STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366039	A. Building B. Wing	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Point Place Healthcare and Rehabilitation Center	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)
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** 31638 Based on resident record review, staff interview, resident interview, and review of facility policy, the facility failed to provide showers or bathing for dependent residents who required assistance with activities of daily living. This affected two (Residents #71 and 72) of three residents. The facility census was 59. Findings include: 1. Review of Resident #71's medical record revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, diabetes mellitus, chronic kidney disease, peripheral vascular disease, and congestive heart failure. Review of Resident #71's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had intact cognition. He required extensive one-person assist for bed mobility and supervision for dressing, transfers, and ambulation. Review of Resident #71's most recent care plan revealed he had a behaviorial concern as evidenced by self-inflicting wounds, making false allegations regarding care, items missing, meals, removing dressings, stated he was not receiving care, and calling emergency services with false allegations. Interview with Resident #71 on 01/12/23 at 1:13 P.M. revealed he admitted to refusing showers often, but wanted them when it was convenient for him. He stated there were residents in the facility that failed to be showered regularly. Review of the facility shower schedule revealed Resident #71 was to have showers every Tuesday and Friday on first shift. Review of Resident #71's shower sheets dated 10/20/22 through 01/17/23 revealed he received a shower on 10/22/22, 11/04/22, 11/12/22, 11/16/22, and 11/25/22. Showers were offered and refused on 10/21/22, 11/08/22, 11/15/22, 11/18/22, 11/21/22, 12/05/22, 12/10/22, and 12/13/22. Per the shower sheets the resident had not been offered a shower since 12/13/22. 2. Review of Resident #72's medical record revealed an admitted [DATE]. Diagnoses included dementia, hallucinations, and malnutrition. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #72's quarterly MDS dated [DATE] revealed he had high cognitive function. Resident #72 required extensive assistance for all activities of daily living, except eating which required supervision. Review of Resident #72's most recent care plan revealed he had an activity of daily living self-care performance deficit related to dementia, neuropathy, severe protein calorie malnutrition, and weakness. He required extensive assistance of one staff member for bathing and showering. A sponge bath should be provided when a full bath or shower could not be tolerated. If he refused, reapproach later and if he continued to refuse, the charge nurse should be notified. He was noted to refuse showers occasionally. Showering and bathing per schedule or as needed. All refusals were to be documented. Interview with Resident #72 on 01/12/23 at 11:10 A.M. revealed he would like to receive showers more often, but they did not offer them on a regular basis. Review of Resident #72's shower schedule revealed the resident was to receive a shower/bath every Tuesday and Friday on second shift. Review of Resident #72's shower sheets dated 10/15/22 through 01/17/23 revealed he received showers on 11/08/22, 11/28/22, 12/20/22, and 01/05/23. The resident was documented as refusing showers on 10/15/22, 12/19/22, and 12/23/22. Interview with the Director of Nursing (DON) on 01/18/23 at 10:35 A.M. verified all shower sheets for Residents #71 and #72 had been provided to the surveyor and all showers were to be documented on the shower sheets. Review of the facility policy titled, Activities of Daily Living Policy, revised 01/2021 revealed bath/showers may be given at any time the resident chooses. They may be done in the morning, before bed, or any other time of the resident's preference. A shower is typically scheduled twice a week unless the resident requests additional showers. A bed bath should be offered/encouraged on days a resident doesn ot get a shower. This represents non-compliance discovered during the investigation of Master Complaint Number OH00139199 and Complaint Number OH00139064.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, resident interview, review of hospital records, and review of facility policies, the facility failed to provide ongoing monitoring and assessment for a resident with a change of condition. This resulted in actual harm when Former Resident #73 experienced low blood pressure, with the Certified Nurse Practitioner (CNP) being contacted and providing orders for intravenous (IV) hydration and laboratory tests. There was no evidence of any ongoing monitoring or assessment of Former Resident #73's condition throughout the night until the day shift staff discovered the resident remained hypotensive with lethargy, was transferred to the hospital, and was admitted with a diagnosis of hypotension. This affected one (FR #73) of three residents reviewed for change of condition. Additionally, the facility failed to maintain the bed linens of a resident in a manner to prevent the attraction of ants which led to the presence of insects on the resident's body, which was not actual harm. This affected one resident (#57) reviewed for ant infestation. The facility also failed to complete non-pressure wound treatments per physician orders for two (#71 and #25) of three residents reviewed for non-pressure wound treatments, which was not actual harm. The facility census was 59. Findings include: 1. Review of Former Resident (FR) #73's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, intracardiac thrombosis, lupus, chronic kidney disease, and congestive heart failure. Review of FR #73's medical record revealed a progress note dated 12/31/22 at 9:59 A.M. which revealed the nurse went in to administer medications and found the resident's blood pressure to be 66/45 and the heart rate was 116. When the nurse notified the CNP of the findings, the CNP inquired about the orders for IV fluids