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	02/23/2023

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, staff interview and review of policy, the facility failed to ensure timely notification to a physician was made of a significant change in condition. This affected two (#64 and #75) of three residents reviewed for change in condition. The facility census was 64. Findings include: 1. Review of Resident #64's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included schizoaffective disorder, bipolar, dementia with moderate behavioral disturbances, chronic obstructive pulmonary disease, type II diabetes mellitus, moderate protein-calorie malnutrition, osteoarthritis, heart failure, acute kidney failure, blindness, hypertension, peripheral vascular disease, malignant neoplasm of the ovary, ischemic cardiomyopathy, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #64 had impaired cognition, required extensive assistance with bed mobility, locomotion, eating, transfers, dressing and personal hygiene and required the total dependence of the assistance of two for transfers. Review of the progress notes dated [DATE] at 5:04 P.M., revealed Resident #64 was lethargic. Review of the progress note date [DATE] at 5:40 P. M., the Nurse Practitioner (NP) #105 was notified by Registered Nurse (RN) #107 of the resident being lethargic and an order was provided to taper Depakote over the next five day and then to discontinue. Interview on [DATE] at 6:40 A.M., with State tested Nursing Assistant (STNA) #119 revealed at 3:00 P.M. on [DATE], Resident #64 was standing next the bed, responded but was not her normal self. At dinner time STNA #119 stated assistance with eating was provided to Resident #64, but the liquids would run out of the resident's mouth. STNA #119 stated she immediately alerted the nurse. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 7:02 A.M., with Licensed Practical Nurse (LPN) #122, confirmed she was responsible for the primary care of Resident #64 from 6:45 P.M. on [DATE] until 7:15 A.M. on [DATE]. LPN #122 verified the nursing assistant had communicated concerns regarding Resident #64 being lethargic and unable to take liquids. LPN #122 added she did not provide Resident #64 evening medications because the resident was too lethargic, and the pills would fall out of the residents mouth. LPN #122 stated Resident #64 was last checked on around midnight and found to be really sleepy. LPN #122 stated no notification was made to the provider regarding the ongoing lethargy or the inability of Resident #64 to take evening oral medications as prescribed. Review of an additional progress not dated [DATE] at 5:28 A.M., revealed Resident #64 was found at 2:04 A. M. not be breathing and unresponsive. Cardiopulmonary resuscitation was started, and emergency services notified. The resident died at 2:55 A.M. Review of the code note for Resident #64 revealed the resident was found unresponsive and without a pulse at approximately 2:04 A.M. on [DATE], cardiopulmonary resuscitation started emergency services were called. Interview on [DATE] at 10:20 A.M., with NP #105, revealed RN #105 had contacted her on [DATE] regarding Resident #64 being lethargic and orders were provided. NP #105 denied having any other communication with the facility regarding Resident #64, until a call was received for the death notification. NP #105 stated interventions could have been provided, but not sure if this would change the outcome and prevented the death of Resident #64. 2. Review of the medical record for Resident #75 revealed an admitted [DATE] and a discharge from the facility due to death on [DATE]. Diagnoses included chronic obstructive pulmonary disease, hyperkalemia, hypertension, type II diabetes mellitus, hypothyroidism, acute pulmonary edema, obstructive sleep apnea, paraplegia, osteoarthritis, iron deficiency anemia, and moderate protein calorie malnutrition. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #75 had intact cognition and required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. Review of the progress note dated [DATE] at 8:44 A.M., revealed Resident #75 had complaints of nausea, oxygen saturations were 84 percent on three liters of oxygen per nasal cannula and when the resident was repositioned in bed the oxygen saturation increased to 88 percent, a breathing treatment was also provided and the provider was notified. Review of the oxygen saturation levels for Resident #75 revealed fluctuations between 84 and 94 percent on three liters of oxygen dependent on how the resident was positioned in the bed. Review of the medication administration record for [DATE] revealed on [DATE] medications were held due to nausea. Review of the progress note dated [DATE] and timed 7:44 A.M., revealed Resident #75 was found unresponsive with no rise and fall of the chest and was without a pulse at approximately 6:15 A.M. cardiopulmonary resuscitation was started and emergency services were called. The resident died at 6:58 A. M. Review of the death certificate signed [DATE] revealed the cause of death for Resident #75 was acute on chronic hypoxic respiratory failure (for weeks), chronic obstructive pulmonary disease and kidney disease. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NP #105 on [DATE] at 10:20 A.M., revealed notification had been received from the day shift nurse regarding Resident #75 being nauseated. The resident had medications already ordered to assist with nausea. NP #105 stated no further communication was received from the facility regarding Resident #75 not receiving medications nor of the continued nausea. NP #105 stated not surprised by the resident's death and not sure new interventions would change the outcome. Review of the policy titled Change in Condition, dated [DATE] stated the facility will consult the resident's physician when a significant change (deterioration) in a resident's physical, mental or psychosocial status in either life threatening or clinical complications. Review of the policy titled Administration and Documentation of Medications dated [DATE] stated documentation must be completed of medications not administered as ordered with the reason why, notification completed and negative outcome to a resident, if any. This deficiency demonstrates non-compliance related to the allegations in Complaint Numbers OH 00139754 and OH00139691.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, hospital medical record reviews, review of the facility ' s daily staffing review, interviews with facility staff, the physician, the nurse practitioner, the physician, review of the emergency squad run sheet, review of facility self-imposed action plan, review of the Enhanced Information Dissemination and Collection (EIDC) electronic reporting system, review of the facility's policies for Enteral Nutrition Therapy ,Admission Assessment and Follow Up: The Role of the Nurse, and Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, the facility failed to ensure Resident #70 was free from neglect, when the facility staff failed to provide appropriate services to ensure the resident received sufficient nutrition and hydration via enteral tube feeding. Resident #70 was not assessed by a dietitian for nutritional and hydration needs, no physician orders were obtained for nutrition, and no interventions were implemented for the care and treatment of the gastrostomy tube. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or negative health outcomes for one (#70) resident who was newly admitted to the facility on [DATE] and whose only means of nutritional intake was via gastrostomy tube (g-tube), when physician orders were not obtained for nutrition and this resident was not provided sufficient enteral nutrition and fluids for five days, from 01/05/23 to 01/10/23. Consequently, Resident #70 suffered an acute change in condition and was sent by emergency squad to the hospital. The resident was admitted to the hospital in critical care for acute hypernatremia (elevated sodium) with dehydration, acute hypoxic (low oxygen levels) respiratory failure and acute metabolic encephalopathy multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia (loss of body weight, muscle mass and weakness), and acute mucositis (inflammation of the mouth). This affected one (#70) of six residents reviewed for potential neglect. The facility identified a total of five (#07, #09, #21, #23 and #37) residents currently receiving enteral nutrition. The facility census was 64. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/09/23 at 3:19 P.M., Corporate Administrator #903, the facility Administrator, Director of Nursing (DON), Regional Director of Clinicals (RDC) #701, and Chief Nursing Officer (CNO) of Clinical Services #802, were notified Immediate Jeopardy began on 01/05/23 when staff failed to assess a newly admitted resident (#70) for nutrition and hydration, who required enteral tube feeding for nutrition, failed to obtain dietary orders, failed to provide sufficient enteral nutrition for five days, failed to provide sufficient fluids to prevent dehydration, failed to facilitate interdisciplinary communication between the Doctor, RD #106, and direct care staff regarding Resident #70's nutritional needs and failed to initiate an acute care plan with interventions to address nutritional requirements. Resident #70 was transferred to the hospital per family request on 01/10/23. Review of emergency department assessment dated [DATE], did not reference tube feeding and the preadmission medication list had no reference of a feeding tube or nutrition in the physical assessment. Review of the emergency department attending physician assessment dated [DATE], revealed Resident #70 was assessed as appearing chronically ill, cachectic (loss of body weight and muscle mass and weakness) with multiple issues that included tachycardia, hypoxia, and hyperglycemia. Resident #70 was admitted to critical care for altered mental status, hypernatremia (elevated sodium level), and hyperammonemia (elevated ammonia level). Review of the hospital admission assessment dated [DATE], referenced a gastrostomy tube and remained silent for tube feeding. Review of the hospital admitting diagnoses included: acute hypernatremia with dehydration, acute hypoxic respiratory failure and acute metabolic encephalopathy, multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia, and acute mucositis (inflammation of the mouth). The Immediate Jeopardy was removed on 02/14/23 when the facility implemented the following corrective actions: On 01/10/23, Resident #70 was transferred out of the facility to the hospital. On 01/12/23, a facility-wide audit was completed to ensure accuracy of residents receiving tube feed orders were documented in the residents ' medical records. On 01/12/2023, the CNO #802 and RDC #701 reviewed the policies and procedures related to enteral nutrition and documentation. There was no revision to the policy made. Beginning on 01/12/23, the DON began weekly audits of medical records for accuracy of diet orders and will continue until 03/09/23 and randomly after. On 02/09/23, the consulting Nurse Practitioner (NP)#105 was made aware by the RDC #701 verbally, the Immediate Jeopardy citations and the systemic actions that were starting to be implemented. On 02/09/23, the DON added Intake and Output orders on resident ' s medical records who receive enteral nutritional orders. On 02/10/23, the interdisciplinary team (IDT) with Registered Dietitian (RD) #106 reviewed all residents for nutritional and hydration (at risk) status. All care plans were validated as being current and correct. On 02/10/23, the IDT, the DON and the RD #106 reviewed all residents ' diets to validate all residents have current diet orders and are correctly listed on the medical record. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/10/23, the Administrator and DON provided the agency nurse who admitted and took care of Resident#70 with a do not return to clip board agency human resource (HR) director. On 02/10/23, a Root Cause Analysis using a Fishbone diagram was completed to review the alleged deficiency. This was completed by the CNO #802 and RDC #701 with other members of the Quality Assurance Performance Improvement (QAPI) Team. Beginning on 02/10/23, all staff will be in-serviced on the policies and procedures related to Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property. This was provided by the DON. Beginning on 02/14/23, an agency binder for all licensed nursing placed on both units all education for current survey(s). The daily schedule will have a notice for agency staff to see Agency Binder. The binder will be reviewed daily at staffing meeting per Administrator, the DON and HR director for completion. Beginning on 02/10/23, the DON will discuss and review all changes in condition of the resident with RD #106 during weekly Quality of Life meeting, that is an IDT meeting currently taking place. Beginning on 02/10/23, the facility will discuss results of the audits during a weekly Ad-Hoc QAPI meeting for the next four (4) weeks to ensure compliance. On 02/13/23 and 02/14/23, random staff interviews with Registered Nurse (RN) #107, Licensed Practical Nurse (LPNs) #114, #115, #116 and #117, Housekeeper #113 and State tested Nurse Aides (STNA) #112 were completed to verify in-service on Abuse and Neglect and was able to verbalize the education. Beginning on 02/14/23, an agency binder for all licensed nursing staff was placed on both units all education for current survey(s). The daily schedule will have a notice for agency staff to see Agency Binder. The binder will be reviewed daily at staffing meeting per Administrator, the DON and HR director for completion. On 02/14/23, review of the daily schedule revealed a statement for agency staff to review the agency staff binder for the education on the facility ' s policy on abuse and neglect before the beginning of their shift. On 02/14/23, random interviews with agency STNAs (#118, #120 and #121) revealed they had reviewed the agency binder and was able to verbalize the facility ' s education. On 02/14/23, review of the agency binder sign in sheet revealed agency staff had been reviewing the binder and they were acknowledging the facility corrective action. Although the Immediate Jeopardy was removed on 02/14/23, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the closed medical record for Resident #70 revealed an admitted [DATE]. Admitting diagnoses for Resident #70 included: hemiplegia, hemiparesis and aphasia following a cerebral infarct (stroke) April 2022, severe protein calorie malnutrition, vascular dementia, chronic obstructive pulmonary disease, traumatic brain injury, epilepsy, hypertension, hypothyroidism, and osteoarthritis. Resident #70 had three wounds: one Stage II to the right hip and two unstageable wounds, to the left hip and left heel. Resident #70 was discharged on [DATE] to the hospital. Review of the hospital inpatient record dated 12/28/22 revealed Resident #70 had a diagnoses of severe protein calorie malnutrition and had received enteral nutrition for a continuous feed for 23 hours a day with 150 milliliters (ml) water flushes every 4 hours, with intake of 2100 (ml) the previous 24 hours. Review of the hospital discharge summary with a print date of 01/04/23 at 3:16 P.M., from the acute hospital revealed there was no orders for enteral feedings. Review of the admission physician orders dated 01/05/23, revealed the resident was ordered to admit to SNF (skilled nursing facility and for long-term care and skilled care) and DNRCC-A (Do Not Resuscitate Comfort Care -Arrest) code status. There were no orders to address the resident ' s nutritional status. Review of diet order changes and communication form dated 01/05/23 revealed Resident #70 was a new admit with a diet order of NPO (nothing by mouth) and did not state how Resident #70 was to receive nutrition. Review of physician orders from 01/06/23 to 01/10/23 revealed no physician orders to address the nutritional status. On 01/08/23, an order to flush enteral tube with 150 ml of water every four hours providing 900 ml per day. Review of the history and physical dated 01/07/23, revealed there was no documentation to address the g-tube or nutritional needs of the resident. This was completed by Nurse Practitioner (NP) #105. Review of the January 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #70 revealed medications administered via g-tube were documented as given per orders. Water flushes of the g-tube tube for 150 ml were documented as being completed beginning on 01/08/23 at 12:00 P.M., 4:00 P.M. and 8:00 P.M., on 01/09/23 at 12:00 A.M., 4:00 A.M., 8:00 A. M., 12:00 P.M., 4:00 P. M. and 8:00 P.M. and on 01/10/23 at 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M. and 4:00 P.M. There was no documentation of any tube feeding being administered. Review of the speech therapy evaluation dated 01/09/23, revealed the referral was made due to feeding tube placement due to dysphagia and malnutrition. The evaluation listed the resident as NPO and with significant weight loss. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the progress note dated 01/09/23 at 4:55 A.M., documented this nurse was called to the resident ' s room, State tested Nurse Aide (STNA) stated heard something from his room and found him on the floor, with his head under the bed lying on his left side. This nurse assessed resident ' s vital signs, with in normal limits for resident. Blood pressure 114/80, oxygen not on, replaced oxygen, respirations 20, temperature 97.6 degrees Fahrenheit. Oxygen levels went up to 95% after 15 minutes. Assessed for injuries, with bruise noted to left scapula of red/purple color, redness starting to form over left hip, small skin tear 0.5 by 0.5 centimeters to back of right hand, with treatment initiated. Family notified and voice mail left for nurse practitioner. Review of the medical record revealed no return call received from the nurse practitioner. Review of the neurological assessment form post fall, dated and timed from 01/09/23 at 4:55 A.M. to 01/10/23 at 11:40 A.M., revealed vitals and neurological checks were completed every fifteen minutes times four, then every 30 minutes for two hours, every one hour for four hours and then every eight hours. Neurological assessment stated the resident was alert with pupil response, equal hand grasps and moved all extremities and had an appropriate response to pain. Blood pressure ranged from 114/80 on 01/09/23 at 4:55 A.M. to 149/86 on 01/09/23 at 10:40 A.M. Heart rate ranged from 97 beats per minute on 01/09/23 at 7:10 A.M. to 117 beats per minute on 01/10/23 at 11:40 A.M. Respirations ranged from 18-20 breaths per minute and the resident remained afebrile (without temperature). Review of Resident #70's weights in the electronic health record (EHR) and paper medical record revealed there were no weights documented as being obtained by the facility. Review of the progress notes throughout the admission for Resident #70, lacked any documented evidence for nutrition or for the resident eating. Review of the progress note dated 01/10/23 at 6:07 P.M., documented the writer noted resident with increased respirations of 42 breaths a minute. Resident not responding to brother as usual, noted lethargic, pulse oximetry 90% with oxygen via nasal cannula at 3 liters, temperature 97.8 degrees Fahrenheit, and blood pressure 100/62. Writer notified on call (physician); orders were given to send resident to emergency room . Emergency 911 was called and arrived about 5:50 P.M. Resident #70 noted with elevated blood sugar of 432. Resident #70 transferred out of facility at 6:07 P.M. Family at bedside aware of it all. Writer called hospital to give report. Review of the complete medical record from admission to discharge revealed no evidence of the physician being contacted for physician orders to address the nutritional need. There was no assessments and treatment plan to address Resident #70 ' s nutritional needs addressed by the Registered Dietitian #106. Review of the emergency squad run sheet dated 01/10/23, reveals no documentation of the resident having any enteral tube feeding being administered. The report documented the chief complaint was for respiratory distress lasting for three days. The level of distress was listed as severe acute respiratory distress. The injury listed was from a fall from the bed at the nursing home on 01/09/23. Review of the hospital record dated 01/10/23 revealed Resident #70 arrived at the emergency department at 6:23 P.M., upon arrival the resident had tachycardia (elevated heart rate) was hyperglycemic (elevated blood sugar) and hypoxic (low oxygen levels) with oxygen saturation in the 80 ' s. Review of the emergency department laboratory test results dated 01/10/23, revealed a blood sugar of 294 (normal range 70 to 99), blood urea nitrogen was elevated at 95 (normal range 8 to 23), creatinine level was 1.19 (normal range 0.7 to 1.2) and the ammonia level was 75 (normal range 11 to 32). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the emergency department assessment dated [DATE], did not reference tube feeding and the preadmission medication list had no reference of a feeding tube or nutrition in the physical assessment. Review of the emergency department attending physician assessment dated [DATE], revealed Resident #70 was assessed as appearing chronically ill, cachectic (loss of body weight and muscle mass and weakness) with multiple issues that included tachycardia, hypoxia, and hyperglycemia. Resident #70 was admitted to critical care for altered mental status, hypernatremia (elevated sodium level), and hyperammonemia (elevated ammonia level) Review of the hospital admission assessment dated [DATE], referenced a gastrostomy tube and remained silent for tube feeding. Review of the hospital admitting diagnoses included: acute hypernatremia with dehydration, acute hypoxic respiratory failure and acute metabolic encephalopathy, multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia, and acute mucositis (inflammation of the mouth). Review of the daily staffing for nurses assigned to care for Resident #70 revealed: on 01/05/23 and 01/06/23, for the 6:45 A.M. to 7:15 P.M. shift and the 6:45 P.M. to 7:15 A.M. shift, revealed agency nurses were assigned; on 01/07/23 and 01/08/23, for the 6:45 A.M. to 7:15 P.M. shift, Registered Nurse (RN) #107 was assigned and for the 6:45 P.M. to 7:15 A.M. shift, an agency nurse was assigned; on 01/09/23, for the 6:45 A. M. to 7:15 P.M. shift, LPN #109 was assigned and for the 6:45 P.M. to 7:15 A.M. shift, an agency nurse was assigned; on 01/10/23, for the 6:45 A.M. to 7:15 P.M. shift, LPN #110 was assigned and for the 6:45 P.M. to 7:15 A.M. shift, an agency nurse was assigned to the care. Review of the facility ' s self- imposed action plan dated 01/12/23, revealed under the area of identified practice there was no area of concern listed. The next category was addressing how corrective action will be accomplished for the residents found to be affected by the identified practice: What did you do for the Resident affected? Resident #70 was transferred to the emergency department on 01/10/23. Review of the Enhanced Information Dissemination and Collection (EIDC) electronic reporting system for the potential neglect being reported to the state agency revealed there was no incidents of potential neglect reported by the facility from January 2023 to February 13, 2023. Interview on 02/07/23 at 7:30 A.M., with LPN #110 verified she had cared for Resident #70. LPN #110 was unable to state if the resident had a feeding tube and was unsure about tube feeding. Interview on 02/07/23 at 10:17 A.M., with the Registered Dietitian (RD) #106 revealed RD #106 did not receive a call when Resident #70 was admitted to the facility and had not seen the resident. RD #106 verified she had not completed a nutritional assessment and did not order tube feeding. When asked about the process for a new admission with a feeding tube, RD #106 stated I am to be notified to ensure a timely assessment and recommendations for those residents at high nutritional risk are made. RD #106 stated I am clueless on what happened and again stated she had not seen the resident. Interview on 02/07/23 at 11:42 A.M., with the Director of Nursing (DON) verified Resident #70 did not have enteral feeding ordered, verified documentation did not exist for any type of feeding in the medical record for Resident #70 and further verified no proof existed for enteral feeding was provided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/07/23 at 3:19 P.M., with LPN #109 verified Resident #70 was transferred to the hospital per family request on 01/10/23. LPN #109 had only provided care to the resident on 01/10/23 and remembered providing water flushes through the g- tube, however, was unable to verify Resident #70 received tube feedings. Interview on 02/08/23 at approximately 10:20 A.M., with Resident #70's NP #105, revealed NP #105 stated she was unfamiliar with the resident and had only seen the resident once after the fall on 01/09/23. NP #105 verified no feeding was ordered for Resident #70 and further verified the history and physical review completed by herself on 01/07/23, did not address the diet or nutritional status of Resident #70. Interview on 02/08/23 at approximately 11:00 A.M., with Registered Nurse (RN) #107 verified Resident #70 had a g-tube; however, RN #107 could not recall if the resident received an enteral feeding and stated, I will have to check the orders. Review of the physician orders by RN #107 verified no enteral feeding formula had been ordered for Resident #70. Interview on 02/08/23 at 4:05 P.M., with RN #108 verified she completed the nutritional section of the admission assessment. RN #108 stated she does not remember if Resident #70 had tube feeding. Interview on 02/08/23 at 5:00 P.M., with the Administrator, the DON, and the RDC #701, verified the electronic medical record for Resident #70 contained no orders for enteral tube feeding and further verified the medical record provided no evidence Resident #70 received feeding while at the facility from 01/05/23 to 01/10/23. Interview on 02/13/23 at 2:32 P.M., with Physician #01 revealed he was unfamiliar with Resident #70 and had only seen him once. Physician #01 stated he knew the resident had a feeding tube. Physician #01 verified the resident did not have an enteral tube feeding order in the record. Interview on 02/13/23 at 3:00 P.M., with the Administrator and the RDC #701 revealed their concern related to the care of residents due to the number of agency staff used by the facility, both nurses and aides. The Administrator stated their hands are tied due to the facility staff being a union as they cannot get staff hired based on the wage offered. The RDC #701 stated the agency staff just do not care and are not vested in the facility, and added it is hard to get consistent care. Review of the policy and procedure titled, Enteral Nutrition Therapy dated April 2018 and revised March 2022, revealed the purpose of the policy was to provide liquid nourishment through a tube inserted into the stomach and to provide hydration through a tube inserted into the stomach. (continued on next page)

