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	05/12/2026

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, and policy review, the facility failed to ensure resident were provided a respectful and dignified dining experience. This affected one (#56) of four residents observed seated at the same table during meal service. The facility census was 75.Findings include:Observation on 05/04/26 at 12:08 P.M. during lunch mealtime revealed approximately 32 residents in the main dining room. Resident #56 was observed at a table with three other residents and standing to the left of Resident #56 was a Certified Nurse Aide (CNA) assisting Resident #56 with feeding the resident lunch. Interview on 05/04/26 at 12:10 P.M. with CNA #130 verified she was standing next to Resident #56 and assisting her with lunch. CNA #130 stated she was not aware she should not be standing when assisting residents with meals. Review of the facility policy titled, Resident Rights, dated 10/2022, revealed residents have the right to be treated with respect, dignity, and care to enhance quality of life and individuality. This deficiency represents non-compliance investigated under Complaint Number 2728038, Complaint Number 2603494, and Complaint Number 1365012 (OH00165158).

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, review of facility investigation documents including written statements, review of pharmacy manifest documents, review of staffing schedules, review of narcotic count sheets, staff interview, policy review, and review facility corrective action, the facility failed to prevent the misappropriation of resident narcotic medications. This affected one (#86) of five residents reviewed for abuse, neglect, and misappropriation. The facility census was 75.Findings Include:Review of the medical record for Resident #86 revealed an admission date of 09/15/25 and a discharge date of 04/14/26. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, anxiety, and cancer of the pharynx.Review of Resident #86's physician orders for active in April 2026 revealed she was prescribed the narcotic pain medication oxycodone 10 milligrams (mg) every four hours as needed, the narcotic pain medication morphine sulfate 20 milligrams per milliliter (mg/ml) with instructions to give 0.25 ml every hour as needed for pain or shortness of breath (SOB), and the antianxiety medication Ativan one (1) mg every four hours as needed for anxiety or SOB, and admission to hospice program.Review of the care plan for Resident #86 revealed she was a focus area for pain related to generalized pain, left foot pain, lung pain, and cancer pain with interventions in place to administer medications as prescribed.Review of the pharmacy manifest for Resident #86 dated 02/14/26 and timed at 1:06 P.M. revealed Licensed Practical Nurse (LPN) #290 signed for the delivery of oxycodone 10 mg with a total of 60 tablets.Review of the daily nursing schedule for 02/14/26 revealed LPN #290 was scheduled to work and assigned to the North unit.Review of the narcotic count sheet for 02/14/26 for the North unit revealed no narcotic count sheets were added for the day of the arrival of Resident #86's oxycodone medication.Review of the written statement dated 02/18/26 at 5:30 P.M., authored by Registered Nurse (RN) #249, revealed she was working with LPN #138 when LPN #138 asked for assistance related to Resident #86's oxycodone that was allegedly delivered to the facility on [DATE] and she was not able to locate it. RN #249 further indicated both nurses looked for the medication, were not able to find it, and requested a copy of the pharmacy manifest be faxed to the facility. RN #249 revealed stated upon receipt of the copy of the pharmacy manifest the Director of Nursing (DON) was notified of the incident.Review of the written statement dated 02/16/26, authored by LPN #138, revealed she was getting pain medication ready for Resident #86 and had to call the pharmacy for permission to pull the oxycodone 10 mg from the Cubex machine (machine that holds commonly used medication for quick access, usually holds common pain medication and antibiotics for ease of access). LPN #138 indicated the pharmacy advised the medication was just delivered with a card of 60 tablets. LPN #138 documented the pharmacy granted permission for administration of the medication from the Cubex machine.Review of the statement from a telephone interview with RN #150 revealed she worked on 02/14/26 and observed LPN #290 interact with the pharmacy delivery person, and LPN #290 delivered the medication to RN #150 that belonged to her for the medication cart.Review of the telephone statement obtained from LPN #290 dated 02/16/26 revealed LPN #290 did not know what occurred with the oxycodone 10 mg card and did not recall receiving the