and immediate laboratory tests that were given to the night nurse. The day nurse did not note any orders in the electronic medical system and was not informed of these orders by night nurse in report. The day nurse followed through with the orders given on the previous shift and pulled the fluids. The CNP ordered midodrine to be given one time which the nurse administered. FR #73 was stating repeatedly that she did not feel good. The nurse asked her if she would like to go to the hospital, or receive fluids here and let the facility treat her low blood pressure. FR #73 stated Yes, hospital. The resident was transferred to the local hospital and did not return to the facility. Review of the medical record revealed no assessment or monitoring of the resident's change in condition which occurred the evening of 12/30/22. Review of the hospital record revealed FR #73 was admitted with the diagnosis of hypotension. Interview with Licensed Practical Nurse (LPN) #127 on 02/01/23 at 12:35 P.M. revealed on the morning of 12/31/22 she found FR #73 lethargic and hypotensive. The LPN contacted CNP #190 to inform her of the situation and the CNP was upset because the orders she gave to the night nurse were not carried out. It was decided to send FR #73 to a local hospital due to her condition. In addition, LPN #127 verified the night nurse failed to complete any documentation regarding the resident's condition throughout the night nor put orders into the electronic medical records. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Telephone interview with CNP #190 on 02/01/23 at 12:51 P.M. revealed on 12/30/22 at approximately 10:30 P.M. she was alerted that FR #73 was hypotensive by the night staff. The CNP ordered immediate blood work which included a complete metabolic panel (CMP), a complete blood count (CBC), and a urinalysis. She also ordered 0.45% normal saline via IV for hydration. The CNP stated the following morning she received a call from LPN #127 who informed her the previous orders were never followed, and FR #73 continued to be hypotensive and lethargic. The CNP decided to send the resident out to be evaluated at the local hospital. CNP #190 revealed it was possible, but hard to say if the hospitalization was a result from FR #73 failing to received the ordered IV fluids. Interview with the Director of Nursing on 01/18/23 at 10:33 A.M. verified the night nurse on 12/31/22 failed to implement the orders provided from CNP #190. The DON stated The night nurse obviously did nothing. 2. Review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses included multiple sclerosis, acute kidney failure, pressure ulcer stage three to the buttock, crohns disease with a colostomy, and peripheral vascular disease. Review of Resident #57's quarterly Minimum Data Set (MDS) dated [DATE] revealed she had a high cognitive function. The resident was dependent on staff for bathing and toilet use. An extensive two person assist was used for bed mobility. Review of Resident #57's Social Service note dated 12/23/22 revealed the social worker had spoke with the resident's sister who reported the resident having ants in her bed. The sister required the resident receive a bath and have the linens changed. The Director of Nursing and Unit Manager completed a bed bath and changed her gown and her linens. The resident was educated on not eating in her bed and asked if she would like to move to another room. Resident #57 refused either option choosing to stay in her current room and bed. Review of Resident #57's medical record revealed a nurses note dated 12/25/22 which stated the resident was difficult to arouse, not responding to questions, and only making moaning sounds. Vitals were assessed, the physician was notified and the resident was transported to a local hospital. Review of Resident #57's hospital emergency room note, dated 12/25/22, revealed the resident presented to the emergency room due to complaints of altered mental status. On examination the patient did have several dozen ants crawling on her abdomen and extremities. Review of the hospital Licensed Social Worker's note dated 12/25/22 revealed she was notified by the medical staff that Resident #57 returned to the hospital for altered mental status and sores/wounds to her body. Emergency Medical Services (EMS) staff reported they found the patient at the nursing facility with ants crawling on her. Adult Protective Services were notified and referred the case to the Ombudsman who was notified. Interview with the Ombudsman on 01/18/23 at 12:01 P.M. revealed she had been working with Resident #57 and the family regarding a lack of peri care and ants in the resident's bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with the Administrator and DON on 01/18/23 at 12:25 P.M. revealed Resident #57 was hospitalized and ants were found in her peri-area in the emergency room . The Administrator revealed the ants were due to the resident eating in bed and dropping crumbs. The room had since been treated by an extermination company and the problem was resolved. Interview with Resident #57 on 01/18/23 at 1:07 P.M. revealed the ants she recently had ants in her room. She reported she had only seen one ant recently. Review of the facility policy titled Pest Control dated 2018 revealed it was the policy of the center to maintain a routine pest control program that consisted of monthly visits from the pest control company and monthly visits would include the resident's rooms. 