

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 08/05/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44815</p> <p>Based on observation, staff interview and review of the facility policy, the facility failed to ensure staff practiced proper hand hygiene. This had the potential to affect all 62 residents in the facility.</p> <p>Findings include:</p> <p>1. Observation on 08/05/24 at 9:09 A.M. revealed Registered Nurse (RN) #203 was taking Resident #14's blood pressure at the medication cart. RN #203 removed the cuff from Resident #14's arm, documented the data, and handed Resident #14 a medicine cup with pills. After Resident #14 consumed the pills, he handed the cup to RN #203 to throw away. RN #203 then proceeded to chart and document at her medication cart. RN #203 was not observed to perform hand hygiene after providing care to Resident #14. Continued observation revealed RN #203 pushed the medication cart to the outside of Resident #15's room. RN #203 opened her medication cart and pulled out a medication push-card and pushed a pill into a medicine cup. RN #203 then opened a bottle and extracted one pill and put it into the medicine cup. Concurrent interview with RN #203 confirmed she did not perform hand hygiene after providing care and medication to Resident #14 and before she started the medication pass for Resident #15. RN #203 confirmed no hand sanitizer was on her medication cart, as she walked to a wall dispenser and dispensed hand sanitizer into her hands.</p> <p>2. Observation on 08/05/24 at approximately 10:35 A.M. of the 200-hall revealed State tested Nurse Aide (STNA) #104 wearing a pair of disposable gloves and carrying a bag of trash down the hall. STNA #104 used the keypad to unlock the shower room door, entered the shower room, and very quickly returned to the hallway without trash or disposable gloves. Interview with STNA #104 at the time of the observation revealed she had just finished providing incontinence care to a resident and did not like to carry a dirty bag down the hall with her bare hands. Further interview confirmed STNA #104 provided incontinence care to a resident, removed soiled gloves, did not perform hand hygiene, then put on a new pair of gloves before leaving the resident's room and carrying the trash to the shower room. Additionally, STNA #104 confirmed she did not wash her hands in the shower room but came back out to use the bathroom at the nurses' station. Further observation revealed the bathroom was occupied and STNA #104 used the keypad, with uncleaned hands, to unlock the shower room door and wash her hands.</p> <p>Review of the facility policy titled Hand Washing, revised May 2021, revealed hands should be washed before and after each resident contact and after touching a resident or handling his/her belongings.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00156012</p>