STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365996	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Swan Creek	1650 Swan Creek Lane Toledo, OH 43614

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility policy the facility failed to store and handle food safely. This had the potential to affect all residents. The census was 32.Findings include: 1. Observation on 03/30/26 at 7:34 A.M. of the main kitchen revealed in the walk-in refrigerator baby carrots stored in a plastic container and chopped celery stored in a plastic container were not labeled or dated, two opened bags of cubed cheese were not dated, and the stand-alone freezer included an opened personal water bottle. Interview on 03/30/26 at 7:45 A.M. with Assistant Dietary Manager #350 verified the carrots, celery, and two opened bags of cubed cheese were not labeled or dated and verified the personal water bottle in the stand-alone freezer. Review of the policy, Food Storage, dated 2023, verified leftover food should be stored in a covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. All foods should be covered, labeled and dated and routinely monitored to assure that foods will be consumed by their use by dates or frozen or discarded. 2. Observation on 03/30/26 at 9:17 A.M. revealed Certified Nursing Assistant (CNA) #351 providing a breakfast tray to Resident #3 who was in bed. CNA #351 placed Resident #3's meal tray on the overbed table and used a control to raise Resident #3's head of the bed. CNA #351 then rolled the overbed table across Resident #3's lap. CNA #351 used her right hand to move an electric cord that was lying on the ground and blocking the wheel of the overbed table. CNA #351 then left the room, did not perform hand hygiene, and returned to the kitchen. Continuous observation revealed CNA #351 obtained Resident #38's plate, covered it with plastic wrap, and wrapped plastic silverware in paper napkins for Resident #38 and Resident #6. CNA #351 placed the silverware and plate on a serving tray where Resident #6's breakfast plate was already covered and waiting. CNA #351 then carried the serving tray to the hall, placed it in on a shelf, and carried Resident #6's tray into her room. Interview on 03/30/26 at 9:23 A.M. with CNA #351 confirmed she did not perform hand hygiene after adjusting Resident #3's bed and touching the electric cord on the floor and before rolling silverware for Resident #6 and Resident #38. CNA #351 stated she was aware she should perform hand hygiene after serving each resident.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, pharmacist recommendations, and policy review, the facility failed to ensure adequate monitoring for psychotropic medication effectiveness, side effects and adverse effects. This affected four (#5, #13, #32, and #38) of five residents reviewed for unnecessary medications. This had the potential to affect 24 residents the facility identified as receiving psychotropic medications. The facility census was 32.Findings include: 1. Review of Resident #13's medical record revealed the resident was admitted to the facility on [DATE] with the diagnosis including heart failure, respiratory disorders, nonrheumatic mitral valve insufficiency, depression, unspecified sequalae of cerebral infarction, presence of cardiac pacemaker, shortness of breath, and dysphagia following cerebral infarction. Review of the most current minimum data set assessment (MDS) dated [DATE] Resident #13 had moderately impaired cognition, required staff assistance for all activities of daily living (ADL's), and received antidepressant, diuretic, opioid, antiplatelet, and anticonvulsant medications. Review of a physician order dated 05/01/24 revealed Resident #13 was prescribed Zoloft (antidepressant) tablet 100 milligrams (mg) oral once a day. There were no orders to monitoring for medication effectiveness, adverse effects, and side effects. Review of Resident #13's care plan dated 03/17/26 revealed the use of antidepressant medications that places the resident at risk for drug related hypotension, gait disturbance, cognitive impairment, ADL decline, decline in appetite, and abnormal involuntary movements. Review of the nurses' notes, medication administration records (MARs) and treatment administration records (TARs) from 01/01/26 through 04/02/26 revealed no documentation the Resident was monitored for medication effectiveness, adverse effects, and side effects of the psychotropic medications. Interview on 04/02/26 at 12:59 P.M. with Director of Nursing (DON) verified there was no documentation Resident #13 was monitored for adverse effects and side effects of the psychotropic medication. 