3. Review of Resident #71's medical record revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, diabetes mellitus, chronic kidney disease, peripheral vascular disease, and congestive heart failure. Review of Resident #71's physician's order dated 12/13/22 revealed an order to treat the left gluteal fold by cleansing with soap and water, pat dry, and apply Triad wound paste every shift and as needed. Review of Resident #71's Treatment Administration Record (TAR) for December 2022 revealed there was no documentation showing completion of the treatment to the gluteal fold on 12/18/22, 12/21/22, 12/23/22, and 12/27/22 on the day shift and on 12/16/22, 12/23/22, 12/24/22 on the night shift. On 12/20/22 on the day shift, the TAR read 9 which indicated other/see progress note. Review of Resident #71's progress notes for 12/20/22 revealed no documentation regarding the missed dressing change for that day. Review of Resident #71's physician's orders revealed an order dated 11/08/22 to treat the right lower extremity by scrubbing the leg with dandruff shampoo, allow to sit for 10-20 minutes, rinse well, pat dry, apply thick layer of ammonium lactate lotion, apply Medi honey, cover with abdominal dressing, and wrap with kerlix from the base of the toes to below the knee every other night shift and as needed. Review of Resident #71's TAR dated December 2022 revealed the treatment to the right lower extremity was not documented as completed on 12/06/22, 12/12/22, 12/16/22, 12/24/22, and 12/26/22. Review of Resident #71's January 2023 TAR revealed staff were to apply Medi honey to the right lower extremity wound bed twice daily and as needed. The staff failed to complete the treatment on 01/02/23, 01/05/23, 01/09/23, and 01/12/23 in the morning and on 01/02/23 on the evening shift. Further review of Resident #71's physician's order revealed an order to apply Aquaphor ointment to open sores every shift for sores to the arms and legs. Review of Resident #71's TAR for December 2022 revealed staff failed to complete the Aquaphor ointment application on 12/02/22, 12/07/22, 12/08/22, 12/18/22, 12/121/22, 12/24/22, 12/27/22, and 12/31/22 on the day shift. The night shift failed to be completed on 12/06/22 and 12/28/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #71's TAR dated January 2022 revealed the resident failed to have the Aquaphor treatment on 01/02/23, 01/05/23, and 01/09/23 on the day shift. It was also not completed on 01/02/23 on the night shift. Review of Resident #71's physician's orders revealed an order dated 10/25/22 for the left heel to be cleansed with wound wash, pat dry, filled with calcium alginate, cover with an abdominal pad and wrapped with kerlix every night shift every other day and as needed. Review of Resident #71's December 2022 TAR revealed staff failed to cleanse the left heel wound on 12/06/22, 12/12/22, 12/16,22, 12/24/22, and 12/26/22. Review of Resident #71's physician's orders revealed an order dated 12/30/22 to treat the left lower extremity by applying Dakin's 1/4 strength, apply a moist-to-moist dressing to wound bed, cover with an abdominal pad, and wrap with Kerlix, change twice daily every shift for wound care. Review of Resident #71's January 2023 TAR revealed staff failed to complete the treatment to the left lower extremity wound on 01/02/23 and 01/05/23 on the day shift and on 01/02/23 on the night shift. Additionally, Resident #71 had an order to cleanse the left lower extremity with dandruff shampoo and review of the TAR revealed this did not get completed on 12/06/22, 12/12/22, 12/16,22, 12/24/22, and 12/26/22. Review of Resident #71's physician's orders revealed an order dated 12/30/22 to apply Ace wraps in the morning and off at night one time a day for wound care. Further review of Resident #71's medical record and progress notes from November 2022 to January 2023 revealed no documentation as to why wound treatments were not completed as ordered. Observations of Resident #71 on 01/17/23 at 7:20 A.M. and 10:22 A.M. revealed the resident failed to have the ace wraps applied to his bilateral lower extremities. Interview with Resident #71 on 01/17/23 at 10:22 A.M. revealed the ace wraps had not been applied in over two weeks. Interview with Registered Nurse (RN) #173 on 01/17/22 at 10:25 A.M. revealed the night shift were to place the ace wraps on Resident #71 at 6:00 A.M. and it was not her responsibility. RN #173 verified the ace wraps were not applied regularly and she would place them on the resident after her medication pass. 4. Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, epilepsy, acute kidney failure, pulmonary embolism, and myocardial infarction. Resident #25 was under the care of Hospice. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #25's quarterly MDS assessment dated [DATE] revealed the resident had high cognition level. She required extensive two-person assistance for transfers and extensive one-person assistance for bed mobility, dressing, toilet use, and personal hygiene. Resident #25 was at risk for developing pressure ulcers but had none at the time of the assessment. It was noted Resident #25 had an open lesion. Review of Resident #25's most recent care plan revealed she had a cancerous lesion to the left scalp and was refusing a dermatology consult. Interventions were to consult with the physician, provide education to the resident of the need to not disturb the site, observe the skin daily, and to give showers/shampoo twice weekly. Other skin interventions were to document all refusals. Review of Resident #25's Wound Assessment and Plan dated 12/13/22 revealed the wound to the top of the head was a recurrent dermal lesion which began on 02/08/20. The wound was stable and measured 0.2 cm x 0.2 cm x less than 1 cm. Review of Resident #25's Wound Assessment and Plan dated 01/10/23 revealed the wound was healing. It measured 0.7 cm x 0.5 cm x less than 0.1 cm with a moderate amount of exudate. Review of Resident #25's physician's orders revealed an order dated 11/08/22 to treat the scalp lesion by cleansing with Dakin's, lightly scrub scabbed areas to loosen, pat dry, and cover with Vaseline (petroleum gauze) every shift. Review of Resident #25's December 2022 TAR revealed the treatments failed to be completed on 12/20/22, 12/29/22, 12/30/22, and 12/31/22 on the day shift and 12/04/22 and 12/23/22 on the night shift. Review of Resident #25's January 2022 TAR revealed the treatments failed to be completed on 01/03/23 and 01/04/23 on the day shift and 01/02/23 on the night shift. Further review of Resident #25's medical record and progress notes from November 2022 to January 2023 revealed no documentation explaining why the treatments were not completed as ordered. This is an example of non-compliance found during the investigation of Master Complaint Number OH00139199, and Complaint Number OH00139604.

