the medical record revealed Resident #94 was admitted on [DATE]. Diagnoses included acquired fibrokeratoma, cellulitis of the right lower leg, opioid use, cerebral infarction, asthma, and epilepsy. Review of the MDS assessment, dated 12/27/24, revealed the resident was cognitively intact. Resident #94 required substantial/maximal assistance with bathing/showering. Review of the care plan, dated 12/23/24, revealed Resident #94 was at risk for ADL self-performance deficit due to weakness, difficulty ambulating, spasticity, cognitive deficits, asthma, pain, fall risks, anxiety, and history of stroke. The resident required one person assistance with bathing/showering and personal hygiene. Review of request for services documentation, signed 03/25/25, revealed signed consent for eye care and podiatry care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/25/25 at 9:14 A.M. revealed Resident #94 in the resident room with no socks on. Resident #94 toe nails were all long and jagged with rough edges. Interview on 03/25/25 at 9:15 A.M. with Resident #94 verified her toe nails are uncomfortable and snag on everything. Interview on 03/25/25 at 9:21 A.M. with Certified Nursing Assistant (CNA) #206 verified Resident # 94's toe nails were long and stated she should be on the podiatry list. Interview on 03/26/25 at 12:23 P.M. with Social Services #309 verified Resident #15 and Resident #94 have not been on the podiatry list. The residents were approved for podiatry services effective 03/24/25 and 03/25/25. Review of the Podiatry List, scheduled 04/10/25, revealed Resident #15 had been add to the list by hand and Resident #94 had not been added to the list. This deficiency represents non-compliance investigated under Complaint Number OH00163817, Complaint Number OH00162850, and Complaint Number OH00163167.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, and policy review the facility failed to ensure medical records were properly documented. This affected one resident (#73) of three reviewed for skin issues. The facility census was 86. Findings include: Review of Resident #73's medical record revealed an admitted [DATE]. Diagnoses included schizophrenia and metabolic disorders. Review of Resident #73's Minimum Data Set, dated dated dated [DATE] revealed he had an intact cognition. He was independent for dressing and required supervision or touch assistance for hygiene. No skin conditions were noted. Review of Resident #73's most recent care plan revealed he was at risk for impaired skin integrity related to weakness, difficulty ambulating, refusing showers, refusing to take off layers of clothing, refusing skin checks, schizophrenia, and cognitive deficits. Interventions included to inspect the skin during routine daily care. The resident was non-compliant related to refusals of personal care/showers, refusing to change clothing, layering clothing, and refusing skin checks. Review of Resident #73's weekly body audits dated 02/03/25, 02/07/25, 02/14/25, 02/21/25, 03/01/25, 03/08/25, and 03/15/25 revealed the resident's skin was intact and there were no new concerns. Review of Resident #73's progress note dated 02/04/25 revealed the resident refused weekly showers and skin sweeps. The provider was made aware. Review of Resident #73's progress note dated 02/20/25 revealed the physician's assistant gave a verbal order for Permethrin (antiparasitic) to be used for lice and possible scabies. Review of Resident #73's progress note dated 03/25/25 revealed the resident continued refusal to comply with treatment for body lice. The resident continued to refuse treatments and to bathe. Telephone interview with the Corporate Nurse #400 the Director of Nursing (DON) on 03/26/25 at 11:07 A.M. revealed Resident #73 had continually refused bathing and skin assessments for quite a while and failed to comply with treatment of bedbugs and scabies. Interview on 03/27/25 at 2:40 P.M. with the Administrator and Director of Nursing (DON) revealed facility staff declined to verify inaccurate skin assessments for Resident #73. Review of the facility policy titled Skin Management Plan undated revealed skin evaluations will be completed on a weekly basis for all residents. The results will be documented in the electronic medical record using the weekly skin assessment documentation tool. Any new skin alterations will be followed up on as described in this guide. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00163858.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and review of facility policy, the facility failed to ensure infection control standards were maintained during medication administration. This affected one resident (#60) of four residents (#16, #37, #40, and #60) observed for medication administration. The facility census was 86. Findings include: Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses of chronic respiratory failure, cerebral vascular accident (CVA), quadriplegia, and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #60 revealed he was cognitively intact. Observation on 03/27/25 at 8:10 A.M. of Licensed Practical Nurse (LPN) # 221 completed medication administration for Resident #63. Concurrent observation during medication observation revealed LPN #221 moved her medication cart across the hall and began medication preparation for Resident #60 without performing hand hygiene. Continued observation of LPN #221 during medication administration revealed she prepared the prescribed oral medication for Resident #60 which included 11 pills. Observation on 03/27/25 at 8:15 A.M. of LPN #221 revealed she counted the number of pills by dumping the entire medication cup of 11 pills into her ungloved hand, counted the pills for administration and returned them to the medication cup for administration. Observation on 03/27/25 at 8:17 A.M. Resident #60 was presented with his medication cup of pills and he consumed all the medication. Interview on 03/27/25 at 8:18 A.M. with LPN #221 verified she did not complete hand hygiene following medication administration to Resident #63 and prior to preparing medication for Resident #60. Concurrent interview with LPN #221 verified she dumped the medication cup of pills into her ungloved, uncleaned, hand and counted the pills and then administered them to Resident #60. Review of the facility policy titled Medication Administration and General Guidelines dated 2022 revealed medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices. The person administering medications adheres to universal precautions, using proper hand hygiene, gloves when appropriate, before beginning a medication pass, prior to handling any medication, and after coming into direct contact with a resident.