STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365996	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Swan Creek	1650 Swan Creek Lane Toledo, OH 43614

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, family interview, staff interviews, and policy review, the facility failed to ensure a resident who experienced an unwitnessed fall with injury was provided timely treatment including notifying the physician of complaints of pain, inability to fully move extended leg and obtaining an x-ray. Actual harm occurred on 05/31/25, when Resident #30 experienced an unwitnessed fall from the bed with an injury. Following the incident, the resident continually complained of pain in his hip and had limited mobility with his leg. The facility did not obtain an x-ray of the hip until nine (9) days after the fall. Subsequently, Resident #30 was transferred to the hospital for surgical repair of a broken hip from the fall. This affected one (#30) of three residents reviewed for change in condition. The facility census was 28.Findings include:Review of the medical record for Resident #30 revealed an admission date of 02/24/24 and a discharge date of 06/13/25. admission diagnoses for Resident #30 included parkinsonism, malnutrition, atrial fibrillation, congestive heart failure, hypertension, type two diabetes mellitus, cardiomegaly, gastroesophageal reflux disease, benign prostatic hyperplasia, chronic pain, anxiety, depression, syncope and collapse, and history of transient ischemic attack. Resident #30 was admitted to Hospice on 12/29/24 for Parkinson's Dyskinesia.Review of the most recent quarterly Minimum Data Set (MDS) Assessment for Resident #30, dated 05/16/25, revealed a Brief Interview of Mental Status (BIMS) Score of 00, indicating Resident #30 had severely impaired cognition. Further review of the MDS Assessment revealed Resident #30 required substantial to maximum assistance for all functional abilities. Review of the Facility Fall Investigation for Resident #30 revealed he experienced an unwitnessed fall on 05/31/25 at 9:30 P.M. The facility investigation revealed the nurse heard a loud thud and went into Resident #30's room and observed the resident to be lying on the floor on his right side. ROM (range of motion) was performed and the resident (#30) complained of right hip pain. Morphine was given for pain, and hospice was notified and the hospice nurse stated she was going to contact the hospice NP (nurse practitioner) for further treatment. The facility investigation concluded Resident #30 attempted to get up, unassisted, and fell to the floor. Review of the hospice visit note dated 05/31/25 revealed Resident #30 had sustained an unwitnessed fall and was complaining of right hip pain. The hospice progress notes stated it was difficult to assess for leg length discrepancy as Resident #30 was either unwilling or unable to fully straighten his right leg. Review of the facility progress note dated 06/01/25 at 3:35 A.M. revealed Resident #30 stated he was in pain and Morphine was given. No other injuries were noted from previous fall. Review of the hospice visit note dated 06/01/25 revealed Resident #30 reports pain in right hip and it was difficult to assess for leg length discrepancy as Resident #30 was either unwilling or unable to fully straighten his right leg. The hospice progress note indicated Resident #30 had a slight grimace while his right leg was examined. The hospice nurse consulted the hospice physician who decided against sending Resident #30 to the emergency room (ER) on 06/01/25. Resident #30 continued to complain of right hip pain and requested a Lidocaine patch to his right hip. Hospice NP #202 declined ordering an x-ray at this time and a new order was placed for 4% Lidocaine topical patch to the right hip for five days. Review of the facility progress note dated 06/01/25 at 9:56 P.M. revealed Resident #30 received a new order for Lidocaine patch 4% to be applied to right hip x 5 days d/t (due to) fall. Resident #30's POA (power of attorney) aware.Review of the hospice visit note dated 06/02/25 revealed Resident #30 continued to report right hip pain.Review of the facility progress note dated 06/02/25 at 1:45 P.M. revealed Resident #30 stated he could not stand up. Review of the facility progress note dated 06/03/25 at 12:59 P.M. revealed Resident #30 complained of pain on his right side where he fell. Review of the hospice visit note dated 06/05/25 revealed Resident #30 was lying in bed with his right leg bent and when asked to straighten his leg, he tried but was unable to straighten it. The hospice nurse contacted NP #202, and an x-ray was ordered of Resident #30's right hip. Review of the facility progress note dated 06/05/25 at 9:15 