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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 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** 31638 Based on medical record review, resident interview, staff interview, and review of facility policy, the facility failed to complete treatments to pressure ulcers per physician orders. This affected two (#71 and #69) of three residents reviewed for wound care. The facility's census was 59. Findings include: 1. Review of Resident #71's medical record revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, diabetes mellitus, chronic kidney disease, peripheral vascular disease, and congestive heart failure. Review of Resident #71's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. He required extensive one-person assist for bed mobility. Supervision was needed for dressing, transfers, and ambulation. Review of Resident #71's Wound Assessment and Plan dated 12/13/22 revealed the resident had a pressure ulcer to the bilateral buttocks which measured 4 centimeters (cm) by (x) 6 cm, and the depth was unable to be determined (UTD). The wound showed 20% epithelial tissue, 20% granulation tissue, and 60% sloughing. The wound had declined and was macerated. There was a moderate amount of exudate. The physician discussed offloading and suggested not to spend a large amount of time in his wheelchair and the resident declined. It was also recommended the resident wear a brief, but he also declined. It was also discussed wearing a brief and Resident #71 declined. Review of Resident #71's physician's order dated 12/13/22 revealed an order to cleanse the bilateral buttocks with soap and water, pat dry, and apply Triad wound paste every shift and as needed. Review of Resident #71's Treatment Administration Record (TAR) for December 2022 revealed staff failed to complete the treatment to the bilateral buttocks on 12/18/22, 12/21/22, 12/23/22, 12/27/22, and 12/30/22 on the day shift and on 12/16/22, 12/23/22, 12/24/22 on the night shift. On 12/28/22 a '9' was charted which indicated other/see progress note. Review of Resident #71's progress notes revealed no documentation explaining why the treatment was not completed. 2. Review of Resident #69's medical record revealed an admitted [DATE]. Diagnoses included diabetes mellitus, chronic obstructive pulmonary disease, history of transient ischemic attack, hemiplegia left side, chronic kidney disease, coronary artery disease, peripheral vascular disease, and congestive heart failure. Review of Resident #69's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had high cognitive function. He required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of Resident #69's most recent care plan revealed the resident was at risk for further skin alteration related to decreased mobility, a fall at home that resulted in a fracture, skin alterations, incontinent episodes, nutritional risk related to diet and fluid texture, diabetes, peripheral vascular disease, and he was dependent for daily needs. (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 Resident #69's Wound Assessment Plan dated 11/08/22 revealed the resident had a pressure ulcer to the great left toe measuring 0.3 cm x 0.4 cm and the depth was unable to be determined. It was 100% eschar and measured the same on 11/15/22. On 12/13/22 the wound was noted to have declined and measured 0.5 cm x 0.5 cm x 0.5 cm. The toenail was removed due to an infection. The wound was 80% granulation and 20% slough. Review of the Wound Assessment Plans dated 12/20/22 and 01/03/23 revealed the toe was healing. Review of Resident #69's physician's orders revealed an order dated 10/11/22 to cleanse the left great toe with wound wash, pat dry, and apply skin prep every shift and as needed. Review of Resident #69's November 2022 TAR revealed the order to the left great toe was not completed on 11/04/22 on day shift and on 11/01/22, 11/04/22, 11/13/22, 11/17/22, 11/19/22, 11/20/22, 11/21/22, 11/24/22 and 11/25/22 on night shift. According to the December 2022 TAR treatment failed to be completed on 12/02/22 and 12/06 22 on the day shift. Continued review of Resident #69's physician's orders revealed an updated order dated 12/06/22 to cleanse the great left toe with wound wash, pat dry, pack with iodoform strips, and cover with a dry dressing every day shift and as needed. Review of Resident #69's December 2022 TAR revealed the treatment to the great left toe failed to be completed on 12/07/22, 12/08/22, 12/16/22, 12/18/22, 12/21/22, 12/23/22, 12/27/22, and 12/31/22. Review of Resident #69's Wound Assessment Plan dated 12/20/22 revealed the resident had a pressure ulcer to the right knee, which had declined and measured 3.5 cm x 1.8 cm x 0.3 cm and was 80% granulation tissues and 20% slough. On 01/03/23 the wound was documented as healing and measured 3.3 cm x 1.8 cm x 0.3 cm. On 01/17/23 the physician documented the wound as declining, and it measured 3.0 cm x 3.1 cm x 0.3 cm and a stage four pressure ulcer. Review of Resident #69's physician's orders revealed an order dated 10/04/22 to treat the right knee by cleaning with wound wash, pat dry, and cover with a foam dressing every night shift every Tuesday, Thursday, Saturday, and as needed. Review of Resident #69's TAR for November 2022 revealed the resident's right knee treatment failed to be completed on 11/15/22, 11/17/22, 11/19/22, and 11/24/22. Further review of Resident #69's physician's orders revealed an updated order dated 11/29/22 to treat the right knee by cleansing the wound with wound wash, pat dry, apply collagen, apply silver alginate, and cover with a foam dressing every night shift every Tuesday, Thursday, Saturday and as needed. Review of Resident #69's TAR dated December 2022 revealed the