narcotics in question. LPN #290 stated she signed the paperwork from the pharmacy technician and further stated she did not look at or verify the medications at the time she signed for them. LPN #290 further stated she was in a rush to leave the facility for her lunch break.Review of the written statement dated 02/17/26 authored by LPN #290 revealed she signed for medication from the pharmacy delivery driver, she did not verify what medication she was signing for, and was going on break while receiving orders from her unit manager and the DON regarding a different medication. LPN #290 stated she was not sure if she took possession of the narcotics or if they were left on the nurses station.Interview on 05/11/26 at 3:48 P.M. with the DON confirmed the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information contained in the facility self-reported incident related Resident #86's oxycodone medication. The DON stated LPN #290 signed for Resident #86's oxycodone on 02/14/26, confirming receipt of the medication, but the medications were never found in the facility. The DON stated the facility completed a thorough investigation and ultimately terminated LPN #290's employment from the facility.Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated 10/22, revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation.The deficient practice was corrected on 02/23/26 when the facility implemented the following corrective actions: - On 02/16/26, the DON and unit managers searched all medication carts, the nursing units, and the medication room for the missing narcotics and the medications was not found.- On 02/16/26, the DON/designees conducted interviews with all staff members involved in the missing medication. - On 02/16/26, the DON began an investigation and filed a self-reported incident to the State Survey Agency. - On 02/16/26, the DON completed interviews with all residents on the North unit and all residents were assessed for pain management with no concerns noted.- On 02/16/26, per direction from the DON, Resident #86 was administered oxycodone as ordered following notification to the pharmacy for permission to dispense the medication STAT (immediately). The facility paid for replacement of the missing narcotics.- On 02/16/26, notification was made to the physician and the hospice provider for the missing narcotics. Orders were received for Resident #86 to continue pain control until the replacement medication was received.- On 02/16/26, the Administrator and the DON contacted LPN #290 for a statement and completed a urine toxicology screening which was negative. LPN #290 was suspended for performance failure to follow duties in job description and adhering to policies and procedures according to pharmacy standards and practice. - On 02/16/26, a police report was filed with the local police department by the DON for suspicion of drug theft by LPN #290.- On 02/16/26, a report was filed with the pharmacy by the DON.- On 02/16/26, the State Board of Nursing was notified of the alleged narcotic theft by the DON.- On 02/18/26, the DON completed all staff education on abuse, neglect, and misappropriation. Nurse education was completed on 02/18/26 which included instructions that two nurses must sign narcotic medication manifests as well as shift-to-shift narcotic sheet counts.- On 02/20/26, the facility initiated audits of resident narcotics through review of the shift-to-shit sheets and pharmacy manifests with no concerns noted. The audits consisted of review for two nurse signatures and initials, audits of the spenddown sheets for two nurse signatures when accepting narcotics from delivery, and narcotics removed and added to shift-to-shift narcotic count sheets with review completed twice weekly. Additionally, the shift-to-shit narcotic sheets were audited three times weekly by facility nurses. The audits were completed through 04/28/26 with no additional concerns identified.- On 02/23/26, LPN #290 was terminated by the DON.- On 04/30/26, the Quality Assurance and Performance Improvement (QAPI) committee met and made no changes to the processes put in place for the receipt of narcotic medications into the facility. - Review of four (#12, #82, #83, and #85) additional resident medical records for abuse, neglect, and misappropriation on 05/12/26 revealed no further concerns related to misappropriation of medications.- Interviews on 05/12/26 from 8:49 A.M. to 9:01 A.M. with RN #117, RN #257, LPN #169, LPN #201, and LPN #277 verified they received education on abuse, neglect, and misappropriation. All nurses also confirmed they received education on the process to sign in narcotic medications, the requirement of two nurses to sign the pharmacy manifest, and the requirement to have two nurses sign the narcotic sheet count at each shift change.This deficiency represents non-compliance investigated under Complaint Number 2804787, Complaint Number 2786880, Complaint Number 1365108 (OH00166363), and Complaint Number 1365106 (OH00166222).