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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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy titled, Admission Assessment and Follow Up: The Role of the Nurse, dated April 2018, revealed the policy indicated the nurse is to gather information about the resident ' s physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. The nurse is required to reconcile the list of medications from the medication history, admitting orders, the previous medication administration record (if available), and the discharge summary from the previous institution, contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings and notify other disciplines and departments of the resident ' s admission. The nurse is also responsible to for reporting immediate needs of the resident to the supervisor and the attending physician. Review of the policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated October 2022, indicated residents have the right to be free from neglect and further revealed neglect is the failure of the facility, its employees or facility services providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review, staff interviews and review of the policy, the facility failed to ensure timely admission orders were received to meet the essential needs of residents. This affected two (#21 and #70) of ten residents reviewed for timely admission orders. The facility census was 64. Findings include: 1. Review of Resident #21's medical record revealed an admitted [DATE]. Diagnoses included pericardial effusion, type II diabetes mellitus, severe protein - calorie malnutrition, acute respiratory failure, emphysema, hypertension, atrial fibrillation, and epilepsy. Review of the hospital discharge instructions for the continuation of care printed on 12/30/22 at 3:39 P.M., stated Resident #21 had a gastrostomy tube, was to have nothing by mouth and received tube feedings at 45 ml per hour continuously for 20 hours and received a water flush of 200 ml every six hours. Review of the comprehensive [NAME] Data Set (MDS) assessment dated [DATE] revealed Resident #21 had moderate cognitive impairment, required total dependence for eating and had a gastrostomy tube and received more than fifty-one percent of total calories through the feeding tube with an average fluid intake of 501 milliliters (ml) or more per day via the feeding tube. Review of the admission orders written on 12/31/22 revealed a nothing by mouth diet, tube feeding administered via pump at 45 ml per hour 24 hours a day. Review of the physician orders dated 01/02/23 revealed Resident #21 was not to receive anything by mouth, tube feeding at 45 ml per hour and advanced by 10 ml per hour as tolerated to a goal rate of 75 ml per hour, six times a day flush the feeding tube with 100 ml water. Review of the nutrition assessment completed on 01/02/23 at 1:51 P.M., revealed Resident #21 was severely underweight, and it was recommended for the tube feeding to be increased to 75 ml per hour at 10 ml increments as tolerated and 100 ml water flushes to be administered every four hours. Review of the medication administration record for January 2023 revealed the first bolus of water received by Resident #21 via the feeding tube was at 5:00 P.M. on 01/02/23. Interview on 02/14/23 at 11:25 A.M., with the Director of Nursing (DON) verified the recommended continuation of care order for water flushes were not followed and the DON further verified Resident #21 admitted to the facility on [DATE] and had not received the recommended water flushes per feeding tube until 01/02/23. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the closed medical record for Resident #70 revealed an admitted [DATE]. Admitting diagnoses for Resident #70 included: hemiplegia, hemiparesis and aphasia following a cerebral infarct (stroke) April 2022, severe protein calorie malnutrition, vascular dementia, chronic obstructive pulmonary disease, traumatic brain injury, epilepsy, hypertension, hypothyroidism, and osteoarthritis. Resident #70 had three wounds: one Stage II to the right hip and two unstageable wounds, to the left hip and left heel. Resident #70 was discharged on [DATE] to the hospital. Review of the hospital inpatient record dated 12/28/22 revealed Resident #70 had a diagnoses of severe protein calorie malnutrition and had received enteral nutrition for a continuous feed for 23 hours a day with 150 milliliters (ml) water flushes every 4 hours. With intake of 2100 (ml) the previous 24 hours. Review of admission physician orders dated 01/05/23, revealed the resident was ordered to admit to SNF (skilled nursing facility and for long-term care and skilled care), DNRCC-A (Do Not Resuscitate Comfort Care -Arrest) code status, verbal order for I approve the plan of care and discharge, may crush meds (medications) as appropriate, may crush meds or open capsules as mix with food if not contraindicated, may have annual flu vaccine, may substitute generics unless otherwise indicated, may use OTC (over the counter) meds from house supply, may use liberal medication administration times, Tiotropium Bromide Monohydrate capsule 18 micrograms (mcg), one inhalant each morning and at bedtime, pain evaluation every shift for monitoring of patient's pain level, POC (point of care) testing PRN (as needed) per regulation until further notice, physical therapy two to five times a week and prescriber written order for overall plan of care approved. There were no orders to address the nutritional status. Review of diet order changes and communication form dated 01/05/23 revealed Resident #70 was a new admit with a diet order of NPO (nothing by mouth). Review of the admission assessment dated [DATE], and started 01/06/23, the nutrition section listed the resident as NPO or un supplemented clear liquid (without enteral total parental nutrition support) for greater than forty-eight hours. Further review of the medical record revealed there was no evidence of a nutrition assessment, or the resident being evaluated by the dietitian. Review of the care plan initiated on 01/05/23, revealed no interventions to address the type or method of enteral nutrition provided. The facility revised the resident's care plan on 01/10/23 (date of discharge) to include encouraged good nutrition and hydration to promote healthy skin due to Resident #70 identified with the potential and actual skin impairments and due to the risk for pain staff were to monitor, record and report to the nurse loss of appetite, refusal to eat and weight loss. Review of additional physician orders dated 01/06/23, revealed Resident #70 was ordered occupational therapy two to five times a week for 30 days. There were no orders to address the nutritional status. Review of physician orders dated 01/07/23, revealed the resident was ordered oxygen at two liters minute to keep oxygen saturation above 90 percent, Aspirin 81 milligrams (mg) once daily administered per gastrostomy tube (g-tube), Carbidopa-Levodopa 25-100 mg tablet twice a day administered per g-tube, Clopidogrel Bisulfate 75 mg twice daily administered per g-tube, Ferrous Sulfate Liquid 5.4 milliliters (ml) via g-tube once a day, Pantoprazole Sodium, delayed release 40 mg once daily via g-tube, Quetiapine Fumarate 25 mg once daily via g-tube, Lacosamide Solution (10 mg per ml) with 20 ml administered per g-tube once daily. There were no orders to address the nutritional status. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/07/23 at 11:42 A.M., with Director of Nursing (DON) verified Resident #70 did not have enteral feeding ordered, verified documentation did not exist for any type of feeding in the medical record for Resident #70 and further verified no proof existed for enteral feeding was provided. Interview on 02/08/23 at 5:00 P.M., with the Administrator, the DON, and the Regional Nurse, verified the electronic medical record for Resident #70 contained no admission orders for enteral tube feeding. Review of the policy titled, Admission Assessment and Follow Up: The Role of the Nurse, dated April 2018, revealed the policy indicated the nurse is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. The nurse is required to reconcile the list of medications from the medication history, admitting orders, the previous medication administration record (if available), and the discharge summary from the previous institution, contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings and notify other disciplines and departments of the resident's admission. The nurse is also responsible to for reporting immediate needs of the resident to the supervisor and the attending physician. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, hospital medical records review, review of the facility's daily staffing, interviews with facility staff, the physician, the nurse practitioner, and the fire captain, review of the emergency squad run sheet, review of the facility's policies for Enteral Nutrition Therapy, Admission Assessment and Follow Up: The Role of the Nurse, Weight Policy, Care Plan Policy, Dietary Communication Pathway and review of the job description of the Registered Dietitian, the facility failed to assess a newly admitted resident for nutrition and hydration who required enteral tube feeding for nutrition, failed to obtain dietary orders, failed to provide sufficient fluids to prevent dehydration, failed to facilitate interdisciplinary communication between the Doctor, Registered Dietitian (RD) #106 and direct care staff regarding Resident #70's nutritional needs and failed to initiate an acute care plan with interventions to address the resident's nutritional requirements. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or negative health outcomes for one (#70) resident who was newly admitted to the facility on [DATE] and whose only means of nutritional and hydration intake was via gastrostomy tube (g-tube), when physician orders were not obtained for enteral nutrition needs, no assessment was completed for nutritional requirements and no documented evidence of this resident being provided sufficient enteral nutrition for five days, from 01/05/23 to 01/10/23. Consequently, Resident #70 suffered an acute change in condition and was sent by emergency squad to the hospital. The resident was admitted to the hospital in critical care for acute hypernatremia (elevated sodium) with dehydration, acute hypoxic (low oxygen levels) respiratory failure and acute metabolic encephalopathy multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia (loss of body weight, muscle mass and weakness), and acute mucositis (inflammation of the mouth). This affected one (#70) of six residents reviewed for nutrition and hydration needs. Additionally, the facility failed to ensure two (#21 and #23) of six residents reviewed were receiving the care and treatment to meet their hydration and nutritional needs that placed the residents at risk for potential for more than minimal harm that is not Immediate Jeopardy. The facility identified a total of five (#07, #09, #21, #23 and #37) residents currently receiving enteral nutrition. The facility census was 64. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/09/23 at 3:19 P.M., Corporate Administrator #903, the facility Administrator, Director of Nursing (DON), Regional Director of Clinicals (RDC) #701, and Chief Nursing Officer (CNO) of Clinical Services #802, were notified Immediate Jeopardy began on 01/05/23 when staff failed to assess a newly admitted resident (#70) for nutrition and hydration, who required enteral tube feeding for nutrition, failed to obtain dietary orders, failed to provide sufficient enteral nutrition for five days, failed to provide sufficient fluids to prevent dehydration, failed to facilitate interdisciplinary communication between the Doctor, RD #106, and direct care staff regarding Resident #70's nutritional needs and failed to initiate an acute care plan with interventions to address nutritional requirements. Resident #70 was transferred to the hospital per family request on 01/10/23. Review of emergency department assessment dated [DATE], did not reference tube feeding and the preadmission medication list had no reference of a feeding tube or nutrition in the physical assessment. Review of the emergency department attending physician assessment dated [DATE], revealed Resident #70 was assessed as appearing chronically ill, cachectic (loss of body weight and muscle mass and weakness) with multiple issues that included tachycardia, hypoxia, and hyperglycemia. Resident #70 was admitted to critical care for altered mental status, hypernatremia (elevated sodium level), and hyperammonemia (elevated ammonia level). Review of the hospital admission assessment dated [DATE], referenced a gastrostomy tube and remained silent for tube feeding. Review of the hospital admitting diagnoses included: acute hypernatremia with dehydration, acute hypoxic respiratory failure and acute metabolic encephalopathy, multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia, and acute mucositis (inflammation of the mouth). The Immediate Jeopardy was removed on 02/14/22 when the facility implemented the following corrective actions: On 01/10/23, Resident #70 was transferred out of the facility to the hospital. On 01/12/23, a facility-wide audit was completed to ensure accuracy of residents receiving tube feed orders were documented in the residents ' medical records. On 01/12/23, CNO #802 of Clinical Services and RDC #701 reviewed the policies and procedures related to enteral nutrition and documentation. There were no revisions made to the policy and procedures. Beginning on 01/12/23, the DON began weekly audits of medical record of physician orders for diet orders and will continue until 03/09/23 and randomly after. On 02/09/23, the consulting Nurse Practitioner (NP) #105 was made aware by RDC #701 verbally, of the Immediate Jeopardy citations and the systemic actions that were starting to be implemented. On 02/09/23, the DON added Intake and Output orders on resident's medical records who receive enteral nutritional orders. On 02/10/23, the interdisciplinary team (IDT) with the Registered Dietitian (RD) #106 reviewed all residents for nutritional and hydration (at risk) status. All care plans were validated as being current and correct. On 02/10/23, the IDT, the DON and the RD #106 reviewed all residents ' diets to validate all residents have current diet orders and are correctly listed on the medical record. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/10/23, the Administrator and DON provided the agency nurse who admitted and took care of Resident#70 with a do not return to the clip board agency human resource (HR) director. On 02/10/23, a Root Cause Analysis using a Fishbone diagram was completed to review the alleged deficiency. This was completed by CNO #802 of Clinical Services and RDC #701 with other members of the Quality Assurance Performance Improvement (QAPI) Team. Beginning on 02/10/23, all licensed nursing staff will be in-serviced on the policies and procedures related to enteral nutrition and documentation. In addition, the policies for notice for change in condition to the physician and implementing admission orders upon admit was also addressed. This was provided by the DON. Beginning on 02/10/23, the DON will discuss and review all changes in condition of residents with the RD #106 during weekly Quality of Life meeting, that is an IDT meeting currently taking place. Beginning on 02/10/23, the facility will discuss results of the audits during a weekly Ad-Hoc QAPI meeting for the next four (4) weeks to ensure compliance. On 02/13/23 and 02/14/23, random staff interviews with Registered Nurse (RN) #107, Licensed Practical Nurses (LPNs) #114, #115, #116 and #117, and State tested Nurse Aide (STNA) #112 were completed to verify in-service on enteral nutrition, documentation and change in condition had been completed and staff were able to verbalize the education. On 02/14/23, review of in-service records revealed all facility staff had received education on the on enteral nutrition, documentation and change in condition. Beginning on 02/14/23, an agency binder for all licensed nursing staff was placed on both units with phone numbers to call for admission orders and change in condition and all education for current survey(s). The daily schedule will have a notice for agency staff to see Agency Binder. The binder will be reviewed daily at staffing meeting per Administrator, the DON and HR director for completion. On 02/14/23, review of the daily schedule revealed a statement for the agency staff to review the agency education binder on the enteral nutrition and documentation, and change in condition. On 02/14/23, random interviews with agency STNAs (#118, #120 and #121) revealed they had reviewed the agency binder and they were able to verbalize the facility's education. On 02/14/23, review of the agency binder sign in sheet revealed agency staff had been reviewing the binder and acknowledging the facility corrective action. Although the Immediate Jeopardy was removed on 02/14/22, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1) Review of the closed medical record for Resident #70 revealed an admitted [DATE]. Admitting diagnoses for Resident #70 included hemiplegia, hemiparesis and aphasia following a cerebral infarct (stroke) April 2022, severe protein calorie malnutrition, vascular dementia, chronic obstructive pulmonary disease, traumatic brain injury, epilepsy, hypertension, hypothyroidism, and osteoarthritis. Resident #70 had three wounds: one Stage II to the right hip and two unstageable wounds to the left hip and left heel. Resident #70 was discharged on [DATE] to the hospital. Review of the hospital inpatient record dated 12/28/22 revealed Resident #70 had a diagnoses of severe protein calorie malnutrition and had received enteral nutrition for a continuous feed for 23 hours a day with 150 milliliters (ml) water flushes every 4 hours, with intake of 2100 (ml) the previous 24 hours. Review of the hospital discharge summary with a print date of 01/04/23 at 3:16 P.M., from the acute hospital, revealed under the area Nursing/Mobility and Activities of Daily Living revealed a subcategory of feeding: medication delivery g-tube. Under the area of Nutrition Therapy revealed a subcategory of Current Nutrition Therapy: oral diet: general; subcategory of Routes of Feeding: g-tube and subcategory of Liquids: no restrictions. The last weight documented as obtained on 01/02/23, was 116 pounds 13.5 ounces (53 kilograms), with a height of five foot ten inches and a body mass index of 16.77. Resident #70's prognosis at discharge was listed as fair; condition at discharge was listed as stable and rehabilitation potential as fair. Review of the admission physician orders dated 01/05/23, revealed the resident was ordered to admit to SNF (skilled nursing facility and for long-term care and skilled care), DNRCC-A (Do Not Resuscitate Comfort Care -Arrest) code status, verbal order for I approve the plan of care and discharge, may crush meds (medications) as appropriate, may crush meds or open capsules and mix with food if not contraindicated, may have annual flu vaccine, may substitute generics unless otherwise indicated, may use OTC (over the counter) meds from house supply, may use liberal medication administration times, Tiotropium Bromide Monohydrate capsule 18 micrograms (mcg), one inhalant each morning and at bedtime, pain evaluation every shift for monitoring of patient's pain level, POC (point of care) testing PRN (as needed) per regulation until further notice, physical therapy two to five times a week and prescriber written order for overall plan of care approved. There were no orders to address the nutritional status. Review of diet order changes and communication form dated 01/05/23 revealed Resident #70 was a new admit with a diet order of NPO (nothing by mouth). Review of the admission assessment dated [DATE], and started 01/06/23, revealed the nutrition section listed the resident as NPO or un supplemented clear liquid (without enteral total parental nutrition support) for greater than forty-eight hours. Further review of the medical record revealed there was no evidence of a nutrition assessment, or the resident being evaluated by the dietitian. Review of the care plan initiated on 01/05/23, revealed no interventions to address the type or method of enteral nutrition provided. The facility revised the resident's care plan on 01/10/23 (date of discharge) to include encouraged good nutrition and hydration to promote healthy skin due to Resident #70 identified with the potential and actual skin impairments and due to the risk for pain staff were to monitor, record and report to the nurse loss of appetite, refusal to eat and weight loss. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of additional physician orders dated 01/06/23, revealed Resident #70 was ordered occupational therapy two to five times a week for 30 days. There were no orders to address the nutritional status. Review of physician orders dated 01/07/23, revealed the resident was ordered oxygen at two liters minute to keep oxygen saturation above 90 percent, Aspirin 81 milligrams (mg) once daily administered per gastrostomy tube (g-tube), Carbidopa-Levodopa 25-100 mg tablet twice a day administered per g-tube, Clopidogrel Bisulfate 75 mg twice daily administered per g-tube, Ferrous Sulfate Liquid 5.4 milliliters (ml) via g-tube once a day, Pantoprazole Sodium, delayed release 40 mg once daily via g-tube, Quetiapine Fumarate 25 mg once daily via g-tube, Lacosamide Solution (10 mg per ml) with 20 ml administered per g-tube once daily. There were no orders to address the nutritional status for Resident #70. Review of the history and physical dated 01/07/23, revealed Resident #70 was admitted from the hospital after being found down and suffering a laceration to the left side of head and was diagnosed with a heart attack. Past medical history of chronic obstructive pulmonary disease, dementia, cardiovascular accident, falls, hypothyroid, hyperlipidemia, osteoarthritis seizure disorder and trans ischemic attack, and a developmental delay related to traumatic brain injury. Surgical history revealed a right carotid stent and a left aneurysm clipping. Social history stated resident was single, had a history of smoking, alcohol, and marijuana use. Advance directive was reviewed and indicated, do not resuscitate, if arrest. Allergies to codeine and Keppra. There was no documentation to address the g-tube or nutritional needs of the resident. This was completed by Nurse Practitioner (NP) #105. Additional review of physician orders dated 01/08/23, included Midodrine Hydrochloride 5 mg, three times a day administered via g-tube and an order to flush enteral tube with 150 ml of water every four hours. There were no orders to address the nutritional status. Review of physician orders dated 01/09/23, included a diet order for nothing by mouth (NPO), speech therapy evaluation and treatment one to three times a week for thirty days. Review of the January 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #70 revealed medications administered via g-tube were documented as given per orders. Water flushes of the g-tube tube for 150 ml were documented as being completed beginning on 01/08/23 at 12:00 P.M., 4:00 P.M. and 8:00 P.M., on 01/09/23 at 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M. and on 01/10/23 at 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M. and 4:00 P.M. There was no documentation of any tube feeding being administered. Review of the speech therapy evaluation dated 01/09/23, revealed the referral was made due to feeding tube placement due to dysphagia and malnutrition. The evaluation listed the resident as NPO and with significant weight loss. Review of the progress note dated 01/09/23 at 4:55 A.M., documented this nurse was called to the resident's room, State tested Nurse Aide (STNA) stated heard something from his room and found him on the floor, with his head under the bed lying on his left side. This nurse assessed resident's vital signs, with in normal limits for resident. Blood pressure 114/80, oxygen not on, replaced oxygen, respirations 20, temperature 97.6 degrees Fahrenheit. Oxygen levels went up to 95% after 15 minutes. Assessed for injuries, with bruise noted to left scapula of red/purple color, redness starting to form over left hip, small skin tear 0.5 by 0.5 centimeters to back of right hand, with treatment initiated. Family notified and voice mail left for nurse practitioner. (continued on next page)