2. Review of Resident #32's medical record revealed the resident was admitted to the facility on [DATE] with diagnosis including cerebral atherosclerosis, unspecified dementia moderate with mood disturbance, atherosclerotic heart disease, and depression. Review of the most current MDS dated [DATE], revealed Resident #32 had severe cognitive impairment, required staff assistance for all ADL's, and received antianxiety, antidepressant, opioid, and antiplatelet medication. Review of physician orders revealed the following: and order for Buspirone (antianxiety) 7.5 mg three times a day, Lexapro (antidepressant) 10mg once a day, and Lorazepam (antianxiety) 0.5mg every four hours as needed. Review of Resident #32's care plan dated 03/17/26 revealed the use of psychotropic drug use with an intervention that included assess for mood and behavior problems. The care plan for Resident #32 also included depression and anxiety with a goal of reduced signs and symptoms of anxiety and depression. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurses' notes, medication administration records (MARs) and treatment administration records (TARs) from 01/01/26 through 04/02/26 revealed no documentation the Resident was monitored for medication effectiveness, adverse effects, and side effects of the psychotropic medications. Interview on 04/02/26 at 12:59 P.M. with Director of Nursing (DON) verified there was no documentation Resident #32 was monitored for adverse effects and side effects of the psychotropic medication. 3. Review of Resident #38's medical record revealed the residenbt was admitted to the facility on [DATE] with diagnosis including encounter for surgical aftercare following surgery on the genitourinary system, muscle weakness, rectal prolapse, hemorrhage of anus and rectum, and depressive episodes. Review of a physician order dated 03/28/26 for Resident #38 revealed Bupropion HCL (antidepressant) tablet extended release 24 hour once a day. Review of the nurses' notes, medication administration records (MARs) and treatment administration records (TARs) from 03/28/26 through 04/02/26 revealed no documentation the Resident was monitored for medication effectiveness, adverse effects, and side effects of the psychotropic medications. Interview on 04/02/26 at 12:59 P.M. with Director of Nursing (DON) verified there was no documentation Resident #38 was monitored for adverse effects and side effects of the psychotropic medication. 4. Review of Resident #5's medical record revealed an admission date of 08/01/25 with diagnoses of pain, stroke, hypertension, depression, and insomnia. Review of the quarterly MDS assessment, dated 03/30/26, revealed Resident #5 had intact cognition and received an antidepressant. Review of Resident #5's care plan, initiated 08/09/25, and updated 03/31/26, revealed the use of antidepressant medication placed the resident at risk for drug-related: hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL (activities of daily life) decline, decline in appetite, and abnormal involuntary movements. Review of the current physician order initiated 10/01/25 revealed Resident #5 received Duloxetine (an antidepressant) capsule, delayed release, 60 milligrams (mg)) 1 capsule orally once daily. Review of a recommendation from the pharmacist to the physician, dated 10/02/25, revealed a recommendation to monitor for behaviors with psychotropic use. Review of the electronic medical record for Resident #5 revealed no evidence staff were routinely monitoring Resident #5 for side effects or efficacy related to the use of Duloxetine to treat Resident #5's depression. Interview on 04/02/26 at 10:58 A.M. with the DON confirmed the facility did not implement orders to monitor residents for efficacy and/or side effects of psychotropic medications. The DON stated nursing staff monitored for side effects and/or efficacy as part of their routine duties and would chart in the medical record if they noted any concerns. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled Psychotropic Medications/Unnecessary Medications, revised 04/28/25, revealed the initiating maintaining, or discontinuing medications are determined by evaluation of the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify the relative benefits and risks. Review of a policy titled Medication Administration, dated 02/06/26, revealed if a Resident is assessed to need medication administration, the Resident will be observed for adverse effects, contraindication, and medication effectiveness.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of beneficiary protection notifications, and review of CMS (Centers for Medicare and Medicaid Services) guidance, the facility failed to ensure beneficiary protection notification included the estimated cost. This affected three (#11, #43, and #45) of three residents reviewed for beneficiary protection notice. The facility census was 32. Findings include:1. Review of the closed medical record revealed Resident #11 was admitted on [DATE] and discharged on 01/02/26. Diagnoses included acute respiratory failure with hypoxia, acute on chronic diastolic heart failure, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 01/02/26, revealed Resident #11 was cognitively intact.Review of the Advanced Beneficiary Notice of Non-coverage (ABN), signed 012/29/25, revealed Medicare may not pay for skilled services effective 01/01/26. The estimated cost was room and board plus therapy at $5.00 a minute. Resident #11 selected option three to not receive skilled services. 