

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Point Place Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6101 N Summit St Toledo, OH 43611	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</p> <p>Based on observation, medical record review, staff interview, review of facility fall investigations and review of facility policy, the facility failed to ensure fall prevention interventions were implemented as ordered and care planned. This affected one (#1) of three residents reviewed for falls. The facility census was 61.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #1 was admitted on [DATE]. Diagnoses included dementia, protein-calorie malnutrition, major depression, polyneuropathy, anxiety disorder, and benign prostatic hyperplasia.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 02/11/24, revealed Resident #1 was cognitively intact, was able to make needs known, required substantial or maximal assistance with activities of daily living (ADLs), required partial to moderate assistance with transfers and repositioning, was incontinent of bowel and bladder, had no weight loss, received a mechanically altered diet, and was at risk for pressure ulcer development with no skin breakdown.</p> <p>Review of a physician order, dated 09/13/23, revealed Resident #1 was ordered a low air loss (LAL) mattress with perimeter edges to bed and to verify function and inflation every shift.</p> <p>Review of the plan of care, revised 02/12/24, revealed Resident #1 was at risk of falling due to decline in functional mobility, diagnosis of dementia, malnutrition, depression, polyneuropathy, anxiety, benign prostatic hyperplasia, visual and auditory hallucinations, insomnia, incontinence, use of psychotropic medications, and weakness. Interventions included an air mattress with perimeter edges to help define edges.</p> <p>Review of an incident and accident investigation form revealed on 04/12/24 at 2:28 P.M., Resident #1 sustained a fall in his room with no injury. All previous interventions were in place at the time of the fall.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nursing progress note, dated 04/12/24 at 6:12 P.M., revealed Resident #1 was on the floor when writer walked into room. Writer asked the resident what happened and the resident stated he was reaching for his bed remote when he fell out of the bed. The nurse assessed the resident and the nurse and an aide assisted the resident up off the floor. The nurse obtained vitals for resident. Resident #1 had no signs of injury and no complaints of pain.</p> <p>Review of a fall risk assessment, dated 04/19/24, revealed Resident #1 was at moderate risk of falling.</p> <p>Review of an incident and accident investigation form revealed on 04/19/24 at 9:05 A.M. Resident #1 sustained an unwitnessed fall in his room with no injury. All previous interventions were in place at the time of the fall. Medical considerations noted resident returned from a hospital stay with a urinary tract infection (UTI). Safety interventions in use at the time included call light and perimeter mattress.</p> <p>Review of incident audit report documentation dated 04/19/24 at 8:32 P.M. revealed Resident #1 notified his roommate he had fallen out of bed. Resident #1 was found lying with his back against the floor, next to the bed.</p> <p>Observations on 05/06/24 at 7:08 A.M., 8:05 A.M., 8:47 A.M., and 9:03 A.M., revealed Resident #1 in bed. A LAL mattress was applied to the bed; however, no perimeter edges were in place.</p> <p>Interview on 05/06/24 at 9:29 A.M. with Licensed Practical Nurse (LPN) #200 confirmed Resident #1 was in bed without the perimeter edges applied to the LAL mattress. LPN #200 verified Resident #1 was at risk of falling and previously fallen from the bed.</p> <p>Interview on 05/06/24 at 9:32 A.M. with Assistant Director of Nursing (ADON) #201 verified no perimeter edges were applied to Resident #1's LAL mattress as ordered by the physician and as indicated on the fall prevention plan of care.</p> <p>Review of the facility policy titled Fall Policy, revised April 2021, revealed an intervention will be put into place after a fall unless the Interdisciplinary Team (IDT) determines all appropriate interventions are in place. An intervention put in place after a fall will be reviewed by the IDT to determine if the intervention put in place is the most appropriate or if it should be changed. Care Plans will be updated with new and discontinued interventions following a fall as appropriate.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153377.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</p> <p>Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure incontinence care was properly administered to prevent infection. This affected one (#1) of three residents reviewed for the provision of incontinence care. The facility census was 61.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #1 was admitted on [DATE]. Diagnoses included dementia, protein-calorie malnutrition, major depression, polyneuropathy, anxiety disorder, and benign prostatic hyperplasia.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 02/11/24, revealed Resident #1 was cognitively intact, was able to make needs known, required substantial or maximal assist with activities of daily living (ADLs), required partial to moderate assistance with transfers and repositioning, was incontinent of bowel and bladder, had no weight loss, received a mechanically altered diet, and was at risk for pressure ulcer development with no skin breakdown.</p> <p>Review of the plan of care, revised on 02/12/24, revealed Resident #1 was frequently incontinent of bowel and bladder and was at risk for skin breakdown and urinary tract infection (UTI). Interventions included: apply barrier cream to perineal area as needed; may use incontinence management products as needed and desired; change per protocol, preference, and as needed; clean peri-area with each incontinence episode; check at routine intervals and as required for incontinence; wash, rinse and dry perineum; and change clothing as needed (PRN) after incontinence episodes.</p> <p>Review of hospital discharge instructions and associated documentation dated 04/19/24 revealed Resident #1 was diagnosed with a UTI and prescribed an antibiotic for the treatment.</p> <p>Review of a bowel and bladder assessment, dated 05/02/24, revealed Resident #1 had mixed incontinence, was occasionally incontinent of bowel, and was continent of bladder with occasional incontinent episodes. Additionally, comments documented stated Resident #1 was continent and incontinent and to check and change and offer toileting.</p> <p>Observation on 05/06/24 at 9:03 A.M. of State tested Nurse Aide (STNA) #300 provide care for Resident #1 revealed STNA #300 placed two basins, one basin with clean water and one basin with soap and water, at the resident's bedside. STNA #300 proceeded to provided Resident #1 with a bed bath. STNA #300 removed Resident #1's adult brief and noted the resident was incontinent of a small amount of urine and stool. STNA #300 obtained a washcloth from the soap basin and wiped Resident #1's perineal area in a circular motion. No soap was observed. STNA #300 turned the resident to the side and cleansed a small amount of stool with the same washcloth. There was no attempt to retract Resident #1 foreskin or rinse with clean water. STNA #300 proceeded to place a clean adult brief, bed linens and clothing to the resident and concluded the procedure.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/24 at 9:32 A.M. with STNA #300 verified she did not properly cleanse Resident #1's perineal area during incontinence care.</p> <p>Interview on 05/06/24 at 9:40 A.M. with Assistant Director of Nursing (ADON) #201 confirmed Resident #1 had returned from the hospital on 04/19/24, following treatment for a UTI, and was at risk for further development of UTI's. Additionally, ADON #201 stated Resident #1 attempted to use the urinal at times but also had episodes of incontinence and used adult briefs. ADON #210 verified, during incontinence care, male resident's foreskin was to be retracted to ensure thoroughness of cleansing and infection prevention.</p> <p>Review of the facility policy titled Incontinent Care, dated March 2015, revealed the male resident procedure was to begin at the tip of the penis, retract foreskin, cleanse from tip downward, place washcloth to the side, obtain a clean washcloth and proceed to scrotum followed by anal area.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153377.</p>