resident's right knee treatment failed to be completed on 12/06/22, 12/15/22, 12/24/22, and 12/29/22. Further review of Resident #69's medical record and progress notes from November 2022 to January 2023 revealed no documentation explaining why wound treatments were missed for the resident's toe and knee wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/17/23 at 11:31 A.M. with the Director of Nursing (DON) verified Resident #71 and Resident #69's TARs reflected multiple missed treatments to pressure wounds. The DON further reported nurses should document why wound treatments are missed and verified there was no documentation explaining why wound treatments were not completed. Review of the facility policy titled Wound Care, revision date 10/21, revealed the purpose was to care for wounds and promote healing. This is an example of non-compliance found during the investigation of Master Complaint Number OH00139199, and Complaint Number OH00139604.

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	366039	A. Building B. Wing	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Point Place Healthcare and Rehabilitation Center	6101 N Summit St Toledo, OH 43611

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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 0694 Level of Harm - Actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, review of hospital records, and policy review the facility failed to follow a health practitioner order to administer intravenous (IV) fluids to a resident with a change of condition. This resulted in actual harm for one resident (#73) who was ordered IV hydration after being found hypotensive. The IV fluid orders were never written by the facility staff and were not administered. The following morning the resident remained hypotensive and was lethargic requiring transfer and admission to the hospital for hypotension. This affected one (#73) of three residents reviewed for IV therapy. The facility census was 59. Findings include: Review of Former Resident (FR) #73 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, intracardiac thrombosis, lupus, chronic kidney disease, and congestive heart failure. Review of FR #73's medical record revealed a progress note dated 12/31/22 at 9:59 A.M. which revealed the nurse went in to administer medications and found the resident's blood pressure to be 66/45 and the heart rate was 116. When the nurse notified the Certified Nurse Practitioner (CNP) of the findings, the CNP inquired about the orders for fluids that were given to the night nurse. The day nurse did not note any orders in the electronic medical system and was not informed of these orders by night nurse in report. The day nurse followed through with the orders given on the previous shift and pulled the fluids. FR #73 was stating repeatedly that she did not feel good. The nurse asked her if she would like to go to the hospital, or receive fluids here and let the facility treat her low blood pressure. FR #73 stated Yes, hospital. The resident was transferred to the local hospital and did not return to the facility. Review of the hospital record revealed FR #73 was admitted to the hospital for hypotension. The resident was transferred to a hospice facility from the hospital. Interview with the Director of Nursing on 01/18/23 at 10:33 A.M. verified the night nurse on 12/31/22 failed to follow the NP's order to administer IV fluids for FR #73. He stated The night nurse obviously did nothing. Interview with Licensed Practical Nurse (LPN) #127 on 02/01/23 at 12:35 P.M. revealed 0.45% normal saline was ordered for FR # about 11:00 P.M. on 12/30/22 by the CNP. LPN #127 revealed on the morning of 12/31/22 she found FR #73 lethargic and hypotensive. The LPN contacted CNP #190 to inform her of the situation and the CNP was upset because the orders she gave to the night nurse were not carried out. It was decided to send FR #73 to a local hospital due to her condition. (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Telephone interview with CNP #190 on 02/01/23 at 12:51 P.M. revealed on 12/30/22 at approximately 10:30 P.M. she was alerted that FR #73 was hypotensive by the night staff. Medications ordered included IV fluids of 0.45% normal saline for hydration. The following morning the CNP stated she received a call from LPN #127 who informed her that the previous orders were never followed and FR #73 continued to be hypotensive and lethargic. The CNP decided to send the resident out to be evaluated at the local hospital. CNP #190 revealed it was possible, but hard to say if the hospitalization was a result from FR #73 failing to received the ordered IV fluids. Review of the facility policy titled Infusion Therapy Responsibilities and Scope of Practice, undated, revealed the nurses' responsibilities included administering medications within specified times, starting treatments within a responsible time after order is written, and administering medications in a safe, responsible manner. This was non-compliance discovered during the investigation of Master Complaint Number OH00139199.