

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Concord Care Center of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 3121 Glanzman Rd 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)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on staff interview, record review, and review of the facility policy, the facility failed to obtain written authorizations by the resident or resident representative to open a Resident Trust account. This affected three (#3, #37 and #74) of ten residents reviewed for Resident Trust accounts. The facility census was 80.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #3 revealed an admitted [DATE].</p> <p>Review of the quarterly statement documentation, Resident #3 had an established trust account with transactions dating between 01/01/24 and 03/31/24. The current balance was \$0.34.</p> <p>No written authorization was provided stating Resident #3 authorized the facility to manage a resident trust account.</p> <p>Interview on 04/24/24 at 2:00 P.M. with Business Office Manager (BOM) #300 confirmed no written authorizations were available showing Resident #3 authorized the facility to manage a resident trust account.</p> <p>2. Review of the medical record for Resident #37 revealed an admitted [DATE].</p> <p>Review of the quarterly statement documentation, Resident #37 had an established trust account with transactions dating between 01/10/24 and 03/31/24. The current balance was \$0.36.</p> <p>No written authorization was provided stating Resident #37 authorized the facility to manage a resident trust account.</p> <p>Interview on 04/24/24 at 2:00 P.M. with Business Office Manager (BOM) #300 confirmed no written authorizations were available showing Resident #37 authorized the facility to manage a resident trust account.</p> <p>3. Review of the medical record for Resident #74 revealed an admitted [DATE].</p> <p>Review of the quarterly statement documentation, Resident #74 had an established trust account with transactions dating between 01/01/24 and 03/31/24. The current balance was \$228.72.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No written authorization was provided stating Resident #74 authorized the facility to manage a resident trust account.</p> <p>Interview on 04/24/24 at 2:00 P.M. with Business Office Manager (BOM) #300 confirmed no written authorizations were available showing Resident #74 authorized the facility to manage a resident trust account.</p> <p>Review of the admission packet revealed the facility may manage the personal funds of residents only upon written authorization of the resident or resident representative.</p> <p>Review of the facility policy titled Resident Funds Policy and Procedure, dated 2023, revealed if a resident chooses to deposit their personal funds with the facility, upon written authorization of a resident, the facility shall act as a fiduciary of the residents funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152252.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on record review and staff interview, the facility failed to ensure funds were conveyed timely upon death for one resident (#100); and failed to notify five residents (#2, #4, #30, #51, and #71) when their personal funds account balance was within two hundred dollars of the state allowed limit. This affected six (#2, #4, #30, #51, #71, and #100) of ten residents reviewed for funds conveyance and notices. The facility census was 80.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #100 revealed Resident #100 expired in the facility on [DATE].</p> <p>Review of the resident account list dated [DATE] revealed Resident #100 had ninety-three dollars and thirty-six cents in the personal funds account.</p> <p>Interview on [DATE] at 2:00 P.M. with Business Office Manager #300 verified Resident #100 had current funds in the account and the funds should have been conveyed within 30 days to social security.</p> <p>2. Review of the medical record for Resident #2 revealed an admitted [DATE].</p> <p>Review of the quarterly statement dated [DATE] revealed Resident #2 had a balance of \$1,923.88.</p> <p>Review of the resident account list dated [DATE] revealed Resident #2 had a balance of \$1,848.80.</p> <p>Review of the business office file revealed no evidence a spend down letter was issued to Resident #2, or their representative as required.</p> <p>Interview on [DATE] at 2:00 P.M. with Business Office Manager #300 verified she had no evidence of spend down notifications being sent to either Resident #2 or the resident representative.</p> <p>3. Review of the medical record for Resident #4 revealed an admitted [DATE].</p> <p>Review of the quarterly statement dated [DATE] revealed Resident #4 had a balance of \$3,286.47.</p> <p>Review of the resident account list dated [DATE] revealed Resident #4 had a balance of \$2,458.04.</p> <p>Review of the business office file revealed no evidence a spend down letter was issued to Resident #4, or their representative as required.</p> <p>Interview on [DATE] at 2:00 P.M. with Business Office Manager #300 verified she had no evidence of spend down notifications being sent to either Resident #4 or the resident representative.</p> <p>4. Review of the medical record for Resident #30 revealed an admitted [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly statement dated [DATE] revealed Resident #30 had a balance of \$2,824.59. The quarterly statement dated [DATE] revealed Resident #30 had a balance of \$3,079.44.</p> <p>Review of the resident account list dated [DATE] revealed Resident #30 had a balance of \$3,063.42.</p> <p>Review of the business office file revealed no evidence a spend down letter was issued to Resident #30, or their representative as required.</p> <p>Interview on [DATE] at 2:00 P.M. with Business Office Manager #300 verified she had no evidence of spend down notifications being sent to either Resident #30 or the resident representative.</p> <p>6. Review of the medical record for Resident #51 revealed an admitted [DATE].</p> <p>Review of the quarterly statement dated [DATE] revealed Resident #51 had a balance of \$1,988.75.</p> <p>Review of the resident account list dated [DATE] revealed Resident #51 had a balance of \$1,926.75.</p> <p>Review of the business office file revealed no evidence a spend down letter was issued to Resident #51, or their representative as required.</p> <p>Interview on [DATE] at 2:00 P.M. with Business Office Manager #300 verified she had no evidence of spend down notifications being sent to either Resident #51 or the resident representative.