P.M. revealed Resident #30 received a new order for an x-ray of the right hip/pelvis and lower spine. Review of the facility progress note dated 06/09/25 at 9:00 A.M. revealed the facility called the external imaging provider regarding the x-ray that was ordered on 06/05/25 and they stated Resident #30 was combative and refused the x-ray. Review of the facility progress note dated 06/09/25 at 9:01 A.M. revealed a STAT (urgent or rushed) x-ray was ordered for Resident #30. Review of the hospice visit note dated 06/09/25 revealed Resident #30 continued to have complaints of right hip pain.Review of the hospice progress notes dated 06/09/25 revealed the x-ray results dated 06/09/25 for Resident #30 revealed he had a mild displaced comminuted intertrochanteric fracture of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, family interview, staff interview, rand review of policy, the facility failed to provide interventions to prevent the development of a pressure ulcer. This affected one (#31) of three residents reviewed for pressure ulcers. The facility census was 28.Findings include: Review of the medical record for the Resident #31 revealed an admission date of 05/13/25 with diagnoses including aftercare following joint replacement surgery, unilateral primary osteoarthritis-left hip, unspecified fall, generalized muscle weakness, need for assistance with personal care, cognitive communication deficit, dementia, hypotension, pain due to internal orthopedic prosthetic devices, other specified personal risk factors, presence of left artificial hip joint, stage three chronic kidney disease, colostomy, malignant neoplasm, unspecified vitamin deficiency, anxiety, other specified depressive episodes, overactive bladder, and personal history of irradiation. The resident was discharged on 06/15/25.Review of Resident #31's physician order dated 05/13/25 revealed skin/oral check every week, to be completed every Tuesday between 6:00 A.M. through 2:00 P.M. Review of the medical record revealed weekly skin checks were completed for Resident #31 as ordered.Review of the admission Minimum Data Set (MDS) Assessment, dated 05/18/25, revealed a Brief Interview of Mental Status (BIMS) Score of 07, indicating Resident #31 had severely impaired cognition. Review of the MDS Assessment revealed Resident #31 required substantial to maximal assistance with all functional abilities.Review of Resident #31's care plan, dated 05/19/25 revealed Resident #31 is at risk for pressure ulcers due to moisture/mobility with a goal of intact skin without evidence of redness, irritation, maceration, or open areas and an intervention of elevating heels off bed or use heel protectors. Review of Resident #31's physician order dated 05/28/25 through 06/15/25 revealed an order to offload bilateral heels and apply skin prep to heels daily between 10:00 P.M. through 6:00 A.M. Review of the medical record revealed this order was completed for Resident #31 as ordered. Review of the skin assessments for Resident #31 dated 05/13/25, 05/19/25, 05/26/25, 06/03/25, and 06/10/25 revealed the resident's Braden risk assessment score for skin breakdown was 15-18, indicating Resident #31 was at risk for skin breakdown. Review of the weekly skin assessments dated 05/19/25, 05/26/25, 06/03/25, and 06/10/25, as well as his admission skin assessment, dated 05/13/25, revealed no areas of skin breakdown or pressure sores noted.Review of the skin assessment dated [DATE] for Resident #31 revealed the writer was notified by therapy that resident has a pressure sore on his left heel. The writer assessed and noted a deep tissue injury (DTI) on the resident's left heel. The writer cleaned the resident's heel with normal saline, patted dry and applied Hydrocolloid dressing to resident's heel. Resident #31 did moan during treatment and scheduled Oxycodone 5/325 milligrams was given and effective. The DTI pressure sore on his left heel measured 6.2 centimeters (cm) by five cm. Review of Resident #31's physician orders dated 06/14/25 revealed to offload heels bilaterally every shift, pressure relief boots to be worn while in bed and sitting in the recliner every shift, and wound care to clean left heel with NS (normal saline), pat dry, and cover with Hydrocolloid dressing every M, W, F, and PRN (Monday, Wednesday, Friday, and as needed).Interview on 08/27/25 at 7:06 A.M. with Unit Manager #131 verified Resident #31 developed a sore on his left heel that he was not admitted with. She stated that the cause of the sore on his left heel was due to his heels not being offloaded properly.Interview on 08/27/25 at 7:56 A.M. with Resident #31's family member revealed the facility called her on 06/14/25 and told her that Resident #31 had a pressure sore on the