2. Review of the closed medical record revealed Resident #43 was admitted on [DATE] and discharged on 03/10/26. Diagnoses included dysphagia, essential hypertension, and ocular hypertension right eye. Review of the MDS assessment, dated 03/10/26, revealed Resident #43 was cognitively intact. Review of the ABN, signed 03/06/26, revealed Medicare may not pay for skilled services effective 03/09/26. The estimated cost was room and board plus therapy at $5.00 a minute. Resident #43 selected option three to not receive skilled services 3. Review of the closed medical record revealed Resident #45 was admitted on [DATE] and discharged on 02/10/26. Diagnoses included acute osteomyelitis, cellulitis of left lower limb, and type two diabetes mellitus with foot ulcer. Review of the MDS assessment, dated 02/10/26, revealed Resident #45 was cognitively intact. Review of the ABN, signed 02/05/26, revealed Medicare may not pay for skilled services effective 02/09/26. The estimated cost was room and board plus therapy at $5.00 a minute. Resident #45 selected option three to not receive skilled services.Interview on 03/31/26 at 2:08 P.M. with Director of Social Services (DSS) #366 confirmed she did not include a dollar amount on the ABNs for Resident #11, Resident #43, and Resident #45. DSS #366 stated the room rates varied based on the room residents occupied, and she was not aware she needed to provide a specific dollar amount on the ABN form.Review of the document titled Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024), accessed at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/snfabn-instructionsv508_clean-11 on 04/02/26, revealed the SNF (Skilled Nursing Facility) should enter an estimated total cost or a daily, per item, or per service cost estimate. SNFs must make a good faith effort to insert a reasonable cost estimate for the care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, staff interview, and policy review, the facility failed to ensure comprehensive care plans reflected each resident's individual needs and conditions. This affected two (#3 and #5) of 17 residents reviewed for comprehensive care plans. The facility census was 32.Findings include:1. Review of the medical record for Resident #3 revealed an admission date of 12/05/25 with diagnoses of cerebral atherosclerosis, psychosis, chronic obstructive pulmonary disease, and congestive heart failure. Review of the comprehensive significant change Minimum Data Set (MDS) assessment, dated 03/10/26, revealed Resident #3 had impaired cognition and required partial/moderate assistance for bed mobility, had one unstageable (slough and/or eschar) wound and one unstageable deep tissue injury(DTI) (purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue). Further review revealed no rejection of care occurred during the lookback period.Review of the care plan initiated 12/09/25 revealed Resident #3 was at risk for pressure ulcers. Review of the weekly wound assessment, completed 03/26/26, revealed Resident #3 had a left heel unstageable pressure ulcer (Pressure ulcer known but not stageable due to coverage of wound bed), originally identified 01/13/26, and a right heel deep tissue injury, originally identified 02/26/26.2. Review of the medical record for Resident #5 revealed an admission date of 08/01/25 with diagnoses of pain, stroke, hypertension, depression, and insomnia.Review of the quarterly MDS assessment, dated 03/30/26, revealed Resident #5 had intact cognition and received an opioid.Review of the current physician order initiated 10/03/25 revealed Resident #5 received Hydrocodone-Acetaminophen - Schedule II tablet (an opioid), 10-325 milligrams (mg), 1 tablet by mouth every six hours as needed.Review of a recommendation from the pharmacist to the physician, dated 10/02/25, revealed recommendations related to opioid use: to monitor for constipation; monitor for signs and symptoms of delirium and/or oversedation and/or change in mental status and reduced respiration.Review of Resident #5's care plan revealed there was not a care plan present for the opioid medication the resident used or to minoitor the side effects of the opioid used by the resident. Interview on 04/02/26 at 11:03 A.M. with MDS Registered Nurse (RN) #315 confirmed she completed MDS assessments and oversaw the implementation of care plans. MDS RN #315 confirmed Resident #3 remained at risk for pressure ulcers and confirmed she did not update the care plan to reflect Resident #3's current status of having one unstageable wound and one DTI. Additionally, MDS RN #315 confirmed Resident #5 did not have a care plan for opioid use and/or a care plan to monitor for the side effects of opioid use, including constipation, delirium, oversedation or change sin mental status or respiration. MDS RN #315 stated residents were monitored by nursing staff for side effects of opioid use, usually through a physician order, but MDS RN #315 did not feel the care plan needed to include a care area for monitoring opioid use. MDS RN #315 confirmed Resident #5 did not have an order at the time of the interview for nursing staff to monitor for side effects of the opioid.