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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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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had total dependence for feeding and had a feeding tube. Review of Resident #70's weights in the electronic health record (EHR) and paper medical record revealed there were no weights documented as being obtained by the facility. Review of the progress notes throughout the admission for Resident #70, lacked any documented evidence for nutrition or for the resident eating. Review of the progress note dated 01/10/23 at 6:07 P.M., documented the writer noted resident with increased respirations of 42 breaths a minute. Resident not responding to brother as usual, noted lethargic, pulse oximetry 90% with oxygen via nasal cannula at 3 liters, temperature 97.8 degrees Fahrenheit, and blood pressure 100/62. Writer notified on call (physician); orders were given to send resident to emergency room . Emergency 911 was called and arrived about 5:50 P.M. Resident #70 noted with elevated blood sugar of 432. Resident #70 transferred out of facility at 6:07 P.M. Family at bedside aware of it all. Writer called hospital to give report. Review of the emergency squad run sheet dated 01/10/23, reveals no documentation of the resident having any enteral tube feeding being administered. The report documented the chief complaint was for respiratory distress lasting for three days. The level of distress was listed as severe acute respiratory distress. The injury listed was from a fall from the bed at the nursing home on 01/09/23. Review of the hospital record dated 01/10/23 revealed Resident #70 arrived at the emergency department at 6:23 P.M. Upon arrival, the resident had tachycardia (elevated heart rate) was hyperglycemic (elevated blood sugar) and hypoxic (low oxygen levels) with oxygen saturation in the 80's. Review of the emergency department laboratory test results dated 01/10/23, revealed a blood sugar of 294 (normal range 70 to 99), blood urea nitrogen was elevated at 95 (normal range 8 to 23), creatinine level was 1.19 (normal range 0.7 to 1.2) and the ammonia level was 75 (normal range 11 to 32). Review of emergency department assessment dated [DATE], did not reference tube feeding and the preadmission medication list had no reference of a feeding tube or nutrition in the physical assessment. Review of the emergency department attending physician assessment dated [DATE], revealed Resident #70 was assessed as appearing chronically ill, cachectic (loss of body weight and muscle mass and weakness) with multiple issues that included tachycardia, hypoxia, and hyperglycemia. Resident #70 was admitted to critical care for altered mental status, hypernatremia (elevated sodium level), and hyperammonemia (elevated ammonia level). Review of the hospital admission assessment dated [DATE], referenced a gastrostomy tube and remained silent for tube feeding. Review of the hospital admitting diagnoses included: acute hypernatremia with dehydration, acute hypoxic respiratory failure and acute metabolic encephalopathy, multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia, and acute mucositis (inflammation of the mouth). (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the daily staffing for nurses assigned to care for Resident #70 revealed on 01/05/23 and 01/06/23, for the 6:45 A.M. to 7:15 P.M. shift and the 6:45 P.M. to 7:15 A.M. shift, revealed agency nurses were assigned; on 01/07/23 and 01/08/23, for the 6:45 A.M. to 7:15 P.M. shift, Registered Nurse (RN) #107 was assigned and for the 6:45 P.M. to 7:15 A.M. shift, an agency nurse was assigned; on 01/09/23, for the 6:45 A. M. to 7:15 P.M. shift, LPN #109 was assigned and for the 6:45 P.M. to 7:15 A.M. shift, an agency nurse was assigned; on 01/10/23, for the 6:45 A.M. to 7:15 P.M. shift, LPN #110 was assigned and for the 6:45 P.M. to 7:15 A.M. shift, an agency nurse was assigned to the care. Interview on 02/07/23 at 7:30 A.M. with LPN #110 verified she had cared for Resident #70. LPN #110 was unable to state if the resident had a feeding tube and was unsure about tube feeding. Interview on 02/07/23 at 10:17 A.M. with Registered Dietitian (RD) #106 revealed RD #106 did not receive a call when Resident #70 was admitted to the facility and had not seen the resident. RD #106 verified she had not completed a nutritional assessment and did not order a tube feeding. When asked about the process for a new admission with a feeding tube, RD #106 stated I am to be notified to ensure a timely assessment and recommendations for those residents at high nutritional risk are made. RD #106 stated I am clueless on what happened and again stated she had not seen the resident. Interview on 02/07/23 at 11:42 A.M., with the DON verified Resident #70 did not have enteral feeding ordered, verified documentation did not exist for any type of feeding in the medical record for Resident #70, and further verified no proof existed for enteral feeding was provided. Interview on 02/07/23 at 3:19 P.M., with LPN #109 verified Resident #70 was transferred to the hospital per family request on 01/10/23. LPN #109 had only provided care to the resident on 01/10/23 and remembered providing water flushes through the g- tube; however, was unable to verify Resident #70 received tube feedings. Interview on 02/08/23 at approximately 10:20 A.M., with Resident #70's NP #105, revealed NP #105 stated she was unfamiliar with the resident and had only seen the resident once after the fall on 01/09/23. NP #105 verified no feeding was ordered for Resident #70 and further verified the history and physical review completed by herself on 01/07/23, did not address the diet or nutritional status of Resident #70. Interview on 02/08/23 at approximately 11:00 A.M., with RN #107 verified Resident #70 had a g-tube; however, RN #107 could not recall if the resident received an enteral feeding and stated, I will have to check the orders. Review of the physician orders by RN #107 verified no enteral feeding formula had been ordered for Resident #70. Interview on 02/08/23 at 4:05 P.M., with RN #108 verified she completed the nutritional section of the admission assessment. RN #108 stated she does not remember if Resident #70 had a tube feeding. Interview on 02/08/23 at 5:00 P.M., with the Administrator, the DON, and RDC #701, verified the electronic medical record for Resident #70 contained no orders for enteral tube feeding and further verified the medical record provided no evidence Resident #70 received feeding while at the facility from 01/05/23 to 01/10/23. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/13/23 at 11:47 A.M., with Fire Captain #111 revealed the run sheet for 01/10/23 for Resident #70 contained no information regarding the resident having a tube feeding and would be on there if the resident had one. Interview on 02/13/23 at 2:32 P.M., with Physician #01 revealed he was unfamiliar with Resident #70 and had only seen him once. Physician #01 stated he knew the resident had a feeding tube. Physician #01 verified the resident did not have an enteral tube feeding order in the record. Interview on 02/13/23 at 3:00 P.M., with the Administrator and RDC #701, revealed their concern related to the care of residents due to the number of agency staff used by the facility, both nurses and aides. The Administrator stated their hands are tied due to the facility staff being a union as they cannot get staff hired based on the wage offered. RDC #701 stated the agency staff just do not care and are not vested in the facility, and added it is hard to get consistent care. 2) Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including pericardial effusion, type II diabetes mellitus, severe protein-calorie malnutrition, acute respiratory failure, emphysema, hypertension, atrial fibrillation, and epilepsy. Review of the hospital continuation of care instructions printed on 12/30/22 at 3:39 P.M. revealed Resident #21 had a gastrostomy tube, was to have nothing by mouth, and received tube feedings at 45 ml per hour continuously for 20 hours and received a water flush of 200 ml every six hours. Review of the comprehensive MDS assessment dated [DATE], revealed Resident #21 had moderate cognitive impairment, required total dependence for eating and had a gastrostomy tube and received more than 51% of total calories through the feeding tube with an average fluid intake of 501 milliliters (ml) or more per day via the feeding tube. Review of the admission physician orders written on 12/31/22 revealed a nothing by mouth diet, tube feeding administered via pump at 45 ml per hour 24 hours a day. Review of the nutrition assessment completed on 01/02/23, revealed Resident #21 was severely underweight and it was recommended for the tube feeding to be increased to 75 ml per hour at 10 ml increments as tolerated and 100 ml water flushes to be administered every four hours. Review of the physician orders dated 01/02/23 revealed Resident #21 was not to receive anything by mouth, tube feeding at 45 ml per hour and advanced by 10 ml per hour as tolerated to a goal rate of 75 ml per hour, six times a day flush the feeding tube with 100 ml water. Review of the medication administration record for January 2023 revealed the first bolus of water was received by Resident #21 via the feeding tube at 5:00 P.M. on 01/02/23. Interview on 02/14/23 at 11:25 A.M. with the DON verified the recommended continuation of care order for water flushes were not followed and the DON further verified Resident #21 admitted to the facility on [DATE] and had not received the recommended water flushes per feeding tube until 01/02/23. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including nontraumatic intracerebral hemorrhage, dysphagia, acute respiratory failure, moderate protein-calorie malnutrition, seizures, hypertension, bipolar disorder, pulmonary hypertension, substance abuse, alcohol dependence, heart failure, Vitamin D deficiency, and depression. Review of the comprehensive MDS assessment dated [DATE], revealed resident had a feeding tube and received 51% or more of total calories from enteral nutrition and 501 ml or more of fluid intake per day via the feeding tube. Review of the current physician orders for February 2023 revealed Resident #23 had an order written on 02/09/23 for enteral tube nutrition at 90 ml hour for twenty hours a day from 1:00 P.M. to 9:00 A.M. per pump and record every shift the amount of enteral intake. An order dated 02/11/23 revealed the enteral feeding tube to be flushed with 65 ml of water every hour while the continuous enteral nutrition formula was running for twenty hours. Observation on 02/13/23 at 7:49 A.M. of the feeding pump for Resident #23 revealed enteral nutrition infusing at 90 ml per hour with 65 ml of water programmed to be infused every zero hours. The water flush bag was dated 02/12/23 and timed 5:50 A.M. and contained approximately 400 ml. Review of the intake for the 65 ml an hour water flush, every hour for 20 hours while the tube feeding was running, revealed an intake on 02/12/23 from 7:00 A.M. to 7:00 P.M. of 130 ml and from 7:00 P.M. to 7:00 A. M. of zero ml. Observation on 02/13/23 at 9:59 A.M. of the feeding pump for Resident #23 revealed the enteral feeding infusing at 90 ml per hour with the total volume infused at 347 ml and the water flush programmed at 65 ml every zero hours with zero volume infused. The water flush bag was observed with approximately 400 ml of fluid and was dated 02/12/23 timed 5:50 A.M. Interview on 02/13/23 at 9:59 A.M. with the DON revealed the water flush was programmed incorrectly for Resident #23 on the pump and verified the total volume for the water infused read zero. The DON further verified Resident #23 had not received water flushes as ordered for an unknown amount of time. Review of the policy and procedure titled Enteral Nutrition Therapy dated April 2018 and revised March 2022, revealed the purpose of the policy was to provide liquid nourishment through a tube inserted into the stomach and to provide hydration through a tube inserted into the stomach. Review of the policy titled, Admission Assessment and Follow Up: The Role of the Nurse, dated April 2018, revealed the policy indicated the nurse is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. The nurse is required to reconcile the list of medications from the medication history, admitting orders, the previous medication administration record (if available), and the discharge summary from the previous institution, contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings and notify other disciplines and departments of the resident's admission. The nurse is also responsible to for reporting immediate needs of the resident to the supervisor and the attending physician. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy titled, Weight Policy, revised May 2021, revealed weights will be obtained within 72 hours of admission then weekly for four weeks. If a resident experiences a significant change in weight, nursing staff will complete a re-weigh within four days. In addition, this policy denoted if a significant weight change is verified, the resident may be weighed on a weekly basis until the weight is stabilized. Review of the policy titled, Care Plan Policy, dated October 2022, revealed a baseline care plan to identify key areas such as diagnoses, medications, care needs, treatments, risks, and other areas of immediate concern will be developed with input from the resident and/or the identified resident representative and implemented within 48 hours of admission. Review of the policy titled Dietary Communication Pathway, dated February 2021 revealed in a healthcare setting such as long-term care, it is very important for the clinical team to have a clear means of communication with the Registered Dietitian. The attending can address any nutritional concerns until the registered dietitian can be present to access. Review of the undated job description for the Registered Dietitian (RD) stated the RD is responsible for the clinical nutrition documentation and medical nutrition therapy using the nutrition care process to assess each individual's nutrition status, diagnose nutrition conditions, assist in the selection of appropriate nutrition intervention, monitor and evaluate progress an provide nutrition education as needed. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record reviews, observations, staff interviews and review of the policies, the facility failed to follow written physician orders for the appropriate care of residents receiving enteral nutrition to ensure adequate nutrition, hydration and care and services to prevent complications. This affected three (#7, #9, and #37) of five residents reviewed with tube feedings. The facility census was 64. Findings included: 1. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included cerebral infarct due to an occlusion or stenosis of the right anterior cerebral artery, hemiplegia and hemiparesis, dysphagia, chronic obstructive pulmonary disease, human immunodeficiency virus, chronic viral hepatitis c, iron deficiency anemia, left above the knee ambulation, and deficiency of B group vitamins. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment and had total dependence for eating, feeding tube in place with 51 percent or more of the residents total calories coming from enteral nutrition with the average of 501 milliliters (ml) or more of fluid coming from the enteral nutrition. Review of the physician orders written on 02/09/23, revealed Resident #7 was to get nothing by mouth, enteral feed orders included Nutren 1.5 via gastrostomy tube per pump to be infused at 105 ml per hour for 20 hours, up at 6:00 P.M. and down at 2:00 P.M., the feeding bag is to be labeled with the resident name, dated and timed, for every night shift to change enteral feeding tubing and flushing syringe, keep head of bed elevate to at least 45 degrees, every day and night shift flush tube with at least five milliliters (ml) of water with each medication administration. Additional orders written on 02/09/23 included every day and night shift flush tube with at least 30 ml of water before and after each medication pass and feeding, every day and night shift flush enteral tube with 60 ml of water every one hour for 20 hours (6:00 P.M. to 9:00 A.M.) while tube feeding is running and each shift record the total intake. Review of the medication administration record for February 2023 revealed the intake shift amounts of 300 ml for nights on 02/09/23, for 02/10/23, 690 ml intake recorded for days and 550 ml for the night shift, on 02/11/23 the intake on days was 840 ml and for nights was 550 ml, on 02/12/23 the intake on days was 840 ml and 500 ml on nights, and for 02/13/23 intake on days was 1277 ml and 840 ml on nights. Review of the nutrition assessment for Resident #7 dated 02/09/23, timed at 9:20 A.M., revealed Resident #7 was underweight but has started to gain weight and the enteral feeding infusion was titrated to continue to achieve a two to four pound weight gain each week. Total enteral nutrition intake titrated to 2100 ml with total water intake at 1801 ml plus medication passes every twenty - four hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/13/23 at 7:51 A.M., revealed Resident #7 had Nutren 1.5 infusing per pump via gastrostomy tube at 105 ml per hour with the feeding pump programmed to infuse 60 ml of water every 1 hour. The enteral feeding bag and the water flush bag were silent for a resident name, date, and time. Additional observation on 02/13/23 at 10:00 A.M., revealed the enteral feeding bag and water flush bag remained silent for a resident name, date and time. Interview on 02/13/23 at 10:00 A.M., with the Director of Nursing (DON) verified the enteral feeding bag and the water flush bags are to be labeled with the resident name, and dated, and timed when hung to ensure communication between shifts and to ensure a way to verify the resident received the correct volume of enteral feeding and water. 2. Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included acute chronic respiratory failure with hypoxia, acute respiratory distress, dysphagia, hemiparesis, hemiplegia, schizophrenia, chronic obstructive pulmonary disease, major depressive, anemia, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed Resident #9 was cognitively impaired, had a total dependence for eating and had a feeding tube in place. Review of the physician orders for Resident #9 revealed the resident was not to receive anything by mouth and enteral nutrition orders written on 01/27/23 for tube feeding to be turned on at 6:00 P.M. and off at 2:00 P.M., Nutren 1.5 was to be infused per gastrotomy tube via feeding pump at 90 ml per hour with a 75 ml of water each hour for 20 hours between 6:00 P.M. and 2:00 P.M. Physician orders written on 02/08/23 for the resident to have enteral feeding residuals checked every eight hours, every shift to record intake, every day and night shift to flush the gastrostomy tube with at least 30 ml of water before each medication pass and feeding and physician orders dated 02/09/23 for every night shift to change enteral feed tubing and flushing syringe, date, time and initial. Review of the medication administration record for February 2022 revealed enteral intake of 500 ml for the night shift on 02/09/23, for 02/10/23 the intake for days was 748 ml and 700 ml for nights, on 02/11/23 the intake for days was 720 ml and 750 ml on nights, for 02/12/23, the intake for days was 720 ml and nights was 720. On 02/13/23 the intake for days was recorded as 970 ml and 720 ml for nights. Observation on 02/13/23 at 7:53 A.M., revealed Resident #9 had Nutren 1.5 infusing per pump via gastrostomy tube at 90 ml per hour with the feeding pump programmed to infuse 750 ml of water every one hour. The enteral feeding bag and the water flush bag were silent for a resident name, date, and time. Additional observation at 10:05 A.M. on 02/13/23 revealed the enteral feeding bag and water flush bag remained silent for a resident name, date and time as ordered. Interview on 02/13/23 at 10:00 A.M., with the Director of Nursing (DON) verified the enteral feeding bag and the water flush bags were not labeled with the resident's name or the date and time the bags were hung and should be per order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, moderate protein calorie malnutrition, anxiety, and major depressive. Review of the quarterly MDS assessment dated [DATE] revealed Resident #37 was impaired cognitively, had a feeding tube and received fifty one percent or more of total calories were received from enteral nutrition and 501 ml or more of fluid intake per day was via the feeding tube. Review of the physician orders for Resident #37 revealed orders written on 02/08/23 for the resident to have enteral feeding residuals checked every eight hours, every shift to record intake, every day and night shift to flush the gastrostomy tube with at least 30 ml of water before each medication pass and feeding and physician orders dated 02/09/23 for every night shift to change enteral feed tubing and flushing syringe, date, time and initial. Observation on 02/13/23 at 7:47 A.M., revealed Resident #37 had an enteral bag of nutrition with approximately 400 ml of feeding in the bag and a water flush bag with approximately 800 ml hanging on a pole with the feeding pump. Neither the enteral formula bag or the water flush bag were label with the resident name or a date and time. Interview on 02/13/23 at 10:11 A.M., with the DON verified the enteral feeding bag and the water flush bags were not labeled with the resident's name or the date and time the bags were hung and should be per order. Review of the policy and procedure titled Enteral Nutrition Therapy dated April 2018 and revised March 2022, revealed the purpose of the policy was to provide liquid nourishment through a tube inserted into the stomach and to provide hydration through a tube inserted into the stomach. Review of the policy titled Administration and Documentation of Medications, dated October 2022 revealed residents are to receive medications safely, properly, and in a timely manner according to physician order and medications shall be accurately and completely documented. The nurse is responsible for the proper administration of all medications scheduled during their shift. Review of the policy titled Documentation, dated December 2021 revealed documentation should reflect a true picture of the care and services provided and any interaction or observation made that reflects the true picture of the resident. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review and staff interview, the facility failed to ensure transportation was arranged to allow a resident to attend a schedule medical appointment. This affected one (#75) of one resident reviewed for attending scheduled appointments. The facility census was 64. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE], with a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, hyperkalemia, hypertension, type II diabetes mellitus, hypothyroidism, acute pulmonary edema, obstructive sleep apnea, paraplegia, osteoarthritis, iron deficiency anemia, and moderate protein calorie malnutrition. Review of the comprehensive Minimum Data Set assessment dated [DATE], revealed Resident #75 had intact cognition and required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. Review of the hospital discharge paperwork dated 01/14/23 and timed 10:43 A.M., revealed in the continuation of care Resident #75 was to be scheduled to the Infectious Disease doctor as soon as possible due to reoccurring urinary tract infections with Extended Spectrum Beta-Lactamase (ESBL) bacterial infections. Review of the physician order dated 01/16/23, revealed Resident #75 was to be scheduled to see Infectious Disease. Review of the undated Professional Care Visit note, revealed Resident #75 was scheduled to see Infectious Disease on 01/24/23. Review of the medical record was silent for an Infectious Disease progress note. Review of the progress notes remained silent for Resident #75 being out of the facility on 01/24/23. Interview on 02/07/23 at 1:50 P.M., with the Director of Nursing (DON) revealed the appointment with Infectious Disease was scheduled on 01/17/23 for 01/24/23, however, transportation needed to be arranged. The DON verified transportation was not arranged and further verified Resident #75 did not attend the scheduled doctors appointment. Review of the policy titled, Admission Assessment and Follow Up: The Role of the Nurse, dated April 2018, revealed the policy indicated the nurse is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. The nurse is required to reconcile the list of medications from the medication history, admitting orders, the previous medication administration record (if available), and the discharge summary from the previous institution, contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders and to contact outside services as needed. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record reviews, staff interviews, and review of the policies, the facility failed to obtain an physician ordered laboratory work. This affected two (#16 and #64) of four residents reviewed for laboratory services. The facility census was 64. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, depressions, biventricular heart failure, hypertension, acute kidney failure, thrombocytopenia and status post orthochorea bypass graft, with bypass surgery completed on 12/05/22. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition, required extensive assistance with the physical help of one for toilet use and was occasionally incontinent of urine. Review of the physician orders dated 01/11/23 revealed an order to collect urine for a urinalysis with culture and sensitivity, the order was written as every shift until urine collected. Review of the medication administration record revealed the urine for Resident #16 was signed off as obtained on 01/16/23. Review of the medical record for laboratory results remained silent for a urinalysis results for Resident #16. Interview on 02/08/23 at 11:00 A.M., with the Director of Nursing (DON) verified the medical record was silent for a urinalysis result for the 01/11/23 order. Upon further review and after a call was made to the laboratory the DON stated the urinalysis was never completed as the laboratory never received a urine sample for Resident #16. 2. Review of the medical record for Resident #64 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar, dementia with moderate behavioral disturbances, chronic obstructive pulmonary disease, type II diabetes mellitus, moderate protein-calorie malnutrition, osteoarthritis, heart failure, acute kidney failure, blindness, hypertension, peripheral vascular disease, malignant neoplasm of the ovary, ischemic cardiomyopathy, and major depressive disorder. Review of the Review of the quarterly MDS dated [DATE] revealed Resident #63 had impaired cognition, required extensive assistance with the physical help of one for bed mobility, locomotion, dressing eating, personal hygiene and was totally dependent for toilet use and required the physical assistance of two people for transfers. Review of the physician orders dated 02/03/23 revealed Resident #64 needed blood drawn for a complete blood count with differential, complete metabolic panel, valproic acid level and thyroid stimulating hormone. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record remained silent for complete blood count with differential, complete metabolic panel, valproic acid level and thyroid stimulating hormone test results. Interview on 02/07/23 at 10:25 A.M., with the Administrator verified the complete blood count with differential, complete metabolic panel, valproic acid level and thyroid stimulating hormone for Resident #64 was not obtained. The Administrator verified the laboratory tests were ordered, however, the paperwork had not been put in the laboratory book, so when the laboratory came to the facility, the resident did not have the blood drawn to completed the laboratory tests as ordered. The Administrator further verified the complete blood count with differential, complete metabolic panel, valproic acid level and thyroid stimulating hormone had no test results. Review of the policy titled Laboratory Order Processing, dated June 2018 stated it is the responsibility of the nurse to process all laboratory orders for the residents in their care. Laboratory results will be reviewed, and appropriate actions taken regarding notification of laboratory results to the physician, the resident and or resident representative as appropriate. Review of the facility policy titled Documentation Guidelines, dated December 2021 stated nursing staff will document on the assigned resident they assisted in providing care and services. This deficiency demonstrates non-compliance related to the allegations in Complaint Numbers OH00139754 and OH00139691.