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, staff interviews, and review of a facility policy, the facility failed to ensure residents received appropriate assistance from staff to maintain adequate personal and oral hygiene. This affected two (Residents #38 and #42) of four residents reviewed for activities of daily living. The facility census was 75.Findings include:1. Review of the medical record for Resident #38 revealed he was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, type two diabetes mellitus, antisocial personality disorder, anxiety, delusional disorders, paranoid personality disorder, and schizophrenia.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/06/26, for Resident #38 revealed he experienced mild cognitive impairment, did not experience behaviors toward himself or others, and he refused care on four to six days during the assessment period. Resident #38 required set up and clean up assistance with oral care.Review of the care plan for Resident #38 revealed a focus area for activities of daily living self-care performance deficit and an intervention dated 08/15/24 indicating he required supervision with oral hygiene.Review of the task sheet dated 04/08/26 through 05/07/26 for Resident #38 revealed oral care was offered three times daily and he received oral care three times on 05/04/26.Observation on 05/05/26 at 8:50 A.M. of Resident #38 sitting up in bed revealed a white debris buildup on his upper and lower front teeth visible from approximately four feet away while he spoke. Concurrent interview with Resident #38 revealed he had not eaten breakfast yet, pointing to the untouched tray of food on his bedside table, could not recall the last time his teeth had been brushed, and was displeased that he had not been offered assistance with brushing his teeth.Interview on 05/05/26 at 9:05 A.M. with Licensed Practical Nurse (LPN) #231 confirmed Resident #38 had a white debris buildup on his upper and lower front teeth while standing approximately four feet away.2. Review of the medical record for Resident #42 revealed she was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis affecting her right dominant side, muscle weakness, and dementia.Review of the care plan for Resident #42 revealed a focus area for activities of daily living self-care performance deficit and an intervention dated 06/25/24 indicating she required supervision with personal hygiene. Observation on 05/05/26 at 8:55 A.M. of Resident #42 in her room revealed she was dressed, sitting up in her wheelchair, and the back of her hair was disheveled, flat, and swirled sticking outward.Interview on 05/05/26 at 9:06 A.M. with LPN #231 confirmed Resident #42's hair was not brushed.Review of facility policy titled, Activities of Daily Living (ADLs), Supporting, dated March 2018, revealed the facility would provide services to maintain good oral hygiene and grooming for those residents identified as unable to complete these tasks independently.This deficiency represents non-compliance investigated under Complaint Number 2687112.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, staff interview, and policy review, the facility failed to ensure measures developed for Legionella control measures were fully implemented, failed to ensure enhanced barrier precautions were in place for residents with indwelling medical devices, and failed to ensure proper infection control measures were maintained during administration of a subcutaneous medication. This had the potential to affect all 75 residents except one (#85) resident identified with orders for nothing by mouth, and directly affected one (#66) of one residents reviewed for dialysis and one (#68) of four residents observed for medication administration. The facility census was 75.1. Interview on 05/06/26 at 7:50 A.M. with Maintenance Supervisor (MS) #260 revealed Legionella control measures being completed and documented included water temperature checks, flushing logs, and hot water tank servicing. No further documentation was provided for Legionella control measures. MS #260 verified there was no documentation for ice machine or shower head cleaning. Interview on 05/06/26 at 8:36 A.M. with Housekeeping Supervisor (HS) #219 revealed housekeeping staff complete monthly deep cleans of shower rooms which included shower head cleaning. HS #219 verified housekeeping was not responsible for ice machine cleaning. Observation of a service log located on the inside area of the ice machine located in the main dining area on 05/06/26 at 10:09 A.M. with MS #260 revealed service dates were in 2025, with the last two services completed in April 2025 and May 2025. Review of the document titled, Risk Management Plan for Legionella Control, dated 02/07/25, revealed control and monitoring measures included facility flushing, measure temperatures weekly, hot water tank inspected and cleaned annually, clean sinks, basins and shower heads monthly, clean ice machine quarterly and weekly flushing of water in low use areas and annual inspection. 