bottom of his heel.Interview on 08/27/25 at 2:34 P.M. with Unit Manager #113 and Division Manager of Quality and Compliance (DMQC) #203 revealed the offloading of Resident #31's heels was not started on admission, it was not started until 05/28/25. DMQC #203 and Unit Manager #113 stated there was nothing brought up for there to be a need to have an order to offload heels on admission. They stated that on 05/28/25 Resident #31 was changed from a Hoyer Lift (a mechanical device designed to assist caregivers in safely transferring individuals with limited mobility) to a [NAME] Steady (a sit to stand manual lift aid) and they feel the offloading of heels order was place at this time in response to this change. Unit Manager #113 and QDMC #203 verified Resident #31's pressure ulcer that was documented on 06/14/25 was facility acquired. Interview on 09/04/25 at 2:30 P.M. with the Administrator verified there was a physician order placed on 05/28/25 to offload Resident #31's heels and there was not an order to offload Resident #31's prior to 05/28/25. He also verified that there was a care plan in place that was dated 05/19/25 to offload Resident #31's heels. He stated that the MDS nurse is relatively new to her role and put the care plan in preventatively on 05/19/25. He stated that the facility has educated her that when a

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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 interventions were implemented timely to address incontinence. This affected one (#11) of four residents reviewed for timely care and treatment in a facility census of 29. Findings include:Review of the medical record revealed Resident #11 admitted to the facility on [DATE] with the diagnoses including, left humerus fracture, history of fall, rhabdomyolysis, muscle weakness, unspecified kidney injury, urinary tract infection, cerebral infarction, aphasia, coronary artery disease, atrial fibrillation, and congestive heart failure. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was assessed with severe cognitive impairment, was dependent on staff for the provision of activities of daily living (ADLs), and was incontinent of bowel and bladder.Review of a nursing plan of care dated 07/16/25 revealed a focus area to address Resident #11's bladder incontinence related to requiring assistance with toileting, transfers, and hygiene. Interventions included to provide staff assistance for toileting task, apply a moisture barrier to the skin, and provide incontinence care after each incontinent episode. Observation on 09/23/25 at 10:44 A.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) # 300 discovered Resident #11 in bed. LPN UM #300 removed Resident #11 top sheet and noted Resident #11 to be heavily soiled with urine and a moderate amount of stool. A pervasive urinary odor was also detected. Interview with LPN UM #300 at the time of the observation confirmed the odor and Resident #11's urinary and bowel incontinence soaking through an adult brief and a Chux (a disposable and absorbent incontinence underpad) pad, and onto the resident's bed linen. LPN UM #300 stated the resident would require a complete bed change and bed bath. LPN UM #300 verified Resident #11 appeared to have been left incontinent for an extensive time. On 09/23/25 at 10:48 A.M. interview with Certified Nurse Aide (CNA) #200 stated Resident #11 was last checked for incontinence at 7:30 A.M. and at that time Resident #11 refused to get out of bed. CNA #200 stated she did not inform the assigned nurse (LPN #301) of the resident's refusal. CNA #200 went on to verify Resident #11 had not been checked for incontinence or re-approached for care since 7:30 A.M. CNA #200 verified Resident #11 was heavily soiled with urine and stool. On 09/23/25 at 10:54 A.M. interview with LPN #301 revealed the nurse was unaware Resident #11 would not allow CNA #200 to check or change her for incontinence since 7:30 A.M.Review of the facility incontinence briefs and pad handling, long-term care guideline, reviewed 11/18/24, revealed to help prevent pressure injuries, nursing staff members should minimize folds and wrinkles when applying incontinence product, regularly check for wetness, change product frequently, and inspect the residents skin when changing the product. Nursing staff should promptly report any changes in the residents skin integrity. Staff should explain the procedure to the resident and family (if appropriate) according to their individual communication and learning needs to increase their understanding, allay their fears, and enhance cooperation. Include the importance of checking the briefs or pad frequently (at least every two hours) and changing it when it is soiled to prevent skin breakdown.