STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365886	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOLEDO HEALTHCARE	**2051 COLLINGWOOD BLVD TOLEDO, OH 43620**

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure incontinent residents received appropriate and timely incontinence care. This deficient practice affected two (#1 and #2) of three residents reviewed for the provision of incontinence care. The facility census was 93. Findings include: 1. Review of Resident #1's medical record revealed admission date of [DATE], with the [DIAGNOSES REDACTED]. Review of the most current Minimum Data Set assessment ((MDS) dated [DATE], the resident is identified with severely impaired cognition, dependent on staff for the completion of activities of daily living, and always incontinent of bowel and bladder. On 12/31/18, a nursing plan of care was developed to address incontinence. Interventions included assess for abdominal distention as needed (prn), medications as ordered, monitor for skin redness and irritation, and provide incontinent care as needed. Review of the individual resident care plan (utilized by state tested nurse aide) dated 10/19 indicated the resident was incontinent of bowel and bladder. No frequency was listed on the plan related to incontinence monitoring. Observation on 03/04/20 at 7:31 A.M., revealed the resident in a wheelchair in the unit dining room. At 9:00 A.M., the resident remained in the dining room. At 9:45 A.M., the resident was taken to a therapy session and returned to the unit at 11:07 A.M. At 11:07 A.M., the resident was propelled by state tested nurse aide (STNA) #300 to the dining room table. At 12:40 P.M., the resident remained at the dining room table. Observation on 03/04/20 at 12:52 P.M., revealed with STNA #300 during incontinence care discovered the resident to be heavily soiled of urine. Further observation noted the resident to have soiled through a brief liner and adult brief. Interview on 03/04/20 at 12:59 P.M., with STNA #300 revealed she was unaware of the resident's incontinence frequency and did not check the resident for incontinence since surveyor observation at 7:31 A.M. 2. Review of Resident #2's medical record revealed an admission date of [DATE], with the [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE], the resident is identified with moderate cognitive impairment, dependent on staff for the completion of activities of daily living, requires extensive assistance of two staff for transfer, utilizes a wheelchair for mobility, and incontinent of bowel and bladder. Review of the care plan initiated on 01/22/19 related to the residents alteration in elimination with no control present with bowel and bladder. Interventions included, resident will be clean dry and odor free, resident will have bowel movement every 1-3 days, monitor for skin redness and irritation, provide incontinent care as needed, note type, color and amount of stool, and provide hydration as prescribed. Review of the individual resident care plan (utilized by state tested nurse aide) dated 10/19 indicated the resident was incontinent of bowel and bladder. No frequency was listed on the plan related to incontinence monitoring. Surveyor observation on 03/04/20 at 7:38 A.M., noted the resident sitting in a wheelchair in the unit dinning room dressed and groomed. At 9:02 A.M., the resident remained in the dining room sitting at the table. At 9:35 A.M., the resident was propelled into the smoking lounge by staff. At 10:00 A.M., the resident was propelled off the unit in the wheelchair. At 11:37 A.M., the resident was returned to the unit and sat at the dining room table. At 12:15 P.M., the resident remained at the dining room table. Observations at 1:03 P.M., revealed the resident was taken to her room by STNA #301. The resident was observed to be incontinent of bowel per an adult brief. Interview with STNA #301 following the observation revealed Resident #2 is not checked. The resident will tell staff when she needs to use the restroom. At the time of the observation STNA #301 confirmed the resident was incontinent of bowel movement and no urine. This deficiency substantiates Complaint Number OH 325.
F 0776 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure a physician ordered diagnostic test (X-ray) of the hip was completed timely after a fall and the physician was notified of the delay. This deficient practice affected one (#3) of three residents reviewed for falls. The facility census was 93. Findings include: Review of Resident #3's medical record revealed an admitted [DATE], with the [DIAGNOSES REDACTED]. Review of the most current Minimum Data Set (MDS) assessment dated [DATE], indicated the resident is identified with moderately impaired cognition, totally dependent on staff for the completion of activities of daily living including wheelchair mobility. The assessment further records the resident as incontinent of bowel and bladder. Review of a fall assessment dated [DATE], revealed the assessment was completed due to 1-2 falls the previous six months and scored the resident at moderate risk of falling. The assessment also noted the resident's primary mode of mobility with the use of an assisstive device such as a cane or walker by utilizing short discontinuous steps and/or shuffling steps. Review of nurses notes revealed on 01/17/20 at 9:00 P.M., Resident #3 was observed on the floor in the bathroom laying on his right side. Interview with the resident at this time, reported he was self transferring off the toilet, when he lost his balance and slipped to the floor. The resident denied striking his head. However, the resident complained of discomfort to the right shoulder and right leg associated with fall. The nurses note also documented the resident had not used the call light for assistance, the resident was in proper footwear, and no noted water on floor at time of incident. Neurological checks were initiated per policy and the physician ordered X- rays to the right shoulder, right arm, right hip and right leg. The nurse administered [MEDICATION NAME] 650 milligrams (mg) for pain. No further documentation is contained in the medical record until nurses notes on 01/18/20 at 10:22 A.M., when the nurse documents the Resident in bed and still having pain from incident. The resident's pain level was assessed at 7 (scale 1-10). The resident was administered [MEDICATION NAME] 650 mg and the facility was awaiting the portable x-ray company to arrive. No notification to the physician was documented regarding the delay in obtaining the X-ray. At 2:21 P.M., the resident was still awaiting X-ray services. The nurse contacted the X-ray company at 12:00 P.M. and was informed X-ray technician would not arrive for another three hours. The nurse documented a private ambulance company was then was contacted for possible transport to the hospital. The nurse was informed by the private ambulance company they would not have available for transport before the X-ray services would arrive. The resident was administered 650 mg of [MEDICATION NAME] at 1:00 P.M. for pain. The record is silent to the physician being notified of the delay in receiving diagnostic testing. Review of X-ray results dated 01/18/20 at 5:00 P.M., identified an acute intertrochanteric femoral fracture with mild displacement. According to nurses notes on 01/18/20 at 5:50 P.M., the X-ray company completed the test and results indicated a fracture to the right hip. The resident was then transported to the hospital via private ambulance which resulted in a 20 hour and 50 minutes delay before Resident #3 was provided treatment for [REDACTED]. Review of a nurse's note dated 02/10/20 at 12:20 P.M., documented the resident was readmitted to the facility. Physician orders [REDACTED]. On 02/13/20, therapy recommendations included the use of a specialized tilt in space wheelchair for positioning. No further

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0776 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) falls were noted in the medical record. Interview on 03/04/20 at 2:45 P.M., with the Director of Nursing during a review of the medical record confirmed no documentation was provided to the physician indicating the X-Ray testing was not obtained timely and resulted in a delay in treatment and subsequent surgical repair. This deficiency is the result of an incidental finding discovered at the time of the complaint.