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review, staff interview and review of facility policy, the facility failed to notify the ordering physician of laboratory test results. This affected one (#75) of four residents records reviewed for notification of laboratory test results. The facility census was 64. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] and a discharge from the facility on 01/26/23. Diagnoses included chronic obstructive pulmonary disease, hyperkalemia, hypertension, type II diabetes mellitus, hypothyroidism, acute pulmonary edema, obstructive sleep apnea, paraplegia, osteoarthritis, iron deficiency anemia, and moderate protein calorie malnutrition. Review of physician orders dated 01/19/23 revealed laboratory tests for a lipid panel, complete blood count and a basic metabolic panel. Additional physician orders written on 01/24/23, revealed laboratory tests for a lipid panel, complete blood count, a basic metabolic panel and a glycated hemoglobin to be completed on 01/25/23. Review of the medical record for laboratory test results remained silent for results from the 01/19/23 and 01/24/23 orders. Review of the faxed copy dated 02/07/23 at 5:13 P.M., of the 01/19/23 ordered laboratory test results for the lipid panel, basic metabolic panel and the complete blood count revealed final result date of 01/22/23, timed 5:06 A.M. with a triglyceride level of 207, the reference range indicated less than 150 identified at low risk for cardiovascular disease and greater than 200 identified as high risk, a glucose level of 287 milligrams per deciliter (mg/dl) (70-100 mg/dl), a calcium of 7.6 mg/dl (8.6-10.3 mg/dl) and an anion gap of 6 millimoles per liter (mmol/L (7-20 mmol/L),a white blood count (WBC) of 3.68 microliters (ul) (4-10.6 ul), red blood cell 2.79 ul (3.8-5.0 ul), hemoglobin 8.5 grams per deciliter (g/dl) (12-15g/dl) and hematocrit of 27.7 percent (36-48 percent.) Review of the faxed copy dated 02/07/23 at 5:13 P.M., of the 01/24/23 orders laboratory test, resulted on 01/25/23 and timed 5:00 A.M. and a triglyceride level on 01/25/23 at 5:00 A.M. of 218, the reference range indicated less than 150 identified at low risk for cardiovascular disease and greater than 200 identified as high risk. The basic metabolic panel also results on 01/25/23 at 5:00 A.M. revealed a sodium of 133 mmol/L (136-145 mmol/L), glucose level of 233 milligrams per deciliter (mg/dl) (70-100 mg/dl), calcium 7.3 mg/dl (8. 6-10.3 mg/dl) and an anion gap of 6 millimoles per liter (mmol/L (7-20 mmol/L), white blood count (WBC) of 3. 17 microliters (ul) (4-10.6 ul), red blood cell 2.73 ul (3.8-5.0 ul), hemoglobin 8.3 grams per deciliter (g/dl) (12-15g/dl) and hematocrit of 27.0 percent (36-48 percent). Interview on 02/07/23 at 2:50 P.M., with the Director of Nursing revealed no test results were received by the facility. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/08/23 at 10:20 A.M., with the Nurse Practitioner (NP) #105 revealed no knowledge of the laboratory tests results from 01/22/23 or 01/25/23 and further verified the facility had not contacted her about the results. Review of the policy titled Laboratory Order Processing, dated June 2018 stated it is the responsibility of the nurse to process all laboratory orders for the residents in their care. Laboratory results will be reviewed, and appropriate actions taken regarding notification of laboratory results to the physician, the resident and or resident representative as appropriate. This deficiency demonstrates non-compliance related to the allegations in Complaint Numbers OH00139754 and OH00139691.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review, staff interview, and review of policy, the facility failed to ensure resident specific laboratory test results were available in the in the resident's medical record. This affected one (#75) of four resident reviewed for laboratory services. The facility census was 64. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] and a discharge from the facility on 01/26/23. Diagnoses included chronic obstructive pulmonary disease, hyperkalemia, hypertension, type II diabetes mellitus, hypothyroidism, acute pulmonary edema, obstructive sleep apnea, paraplegia, osteoarthritis, iron deficiency anemia, and moderate protein calorie malnutrition. Review of physician orders dated 01/19/23 revealed laboratory tests for a lipid panel, complete blood count and a basic metabolic panel. Additional physician orders written on 01/24/23, revealed laboratory tests for a lipid panel, complete blood count, a basic metabolic panel and a glycated hemoglobin to be completed on 01/25/23. Review of the medical record for laboratory test results remained silent for results from the 01/19/23 and 01/24/23 orders. Review of the faxed copy dated 02/07/23 at 5:13 P.M., of the 01/19/23 ordered laboratory test results for the lipid panel, basic metabolic panel and the complete blood count revealed final result date of 01/22/23, timed 5:06 A.M. with a triglyceride level of 207, the reference range indicated less than 150 identified at low risk for cardiovascular disease and greater than 200 identified as high risk, a glucose level of 287 milligrams per deciliter (mg/dl) (70-100 mg/dl), a calcium of 7.6 mg/dl (8.6-10.3 mg/dl) and an anion gap of 6 millimoles per liter (mmol/L (7-20 mmol/L),a white blood count (WBC) of 3.68 microliters (ul) (4-10.6 ul), red blood cell 2.79 ul (3.8-5.0 ul), hemoglobin 8.5 grams per deciliter (g/dl) (12-15g/dl) and hematocrit of 27.7 percent (36-48 percent.) Review of the faxed copy dated 02/07/23 at 5:13 P.M., of the 01/24/23 orders laboratory test, resulted on 01/25/23 and timed 5:00 A.M. and a triglyceride level on 01/25/23 at 5:00 A.M. of 218, the reference range indicated less than 150 identified at low risk for cardiovascular disease and greater than 200 identified as high risk. The basic metabolic panel also results on 01/25/23 at 5:00 A.M. revealed a sodium of 133 mmol/L (136-145 mmol/L), glucose level of 233 milligrams per deciliter (mg/dl) (70-100 mg/dl), calcium 7.3 mg/dl (8. 6-10.3 mg/dl) and an anion gap of 6 millimoles per liter (mmol/L (7-20 mmol/L), white blood count (WBC) of 3. 17 microliters (ul) (4-10.6 ul), red blood cell 2.73 ul (3.8-5.0 ul), hemoglobin 8.3 grams per deciliter (g/dl) (12-15g/dl) and hematocrit of 27.0 percent (36-48 percent). Interview on 02/07/23 at 2:50 P.M., with the Director of Nursing revealed no test results were received by the facility and further verified the medical record (paper or electronic) for Resident #75 had not contained the laboratory results for testing completed on 01/19/23 or 01/24/23. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Laboratory Order Processing, dated June 2018 stated it is the responsibility of the nurse to process all laboratory orders for the residents in their care. Laboratory results will be reviewed, and appropriate actions taken regarding notification of laboratory results to the physician, the resident and or resident representative as appropriate. Review of the policy titled Documentation Guidelines, dated December 2021 stated all relevant assessment data obtained during a procedure should be in the residents medical record. This deficiency demonstrates non-compliance related to the allegations in Complaint Numbers OH00139754 and OH00139691.

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review and physician and staff interviews, the facility failed to notify the ordering physician of chest radiology results, delaying treatment for pneumonia. This affected for one (#75) of two residents records reviewed for radiology results. The facility census was 64. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, hyperkalemia, hypertension, type II diabetes mellitus, hypothyroidism, acute pulmonary edema, obstructive sleep apnea, paraplegia, osteoarthritis, iron deficiency anemia, and moderate protein calorie malnutrition. Review of physician order dated 01/19/23 revealed a chest radiography (x-ray) had been ordered for Resident #75 due to oxygen desaturation when in bed, diminished lung sounds, inability to have a productive cough to remove mucus and bilateral lower extremity edema. Review of the physician order dated 01/21/23 revealed a repeat chest x-ray was to be completed on 01/23/23. Review of the 01/19/23 chest x-ray results revealed the x-ray was completed and the result called on 01/19/23 at 11:17 P.M. The chest x-ray impression revealed opacity in the bilateral lower lungs with small bilateral pleural effusions. Likely secondary to edema, atelectasis and or pneumonia. Review of the chest x-ray ordered on 01/21/23 was completed and signed on 01/23/23 at 9:45 A.M. and transmitted on 01/23/23 at 9:47 A.M., revealed persistent perihilar infiltrated and congestion, persistent left basilar atelectasis, and pleural effusion. Review of the medical record progress notes remained silent for physician notification of either the 01/19/23 or the 01/23/23 chest x-ray result. Interview on 02/08/23 at 10:20 A.M., with the Nurse Practitioner (NP) #105 revealed no knowledge of either of the chest x-ray results. NP #105 stated the results of the 01/23/23 chest x-ray was reviewed when Resident #75 was seen by the NP #105 on 01/24/23. NP #105 stated Ceftin 500 milligrams (mg) twice a day was ordered on 01/24/23 for pneumonia. Interview on 02/13/23 at 2:32 P.M., with the Physician #01 , revealed no knowledge of either of the chest x-ray results. This deficiency demonstrates non-compliance related to the allegations in Complaint Numbers OH00139754 and OH00139691.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 45445 Based on observations, medical record review, staff interviews, review of the Administrator job description, review of the Medical Director job description, review of previous survey results, review of facility assessment, review of Quality Assurance and Performance Improvement minutes, the facility failed to utilize resources including utilizing the facility assessment, hiring a medical director, establishing effective Quality Assurance and Performance Improvement plans, This resulted in repeated surveys of substandard quality of care in Quality of Care and Freedom from Abuse, Neglect and Exploitation. This affected 64 of 64 residents residing in the facility. The facility census was 64. Findings: 1. Record review revealed Resident #70 was neglected with serious life-threatening harm and negative health outcomes when the facility failed provide nutrition for five days, from 01/05/23 to 01/10/23. In addition, Resident #70 suffered a fall from bed with minor injuries, had changes in vital signs and continued to display an acute change in condition related to lack of nutrition and hydration from 01/05/23 to 01/10/23, when family requested the resident be sent out for lethargy. The resident was an emergent transport to the hospital on 01/10/23, where the resident was admitted to the hospital in critical care for acute hypernatremia (elevated sodium) with dehydration, acute hypoxic (low oxygen levels) respiratory failure and acute metabolic encephalopathy, multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia (loss of body weight, muscle mass and weakness), and acute mucositis (inflammation of the mouth). 2. Record review revealed Resident #70 was not assessed for nutritional needs upon admission to the facility and throughout her five day stay at the facility from 01/05/23 to 01/10/23. Resident #70 was admitted to the facility with a via gastrostomy tube (g-tube), and a diet order of nothing by mouth. Resident #70 did not receive a diet nor any nutritional intake during the five days. Resident #70 suffered an acute change in condition on 01/10/23 and was sent by emergency squad to the hospital. The resident was admitted to the hospital in critical care for acute hypernatremia (elevated sodium) with dehydration, acute hypoxic (low oxygen levels) respiratory failure and acute metabolic encephalopathy, multi-factorial due to vascular dementia, severe protein-calorie malnutrition with anorexia and cachexia (loss of body weight, muscle mass and weakness), and acute mucositis (inflammation of the mouth). Record review revealed Residents #21 and #70 revealed admission orders were not received to meet the essential needs of the residents. The facility did not perform a root cause analysis for the falls to identify patterns or trends, thus not implementing appropriate interventions to prevent further falls. 3. Record review revealed Residents #64 and #75 changes in condition had not been timely communicated to the physician to provide continuity of care and delaying any treatments. 4. Record review revealed Residents #16 and #64 did not receive timely laboratory testing as physician ordered for continuity of care and delaying any treatments. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Record review revealed the radiology results for procedures completed for Resident #75 were not received by the facility. Chest x-rays completed on 01/19/23 and 01/23/23 were not reviewed and called to the provider in a timely manner delaying care and treatment for Resident #75, who did subsequently pass on 01/26/23. 