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, resident interview, and review of facility policy, the facility failed to administer medications without any significant errors. This affected one (Resident #66) of three residents reviewed for medication administration. The facility's census was 59. Findings include: Review of Resident #66's medical record revealed an admitted [DATE]. Diagnoses included lymphedema, asthma, pressure ulcers, and morbid obesity. Review of Resident #66's quarterly Minimum Data Set assessment, dated 12/31/22, revealed she had a high cognitive function. She required a one-person extensive assist for all activities of daily living except eating. Resident #66 had been administered opioid pain medication for the seven days prior to the review. Review of Resident #66's most recent care plan revealed she was at risk for pain related to a decrease in mobility, wounds, lymphedema, osteoarthritis, and cardiac disease. Interventions included to administer medication per physician orders. Staff were to anticipate the resident's need for pain relief and respond timely to any complaint of pain. Review of Resident #66's physician orders revealed an order dated 10/26/21 for Percocet (pain medication) tablet 7.5-325 milligram (mg) to be administered by mouth every six hours for pain. Review of Resident #66's January 2023 Medication Administration Record (MAR) revealed the Percocet failed to be administered on 01/03/23 and 01/08/23 at 6:00 A.M. Review of Resident #66's January 2023 MAR revealed on 01/07/23 at 12:00 P.M. and 6:00 P.M., on 01/08/23 at 12:00 A.M., and on 01/16/23 at 12:00 A.M., 6:00 A.M., and 12:00 P.M. the scheduled Percocet was marked 9 which indicated to see the progress notes. Review of Resident #66's progress notes dated 01/07/23, 01/08/23, 01/16/23 revealed there was no information regarding medication administration. Further review of Resident #66's medical record revealed on 01/15/23 the medication was reordered and on 01/16/23 the medication was on order. Interview on 01/11/23 at 12:30 P.M. with Resident #66 revealed she did not have her pain medication for one and a half days because the facility ran out of her pain medication. The resident stated her pain increased. Interview with the Director of Nursing (DON) on 1/17/23 at 11:21 A.M. verified if a resident refused their medication the staff nurse should be typing a 9 on the MAR which means see progress notes and also documenting on the resident's progress note why the medication failed to be administered. The DON also stated he was unaware the medications were not being delivered timely and he would discuss it with the pharmacy. The DON verified Resident #66's MAR indicated the resident was not administered ordered Percocet on 01/03/23, 01/07/23, 01/08/23, and 01/16/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Pain Assessment and Management, revised 03/2022, revealed the facility should alleviate the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Review of the facility policy titled Administering Medications, dated 04/2018, revealed if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose. This is an example of non-compliance found during the investigation of Master Complaint Number OH00139199, Complaint Number OH00139604, and Complaint Number OH00139128.

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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 medical record review, staff interview, and review of facility policy, the facility failed to maintain an accurate medical record regarding the health status of a resident and failed to write orders provided by a health care professional. This affected one (Former Resident #73) out of three residents reviewed for change of condition. The facility census was 59. Findings include: Review of Former Resident (FR) #73 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, intracardiac thrombosis, lupus, chronic kidney disease, and congestive heart failure. Review of FR #73's medical record revealed a progress note dated 12/31/22 at 9:59 A.M. which revealed the nurse went in to administer medications and found the resident's blood pressure to be 66/45 and the heart rate was 116. When the nurse notified the Certified Nurse Practitioner (CNP) of the findings, the CNP inquired about the orders for fluids that were given to the night nurse. The day nurse did not note any orders in the electronic medical system and was not informed of these orders by night nurse in report. The day nurse followed through with the orders given on the previous shift and pulled the fluids. FR #73 was stating repeatedly that she did not feel good. The nurse asked her if she would like to go to the hospital, or receive fluids here and let the facility treat her low blood pressure. FR #73 stated Yes, hospital. The resident was transferred to the local hospital and did not return to the facility. Review of the medical record did not contain an assessment of FR #73 for the evening of 12/30/22 which led to staff calling the CNP. The record did not contain any orders that were provided by the CNP. Review of the hospital record revealed FR #73 was admitted to the hospital for hypotension. The resident was transferred to a hospice facility from the hospital. Interview with the Director of Nursing on 01/18/23 at 10:33 A.M. verified the night nurse on 12/31/22 failed to write the orders that were provided by the CNP to administer IV fluids and obtain laboratory tests for FR #73. Interview with Licensed Practical Nurse (LPN) #127 on 02/01/23 at 12:35 P.M. revealed 0.45% normal saline was ordered for FR # about 11:00 P.M. on 12/30/22 by the CNP. LPN #127 revealed on the morning of 12/31/22 she found FR #73 lethargic and hypotensive. The LPN contacted CNP #190 to inform her of the situation and the CNP was upset because the orders she gave to the night nurse were not carried out. It was decided to send FR #73 to a local hospital due to her condition. LPN #127 verified the night nurse failed to complete any documentation regarding the resident's condition throughout the night nor put orders into the electronic medical records. LPN #127 stated nursing staff were to document all care and changes in resident conditions in the electronic medical record (EMR). All verbal orders were to be placed in the orders and followed through immediately. LPN #127 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview with CNP #190 on 02/01/23 at 12:51 P.M. revealed on 