2. Review of the medical record for Resident #66 revealed an admission date of 01/23/26. Diagnoses included cerebral infarction, type two diabetes mellitus, end stage renal disease, hypertension, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 had intact cognition. The resident was receiving dialysis services. Review of the care plan initiated 01/24/26 revealed Resident #66 received hemodialysis three times per week. Interventions included monitoring of the dialysis access site for signs and symptoms of infection or bleeding. The type of dialysis access site the resident was utilizing was not specified in the care plan. Further review of the care plan revealed there was no interventions in place for enhanced barrier precautions. Review of Resident #66's physician orders dated 01/26/26 revealed an order to observe the hemodialysis catheter in the right upper chest for signs or symptoms of infection, infiltration, and bleeding every day and night shift and as needed. The order was discontinued on 03/16/26. There was no documentation in the medical record that the resident's hemodialysis catheter had been removed. Further review of the physician orders revealed there were no orders for enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/04/26 at 1:13 P.M., with Resident #66 revealed he had an arteriovenous (AV) fistula in his left arm that the dialysis center had not used yet. Resident #66 revealed he was receiving dialysis using the catheter in his chest. Resident #66 revealed the nurses looked at his hemodialysis catheter on dialysis days. The resident revealed he was unaware if he was on enhanced barrier precautions and could not recall if staff wore personal protective equipment (PPE) when providing care. Observation on 05/04/26 at 1:13 P.M. revealed there was no signage of Resident #66's door indicating the resident was on enhanced barrier precautions. Observation on 05/04/26 at 4:25 P.M. with Registered Nurse (RN) #238 revealed Resident #66 had a hemodialysis catheter located in the right upper chest area. Further observation revealed there was no sign posted noting the resident was requiring enhanced barrier precautions. Interview on 05/04/26 at 4:32 P.M. with Unit Manager Licensed Practical Nurse (UM LPN) #201 and Regional Registered Nurse (RRN) #295 revealed a physician order was not required for enhanced barrier precautions. UM LPN #201 verified Resident #66 had no care plan in place for enhanced barrier precautions and there was no sign for enhanced barrier precautions posted on the resident's door. RRN #295 verified Resident #66 should be on enhanced barrier precautions. Review of the facility policy titled, Enhanced Barrier Precautions, dated 08/2022, revealed enhanced barrier precautions (EBP) were an infection control intervention designed to reduce transmission of resistant organisms requiring staff to use gowns and gloves during high contact resident care for residents with wounds and/or indwelling medical devices. Further review of the policy revealed clear signage would be posted on the door or wall outside the resident room indicating the type of precautions and required PPE. 3. Review of the medical record for Resident #68 revealed an admission date of 08/08/25. The resident had a diagnosis of diabetes mellitus type two. Review of the current physician orders from May 2026 for Resident #68 revealed an order for Lantus Solostar 15 units (U) administered subcutaneously. Review of the care plan revised March 26 for Resident #68 revealed she was care planned at risk of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) with interventions in place for administration of medications as ordered by the physician. Observation on 05/06/26 at 8:46 A.M. revealed LPN #115 administered insulin to Resident #68 without the use of gloves. Interview on 05/06/26 at 8:57 A.M. with LPN #115 verified she administered long acting insulin to Resident #68 and she did not wear gloves when she administered the insulin. LPN #115 further stated she usually wore gloves to administer insulin. Review of the undated facility policy titled, Medication Administration and General Guidelines, revealed the person administering medications adheres to universal precautions, using proper hand hygiene and gloves when appropriate. This deficiency represents non-compliance investigated under Complaint Number 1365104.