6. Record review revealed Resident #75 did not attend a schedule immediately infection control appointment as scheduled on 01/24/23 as the facility had not arrange transportation. 7. Based on observation, record review and staff interview, the facility did not implement facility initiated action plans as identified for residents (#7, #9, #21, #23, and #37) with enteral nutrition. Tube feeding and water flush bags were not labeled, dated, or timed, accurate intakes were not documented. Additionally, Resident #23 per observation on 02/13/23 at 7:49 A.M., of the feeding pump for Resident #23 revealed enteral nutrition infusing at 90 ml per hour with 65 ml of water programmed to be infused every zero hours with zero volume infused. Interview with the Director of Nursing (DON), at the time of the additional observation, revealed the water flush was programmed incorrectly for Resident #23 on the pump and verified the total volume for the water infused read zero. The DON further verified Resident #23 had not received water flushes as ordered for an unknown amount of time. 8. Review of the current outstanding surveys from 11/28/22 and 02/02/22, revealed the facility has remained out of compliance for deficiencies at Code of Federal Regulations (CFR) 483.10 Resident Rights, CFR 483. 25 Quality of Care, CFR 483.45 Pharmacy Services, CFR 483.42 Administration and CFR 483.80 Infection Control. The 02/02/22 survey resulted in Severity level three deficiencies in CFR 483.25 Quality of Care. 8. Review of Quality Assurance and Performance Improvement no medical director present for meetings dated 08/22/22, 10/27/22, 12/01/22, 12/29/22 and 02/09/23. 9. Review of the Facility Assessment, dated 02/13/23 stated standards of care and competencies necessary to provide the level and types of support and care needed for the resident population are developed by the medical director and corporation and are reviewed at a minimum annually or quarterly to ensure the highest quality of care is provided. 10. Review of the facilities job description for a Medical Director (MD) stated the MD is responsible for the implementation of resident care policies and coordination of medical care in the facility. Including but not limited to overall coordination, execution, and monitoring of physician services. The MD collaborates in the development and implementation of written policies, procedures, rules, and regulations to govern skilled nursing care and related medical care. The MD is responsible for seeing an awareness of and provisions for meeting the current clinical needs of the patients at the facility and provides oversight of attending physicians, compliance with state requirements for the physician services, actively participates in the facility's quality improvement process. Participation of MD shall include regular attendance at and reporting to the facility's quality assessment and assurance committee, participation exit conferences with any regulatory authority upon reasonable advance request and participation in appropriate facility committee projects and meeting concerning the clinical care and quality improvement that require a physician input including implementation of quality assessment and assurance recommendations concerning safety issues. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. Review of the Administrator job description revealed duties as assigned were not completed to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern long term care facilities and to ensure that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents, to ensure each resident receive care in manner and in an environment that maintains or enhances their quality of life with abridging the safety and rights of other residents and to ensure each resident received the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. Interview with Administrator on 02/13/23 at 3:00 P.M., verified the role of Administrator/Executive Director is to ensure the safety and quality of care of all residents with all areas of concern brought to the monthly quality assurance and performance improvement meetings by the individual departments for review with action plans presented and approved by the committee to ensure concerns are addressed. The Administrator stated her role is to hold individuals accountable to the action plans set forth and agreed upon. The Administrator verified she is part of developing and implementing action plans to correct deficient practice. The Administrator verified she is aware there has not been a current Medical Director to attend QAA and QAPI meetings, review policies and procedures, and oversee the operations in the facility. Additional interview on 02/22/23 at 4:48 P.M., with the Administrator revealed the Facility Assessment had been updated twice since the Administrator started on 08/30/22, once to capture the use agency staff and the second time to update resident acuity and care needs. The Administrator stated the Facility Assessment is not a tool that had been used in quality and performance improvement projects and further stated the Facility Assessment had not been reviewed with a medical director. Per interview when the Administrator was asked directly how she used the Facility Assessment, the Administrator stated she had not used the Facility Assessment. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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	02/23/2023

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 45445 Based on review of key personnel list, review of facility assessemnt, review of job description for Medical Director, review of the Quality Assurance and Performance Improvement meeting minutes physician and staff interview, the facility failed to have a medical director employed. This affected 64 of 64 residents residing in the facility. Findings include: Review of the Facility Assessment, dated 02/13/23 stated standards of care and competencies necessary to provide the level and types of support and care needed for the resident population are developed by the medical director and corporation and are reviewed at a minimum annually or quarterly to ensure the highest quality of care is provided. Updates were made to the Facility Assessment on 08/15/22, 12/29/22 and 02/09/23 by the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Committee (QAPI) committee members. The Facility Assessment was silent for a Medical Director in the facility resources needed to provide competent support and care to the resident population every day and during emergencies. Interview on 02/13/23 at 7:55 A.M., with the Administrator stated Physician #01 was the medical director for the facility. Interview on 02/13/23 at 2:32 P.M., with Physician #01 stated he is not the medical director for Point Place Healthcare and Rehabilitation Center and has not been the medical director for a long time. Physician #01 was unable to speak to the quality and performance improvement at the facility and was unaware of the facility having harm citations. Physician #01 stated the facility administration has not had any formal meetings or discussions with him regarding resident care concerns. Interview on 02/13/23 at 3:00 P.M., with the Administrator verified the facility did not currently have a Medical Director. Review of the list of key personnel provided by the facility on 02/14/23 revealed there was no medical director listed. Interview on 02/15/23 at 12:52 P.M.,with the Administrator verified the last Medical Director resigned effective 10/28/22. Review of the Quality Assurance and Performance Improvement (APIA) meetings dated 08/22/22, 10/27/22, 12/01/22, 12/29/22 and 02/09/23 revealed no medical director in attendance. Attendance sheets were silent for a medical director signature. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facilities job description for a Medical Director (MD) stated the MD is responsible for the implementation of resident care policies and coordination of medical care in the facility. Including but not limited to overall coordination, execution, and monitoring of physician services. The MD collaborates in the development and implementation of written policies, procedures, rules and regulations to govern skilled nursing care and related medical care. The MD is responsible for seeing an awareness of and provisions for meeting the current clinical needs of the patients at the facility and provides oversight of attending physicians, compliance with state requirements for the physician services, actively participates in the facility's quality improvement process. Participation of MD shall include regular attendance at and reporting to the facility's quality assessment and assurance committee, participation exit conferences with any regulatory authority upon reasonable advance request and participation in appropriate facility committee projects and meeting concerning the clinical care and quality improvement that require a physician input including implementation of quality assessment and assurance recommendations concerning safety issues. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45445 Based on review of the facility assessment, review of the Quality Assessment and Assurance Committee members, review of the Quality Assurance and Performance Improvement (QAPI) meeting minutes and attendance records, review of the Medical Director job description, review of the list of key personnel, interview with physician and interview with Administrator, the facility failed to have the minimal required members to conduct effective Quality Assessment and Assurance (QAA) meetings. This affected 64 of 64 residents residing in the facility. Findings included: Review of the Facility Assessment, dated 02/13/23 stated standards of care and competencies necessary to provide the level and types of support and care needed for the resident population are developed by the medical director and corporation and are reviewed at a minimum annually or quarterly to ensure the highest quality of care is provided. Updates were made to the Facility Assessment on 08/15/22, 12/29/22 and 02/09/23 by the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Committee (QAPI) committee members. The Facility Assessment was silent for a Medical Director in the facility resources needed to provide competent support and care to the resident population every day and during emergencies. Review of the facilities job description for a Medical Director (MD) stated the MD is responsible for the implementation of resident care policies and coordination of medical care in the facility. Including but not limited to overall coordination, execution, and monitoring of physician services. The MD collaborates in the development and implementation of written policies, procedures, rules, and regulations to govern skilled nursing care and related medical care. The MD is responsible for seeing an awareness of and provisions for meeting the current clinical needs of the patients at the facility and provides oversight of attending physicians, compliance with state requirements for the physician services, actively participates in the facility's quality improvement process. Participation of MD shall include regular attendance at and reporting to the facility's quality assessment and assurance committee, participation exit conferences with any regulatory authority upon reasonable advance request and participation in appropriate facility committee projects and meeting concerning the clinical care and quality improvement that require a physician input including implementation of quality assessment and assurance recommendations concerning safety issues. Review of the list of key personnel provided by the facility on 02/14/23 revealed no Medical Director. Review of the Quality Assurance committee members was silent for a Medical Director. Review of the Quality Assurance and Performance Improvement (QAPI) meetings minutes dated 08/22/22, 10/27/22, 12/01/22, 12/29/22 and 02/09/23 revealed no medical director in attendance. Attendance sheets were silent for a medical director signature. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/13/23 at 2:32 P.M., with Physician #01 stated he is not the medical director for Point Place Healthcare and Rehabilitation Center and has not been the medical director for a long time. Physician #01 was unable to speak to the quality and performance improvement at the facility and was unaware of the facility having harm citations. Physician #01 stated the facility administration has not had any formal meetings or discussions with him regarding resident care concerns. Interview on 02/13/23 at 3:00 P.M., with the Administrator verified a medical director has not attended quality assurance and performance improvement (QAPI) meetings since June 2022 and further verified other than the individuals present at the QAPI meetings there had not been any consulting or collaboration specific to the history of harm citations. The Administrator stated Nurse Practitioner #105 attended the QAPI meeting on 02/09/23 and was notified of the current survey harm citations. Interview on 02/15/23 at 12:52 P.M., with the Administrator verified the last Medical Director resigned effective 10/28/22 and further verified the Medical Director was not in attendance for the 08/22/22 and 10/27/22 QAPI meetings. This deficiency demonstrates non-compliance related to the allegations in Master Complaint OH00139917, and Complaint Numbers OH00139754 and OH00139691.