12/30/22 at approximately 10:30 P.M. she was alerted that FR #73 was hypotensive by the night staff. The CNP ordered immediate blood work which included a complete metabolic panel (CMP), a complete blood count (CBC), and a urinalysis. Medications ordered included IV fluids of 0.45% normal saline for hydration. The following morning the CNP stated she received a call from LPN #127 who informed her that the previous orders were never followed and FR #73 continued to be hypotensive and lethargic. The CNP decided to send the resident out to be evaluated at the local hospital. Review of the facility policy titled Change of Condition, revised 11/01, revealed upon notification of the resident, physician and if known the resident's legal representative or resident representative documentation will be entered in the resident's record reflecting exchange of information. This represents non-compliance discovered during the investigation of Master Complaint Number OH00139199.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, staff interview, review of facility policy, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure staff followed proper infection control precautions when caring for resident positive for Coronavirus 2019 (COVID-19). This had the potential to affect 24 (Residents #26, #28, #29, #30, #31, #32, #33, #34, #37, #41, #44, #46, #47, #48, #49, #50, #52, #53, #54, #56, #58, #59, #60, and #61) who were negative for COVID-19. The facility census was 59. Findings include: 1. Review of the medical record revealed Resident #42 was admitted on [DATE]. Diagnoses included occlusion and stenosis of right posterior cerebral artery, vascular dementia, type two diabetes mellitus without complications, COVID-19, chronic systolic (congestive) heart failure, essential (primary) hypertension, and hyperlipidemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired. Review of the nurse's notes dated 01/02/23 verified Resident #42 tested positive for COVID-19 on 01/02/23. Review of the medical record revealed Resident #43 was initially admitted on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, acute respiratory distress, unspecified bacterial pneumonia, dysphagia following cerebral infarction, schizophrenia, gastrostomy status, COVID-19, hypoxemia, tachycardia hyperlipidemia, contracture right hand, major depressive disorder recurrent, and essential primary hypertension. Review of the MDS assessment dated [DATE] revealed the resident was severely cognitively impaired. Resident #43 required one person extensive assistance with bed mobility, dressing, and personal hygiene. Review of the nurse's notes dated 01/02/23 verified Resident #43 tested positive for COVID-19 on 01/02/23. Observation on 01/11/23 at 3:08 P.M. revealed Resident #42 and Resident #43 were roommates and had appropriate infection control signage posted to their door alerting staff of precautions in place and a Personal Protective Equipment (PPE) cart with supplies was available outside the door. Upon knocking on the door and being invited in by Resident #42, an observation was made of State tested Nurse Aide (STNA) #112 pulling the privacy curtain and fully stating he was assisting Resident #43. After approximately three minutes, STNA #112 stated he needed to get Resident #43 a gown and exited behind the privacy curtain. STNA #112 was observed to be wearing an N95 and eye protection but no gown or gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/11/23 at 3:12 P.M. with STNA #112 verified he was not wearing a gown or gloves while in a COVID-19 positive resident room. STNA #112 stated he did not know if the residents were still COVID-19 positive. STNA #112 verified the infection control droplet, airborne, and contact precaution signs posted outside the door. 2. Review of the medical record revealed Resident #71 was admitted on [DATE]. Diagnoses include schizoaffective disorder, type two diabetes mellitus with other specified complication, type two diabetes mellitus with foot ulcer, chronic kidney disease stage 3, pressure-induced deep tissue damage of right and left buttock, Morbid (severe) obesity due to excess calories, COVID-19, ventricular tachycardia, major depressive disorder recurrent, peripheral vascular disease, essential (primary) hypertension, and hyperlipidemia. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of the nursing note dated 01/03/23 revealed Resident #71 tested positive for COVID-19. Review of the physician order dated 01/03/23 revealed the resident was on strict single room droplet and respiratory isolation related to diagnosis of COVID-19. All services were to be provided in room. Observation on 01/11/23 at 4:30 P.M. revealed Resident #71 was in a wheelchair ambulating outside of his room in the hallway without a mask on. STNA #185 was approximately 20-30 feet away and within eye sight from the resident preparing a drink cart. STNA #185 did not direct Resident #71 back to his room. Interview on 01/11/23 at 4:32 P.M. with STNA #185 revealed STNA #185 was familiar with Resident #71 and commented on how he would occasionally come out in the hall. STNA #185 verified she did not know Resident #71 was COVID-19 positive. STNA #128 joined the conversation and stated Resident #71 was not compliant and came out of his room whenever. Observation on 01/11/23 at 4:34 P.M. revealed without intervention, Resident #71 returned to his room. Director of Rehabilitation #148 was observed to walk into Resident #71's room without applying PPE. The infection control signage and PPE bins were absent from the resident's room door. Observation on 01/11/23 at 4:37 P.M. Director of Rehabilitation #148 was observed talking closely (within three feet) of Resident #71. The only PPE worn was an N95 mask with the bottom strap not attached and eye protection. Subsequent interview with the Director of Rehabilitation #148 revealed she was not aware Resident #71 was still COVID-19 positive and on isolation. Director of Rehabilitation #148 reported Resident #71 would remove the sign alerting staff of precautions and what PPE to wear upon entering, as well as move the PPE supplies. Observation on 01/12/23/at 11:41 A.M. revealed Receptionist #102 exiting Resident #71's room wearing only a surgical mask. Interview on 01/12/23 at 11:42 A.M. with Receptionist #102 verified she just walked into Resident #71's room to deliver a meal. Receptionist #102 verified signage on the door and verified she knew better. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy, Infection Control Guidelines, revised October 2022 verified staff caring for residents with suspected of confirmed COVID-19 infection should use full PPE including gowns, gloves, eye protection, and approved N-95 or equivalent or higher level respirator. Healthcare professionals who enter the room of a resident who is suspected or confirmed of COVID-19 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. Residents who are suspected or confirmed positive for COVID-19 will be placed in transmission-based precautions. Staff will done PPE outside of room and PPE will be doffed just inside of room and disposed of in the trash container located just inside the room door. Review of the CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 09/23/22 verified healthcare professionals who enter the room of a patient with suspected of confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). The duration of transmission based precautions for a patient who is positive for COVID-19 is 10 days from the date of the positive test or from the date of the first symptom. This deficiency represents non-compliance investigated under Master Complaint Number OH00139199 and Complaint Number OH00139128.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review and staff interview, the facility failed to ensure residents were offered the Coronavirus 2019 (COVID-19) vaccine in a timely manner. This affected five (Residents #42, #43, #65, #71, and #75) of five residents reviewed for COVID-19 vaccination. The facility's census was 59. Findings include: 1. Review of the medical record revealed Resident #42 was admitted on [DATE]. Diagnoses included occlusion and stenosis of right posterior cerebral artery, vascular dementia, type two diabetes mellitus without complications, COVID-19, congestive heart failure, hypertension, and hyperlipidemia. Review of the Minimum Data Set (MDS) assessment, dated 12/20/22, revealed the resident was moderately cognitively impaired. Review of the immunization record revealed Resident #22 last received the COVID-19 vaccine on 11/09/21. 2. Review of the medical record revealed Resident #43 was initially admitted on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, acute respiratory distress, unspecified bacterial pneumonia, dysphagia following cerebral infarction, schizophrenia, gastrostomy status, COVID-19, hypoxemia, tachycardia hyperlipidemia, contracture right hand, major depressive disorder recurrent, and essential primary hypertension. Review of the MDS assessment, dated 10/27/22, revealed the resident was severely cognitively impaired. Review of the immunization record revealed Resident #43 no COVID-19 vaccine recorded. 3. Review of the medical record for Resident #65 revealed an initial admitted [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, vascular dementia mild with anxiety, chronic obstructive pulmonary disease, generalized anxiety, hypertension, chronic kidney disease, anemia, and hyperlipidemia. Review of the MDS assessment, dated 12/22/22, revealed the resident was cognitively intact. Review of the immunization record revealed Resident #65 last received the COVID-19 vaccine on 06/09/21. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record revealed Resident #71 was admitted on [DATE]. Diagnoses included schizoaffective disorder, type two diabetes mellitus with other specified complication, type two diabetes mellitus with foot ulcer, chronic kidney disease stage III, pressure-induced deep tissue damage of right and left buttock, morbid obesity, COVID-19, ventricular tachycardia, major depressive disorder recurrent, peripheral vascular disease, hypertension, and hyperlipidemia. Review of the MDS assessment dated , 12/22/22, revealed the resident was cognitively intact. Review of the immunization record revealed Resident #71 last received the COVID-19 vaccine on 10/13/21. 5. Review of the medical record revealed Resident #72 was admitted on [DATE]. Diagnoses included protein-calorie malnutrition, dementia, major depressive disorder recurrent severe with psychotic symptoms, polyneuropathy, benign prostatic hyperplasia, anxiety disorder, visual hallucinations, auditory hallucinations, and insomnia. Review of the MDS assessment, dated 11/17/22, revealed the resident was cognitively intact. Review of the immunization record revealed Resident #72 last received the COVID-19 vaccine on 11/09/21. Interview on 01/12/23 at 3:30 P.M. with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #164 verified a COVID-19 vaccination clinic had not been offered since the end of the year of 2021. LPN #164 stated the facility had four DON's since that time. The DON stated the facility was in the process of obtaining consents for COVID-19 vaccines through the pharmacy. Interview via telephone on 01/13/23 at 2:48 P.M. with the DON verified COVID-19 vaccines had not been offered to new admissions or current residents since the end of 2021. This deficiency represents non-compliance investigated under Master Complaint Number OH00139199 and Complaint Number OH00139128.