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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. Based on observation, staff interview, record review, and policy review, the facility failed to ensure dependent residents received adequate oral hygiene. This affected one (#19) of two residents reviewed for activities of daily living.Findings include:Review of the medical record for Resident #19 revealed an admission date of 09/11/24 with diagnoses of dementia, anxiety, and heart failure.Review of the quarterly Minimum Data Set assessment, dated 01/09/26, revealed Resident #19 had impaired cognition, and required substantial/maximal assistance for oral hygiene.Review of the care plan, initiated 09/12/24, and revised 03/17/26, revealed Resident #19 will resist care with personal care and medications. Interventions included re-direct and re-approach as needed. Further review revealed Resident #19 required substantial/maximal assistance for personal hygiene and oral hygiene.Observation and interview on 03/30/26 at 10:43 A.M. Revealed Resident #19 sitting in a wheelchair in the common area. Resident #19 appeared groomed. Resident #19 stated the care she received was good. Observation during the interview revealed an off-white film between Resident #19's upper and lower lips that stretched but did not break while she spoke. The film was in both corners and covered most of the space between her lips except at the very middle. Interview on 03/30/26 at approximately 10:45 A.M. with Activities #365 and concurrent observation of Resident #19's mouth, confirmed Resident #19 had a film between her lips stretching between her lips as she spoke. Interview on 03/31/26 at 11:23 A.M. with Director of Social Services (DSS) #366 and concurrent observation of Resident #19 revealed Resident #19 had a sticky film between her upper and lower lips on the left side of her mouth, and Resident #19 had a buildup of food between her teeth. Interview on 03/31/26 at 11:54 A.M. with Certified Nursing Assistant (CNA) #351 revealed she was familiar with Resident #19. CNA #351 stated Resident #19 would sometimes allow oral care and would sometimes keep her mouth closed. CNA #351 stated if she was unable to brush Resident #19's teeth because Resident #19 was keeping her mouth too tightly closed, CNA #351 would use a swab to provide oral hygiene. Further interview revealed CNA #351 did not provide oral care to Resident #19 on the morning of 03/31/26 because CNA #351 was rushed and did not have time. Interview on 04/02/26 at 10:10 A.M. with CNA #304 and concurrent observation of Resident #19 revealed Resident #19 was hesitant to open her mouth or respond to questions. However, when Resident #19 did briefly speak, no film was observed between her lips. Further interview with CNA #304 revealed she showered Resident #19 earlier in the morning and washed Resident #19's face. CNA #304 stated washing Resident #19's face helped with removing the film that was sometimes present between Resident #19's lips. Review of the policy Oral Care, revised 02/24/25, revealed oral care promotes patient comfort, nutritional intake, and oral health and reduces dental plaque, oral colonization, and mucosal inflammation. Providing oral care - including brushing the teeth, gums, and tongue with a soft compact-head toothbrush; using an oral rinse; and moisturizing the oral mucosa - is essential for maintaining the patient's general health.

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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** Based on observation, record review, review of a delivery invoice, staff interview, and policy review, the facility failed to ensure wound treatments were implemented timely and failed to ensure pressure ulcer prevention devices were in place. This affected one (#3) of two residents reviewed for pressure ulcers. The facility census was 32.Findings include:Review of the medical record for Resident #3 revealed an admission date of 12/05/25 with diagnoses of cerebral atherosclerosis, psychosis, chronic obstructive pulmonary disease, and congestive heart failure. Review of the comprehensive significant change Minimum Data Set (MDS) assessment, dated 03/10/26, revealed Resident #3 had impaired cognition and required partial/moderate assistance for bed mobility, had one unstageable (Pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar.) wound and one unstageable deep tissue injury (DTI)(Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.). Further review revealed no rejection of care occurred during the lookback period.Review of Resident #3's discontinued physician order dated 12/05/25 to 03/30/26 revealed staff should offload heels with pillow while in bed.Review of the care plan initiated 12/09/25 revealed Resident #3 was at risk for pressure ulcers. Further review of Resident #3's record revealed a left heel deep tissue pressure injury was identified and assessed by facility staff on 01/13/26 and a treatment was initiated. Further review revealed a wound consultant assessed the left heel DTPI on 01/15/26 and initiated a new treatment.Review of Resident #3's physician order initiated 01/15/26 revealed Resident #3 should have heel protector boots while in bed with special instructions to use the green boot for the left foot.Review of the discontinued physician treatment order dated 01/15/26-02/26/26 revealed Resident #3's left heel should be cleansed with normal saline, patted dry, skin prep applied, ABD pad and wrap with kerlix (gauze). Change Tuesday, Thursday, and Saturdays. Further review of the record revealed Resident #3's left heel wound was assessed weekly from 01/15/26 through 03/05/26 by the consultant wound provider in conjunction with facility staff.Review of the weekly skin assessment, dated 02/19/26, revealed Resident #3's left heel wound changed from a DTPI to an unstageable wound, measuring 1.2 centimeters (cm) x 1.7 cm x unable to determine (UTD) depth, with 20% granulation and 80% slough, with wound status notes: improving/healing. Has now opened up to a dry layer of firmly adhered slough. Will start hydrogel to the wound bed. Slough was not sharply debrided due to pain. Observable depth is 0.1 cm. Further review revealed a new treatment recommendation: cleanse with normal saline, use hydrogel impregnated gauze, cover with bordered gauze dressing, Tuesday/Thursday/Saturday.Review of the weekly skin assessment, dated 02/26/26, revealed Resident #3's wound declined and measured 1.5 cm x 2.3 cm x UTD depth, with 30% granulation and 70% slough. Further review revealed the provider noted: The patient has the following factors: resident is poorly compliant with offloading, dementia/confusion, overall poor medical condition that may have contributed to the decline of the wound. Larger today. Slough remains very dry. Hydrogel gauze has not been received from supplier. Until product is received, utilize xeroform gauze daily. Slough was not sharply debrided due to pain. Observable depth is 0.1cm.Review of the discontinued physician order dated 02/26/26-03/05/26 revealed Resident #3 received the following treatment to the left heel: cleanse with normal saline, pat dry, apply xeroform and secure with bordered gauze dressing, change Tuesday, Thursday, Saturday and as needed. Review of the discontinued physician order dated 03/07/26-03/12/26 revealed Resident #3 received the following treatment to the left heel: cleanse with normal saline, pat dry apply hydrogel impregnated gauze, then secure with bordered gauze dressing, change Tuesday, Thursday, Saturday, and as needed.Review of the physician order dated 03/10/26 revealed Resident #3 was admitted to hospice for cerebral atherosclerosis.Observation on 03/30/26 at 9:55 A.M. revealed Resident #3 was lying in bed. Offloading boots were on the floor and the dresser at the end (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the bed. Concurrent interview with Resident #3 revealed she would wear the offloading boots if they were offered.Interview on 03/30/26 at 10:01 A.M. with Registered Nurse (RN) #363 confirmed Resident #3 had physician orders for offloading boots and for offloading heels with a pillow. Further interview, and observation of Resident #3, confirmed Resident #3's heels were not offloaded with a pillow, and the offloading boots were not in place. Interview on 04/02/26 at 10:46 A.M. with Licensed Practical Nurse (LPN) #329 revealed she rounded weekly with the wound care consultant and was familiar with Resident #3's left heel wound. LPN #329 stated she advised the wound care consultant Nurse Practitioner (NP) on 02/19/26, when the hydrogel was ordered to treat the heel after it opened to a dry layer of slough, the facility did not have any hydrogel in stock and the facility would need to order it. LPN #329 stated the NP was aware the orders would not be implemented as written on 02/19/26. LPN #329 stated no alternative treatment orders were provided until 02/26/26 when the facility was still awaiting delivery of hydrogel. LPN #329 confirmed the treatment initiated 01/17/26 for the left heel (cleanse with normal saline, pat dry, apply skin prep, allow to try, cover with ABD pad and wrap with kerlix) remained in place until 02/26/26. Interview on 04/02/26 at approximately 1:35 P.M. with the Director of Nursing (DON) and concurrent review of a delivery invoice revealed the hydrogel was delivered to the facility on [DATE].Interview on 04/02/26 at 2:00 P.M. with the Administrator revealed central supply orders were placed on Mondays every week. The Administrator stated the order for hydrogel was entered too late in the day on Monday 02/23/26 to meet the ordering timeframe and therefore the hydrogel was not ordered until the following Monday, 03/02/26.Review of the policy, Prevention, Detection and Treatment of Pressure Ulcers, revised 01/07/26, revealed interventions included providing appropriate redistributing support surfaces.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, review of pharmacy recommendations, and staff interview, the facility failed to ensure pharmacy recommendations were addressed by the facility's provider. This affected one (#5) of five residents reviewed for pharmacy recommendations. The facility census was 32.Findings include:Review of the medical record for Resident #5 revealed an admission date of 08/01/25 with diagnoses of pain, stroke, hypertension, depression, and insomnia.Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/30/26, revealed Resident #5 had intact cognition and received an antidepressant and an opioid.Review of the current physician order's revealed Resident #5 received Duloxetine (an antidepressant) capsule, delayed release, 60 milligrams (mg)) 1 capsule orally once daily, dated 10/01/25, and Hydrocodone-Acetaminophen - Schedule II tablet (an opioid), 10-325 mg, 1 tablet by mouth every six hours as needed, dated 10/03/25.Review of a recommendation from the pharmacist to the physician, dated 10/02/25, revealed recommendations to monitor for behaviors with psychotropic use and to change Hydrocodeon-Acetaminophen 10-325 mg from scheduled every six hours to as needed every six hours and for opioid use to monitor for constipation; monitor for signs and symptoms of delirium and/or oversedation and/or change in mental status and reduced respiration.Review of a undated facility document regarding historical recommendations from the pharmacist revealed a recommendation dated 12/2025 to draw laboratory tests. Interview on 04/02/26 at 10:52 A.M. with the Director of Nursing (DON) and Unit Manager #317 confirmed the recommendations made by the pharmacist on 10/02/25 were not reviewed or addressed by the facility's provider. Additionally, the DON and UM #317 confirmed the recommendations were not implemented to monitor for behaviors with psychotropic use and to monitor for side effects from opioid use were not implemented. Further, the DON confirmed a review of Resident #5's medical record revealed no evidence laboratory tests were completed as recommended on 12/02/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365996	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Swan Creek	1650 Swan Creek Lane 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review, staff interview, and policy review, the facility failed to ensure residents received appropriate antibiotics to treat urinary tract infections. This affected two (#26 and #44) of three residents reviewed for urinary tract infections (UTI). The facility census was 32.Findings include:1. Review of the medical record for Resident #26 revealed an admission date of 07/22/25 with diagnoses of Parkinson's disease with dyskinesia, dementia, and urinary tract infection. Review of the comprehensive annual Minimum Data Set (MDS) assessment, dated 02/02/26, revealed Resident #26 had intact cognition and was on an antibiotic. Review of the discontinued physician order, dated 01/29/26 through 02/03/26, revealed Resident #26 received Macrobid (nitrofurantoin monohydrate/macrocrystals) (an antibiotic) capsule: 100 milligrams (mg), one capsule by mouth twice daily for UTI.Interview on 04/01/26 at 2:14 P.M. with Unit Manager/Infection Preventionist (UM/IP) #317 and concurrent review of Resident #26's laboratory test obtained to diagnose a UTI, results dated 01/29/26, revealed Resident #26 had bacterial growth of two bacteria - Klebsiella pneumoniae with greater than 100,000 colony forming units per milliliter (CFU/ml), and Proteus vulgaris with 50,000-100,000 CFU/ml. Further interview and review of the testing revealed Klebsiella pneumoniae was susceptible to Macrobid, meaning the antibiotic would be able to eliminate the bacteria; however, Proteus vulgaris was resistant to Macrobid, meaning the antibiotic would be ineffective at eliminating the bacteria in Resident #26's UTI. Further interview with UM/IP #317 confirmed Macrobid was not appropriate to treat the Proteus vulgaris infection, and confirmed the test results indicated the two types of bacteria were both susceptible to six other listed antibiotics.2. Review of the medical record for former Resident #44 revealed an admission date of 11/07/25 and a discharge date of 02/03/26. Diagnoses included sick sinus syndrome, presence of cardiac pacemaker, and flaccid neuropathic bladder. Review of the comprehensive admission MDS assessment, dated 11/13/25, revealed Resident #44 had impaired cognition. Review of the discontinued physician order, dated 01/22/26 through 02/03/26, revealed Resident #44 received Cephalexin (an antibiotic) capsule: 500 mg by mouth twice daily. Interview on 04/01/26 at 2:14 P.M. with UM/IP #317 and concurrent review of Resident #44's laboratory test obtained to diagnose a UTI, results dated 01/22/26, revealed Resident #44 had bacterial growth of two bacteria - Klebsiella pneumoniae with greater than 100,000 CFU/ml, and Proteus mirabilis with greater than 100,000 CFU/ml. Further interview and review of the testing revealed Cephalexin was not listed among the antibiotics to which either bacteria was susceptible and therefore it could not be determined whether the antibiotic was appropriate to treat the two bacterial infections.Review of the policy Infections Definitions: Antibiotic Stewardship, revised 09/14/23, provided no guidance regarding ensuring an appropriate antibiotic was prescribed to address bacterial infections.