</p> <p>7. Review of the medical record for Resident #71 revealed an admitted [DATE].</p> <p>Review of the quarterly statement dated [DATE] revealed Resident #71 had a balance of \$3,772.96.</p> <p>Review of the resident account list dated [DATE] revealed Resident #71 had a balance of \$1,830.36.</p> <p>Review of the business office file revealed no evidence a spend down letter was issued to Resident #71, or their representative as required.</p> <p>Interview on [DATE] at 2:00 P.M. with Business Office Manager #300 verified she had no evidence of spend down notifications being sent to either Resident #71 or the resident representative.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152252.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on observation, record review, staff interview, and review of the facility policy, the facility failed to ensure medications were administered to the residents without any significant medication errors. This affected one (#77) of five residents observed for medication administration. The facility census was 80.</p> <p>Finding include:</p> <p>Review of the medical record for Resident #77 revealed an admitted [DATE], Diagnoses included type II diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had moderate cognitive impairment and received insulin injections daily.</p> <p>Review of the physician order dated 04/13/24 Resident #77 was to receive insulin Lispro (100 units per milliliter (u/ml) subcutaneously per sliding scale before meals and at bedtime.</p> <p>Observation of medication administration on 04/24/24 at 8:56 A.M. of Licensed Practical Nurse (LPN) #306 for Resident #77 revealed LPN #306 removed a vial of Novolog insulin from the top drawer of the medication administration cart. The Novolog insulin vial was dated as opened on 04/02/24 and had an expiration date of 04/26/24. LPN #306 cleansed the top of the vial with alcohol swab, also removed from the top drawer of the medication cart. LPN #306 then removed an insulin syringe from the top drawer of the medication cart, removed the orange cap, pulled the plunger back to 2, inserted the needle into the insulin vial, injected the 2 units of air into the vial, and proceeded to withdrawal two units of insulin, removed the needle from the Novolog vial, placed the orange cap back on the syringe, returned the insulin vial to the top drawer of the medication cart, removed an alcohol swab, closed the drawer, and locked the medication cart. At 8:58 A.M. LPN #306 proceeded to Resident #77 room, knocked on the door, and entered. LPN #306 asked Resident #77 where the insulin was to be administered, Resident #77 stated left arm. LPN #306 opened the alcohol swab, cleansed the left upper outer arm of Resident #77, after which the two units of Novolog insulin was administered into the left upper arm. Additional observation at the time of the insulin administration revealed Resident #77 had eaten breakfast as the plate on the tray in front of Resident #77 was empty.</p> <p>Interview on 04/24/24 at 9:00 A.M. with LPN #306 verified Resident #77 received two units of Novolog insulin and further verified the insulin should have been administered prior to Resident #77 eating. LPN #77 stated Resident #77's blood sugar was checked prior to the resident eating breakfast but she got behind and was unable to administer the insulin prior to Resident #77 eating.</p> <p>Interview on 04/24/24 at 3:30 P.M. with the Director of Nursing verified Novolog insulin is not Lispro insulin, and the Director of Nursing further verified Resident #77 has Lispro insulin ordered to be administered per sliding scale before meals and at bedtime.</p> <p>Review of the facility undated policy titled Administering Medications, revealed medications will be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required timeframe.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152519.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on record review, resident and staff interview, observations, and review of the facility policy, the facility failed to ensure medications were stored, labeled, and kept secure at all times. This affected five (#34, #44, #63, and two residents who were not identified) of five residents reviewed for medication storage. The facility census was 80.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder and bipolar disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was cognitively intact.</p> <p>Interview on 04/24/24 at 9:40 A.M. with Resident #44 verified he has entered the medication storage room number two and removed an orange medication box from the medication room for Licensed Practical Nurse (LPN) #301. Resident #44 stated he did this upon LPN #301's request due to the orange medication box being too heavy for LPN #301 to move.</p> <p>Interview on 04/24/24 at 10:00 A.M. with the Assistant Director of Nursing (ADON) #500 stated at no time should a resident be in the medication storage room, with or without a nurse.</p> <p>Interview on 04/24/24 at 3:30 P.M. with the Director of Nursing verified knowledge of Resident #44 being in the medication storage room and obtaining an orange medication box for LPN #301. The DON verified residents were not to be in the medication storage room.</p> <p>Observation of the medication storage room number two on 04/24/24 at 10:00 A.M. with ADON #500 revealed an orange medication tote inside a cupboard to the left of the room upon entering. The orange medication tote was unlocked and contained a variety of stock medications.</p> <p>Review of the undated facility policy titled Medication Storage revealed only persons authorized to prepare and administer medications shall have access to the medication room, including any keys to the medication room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Continuous observation of medication administration on 04/24/24 from 9:22 A.M. to 9:44 A.M. completed by Registered Nurse (RN) #305 revealed at 9:22 A.M., RN #305 removed two plastic medication cups from the side of the medication cart. The two medication cups were labeled with Resident #63's room number and the other cup with Resident #34's room number. RN #305 sat the two medications cups on the top of the medication cart. From 9:23 A.M. to 9:25 A.M., medications for Resident #63 were removed one at time and placed into the medication cup labeled with Resident #63's room number that sat on the top of the medication cart. The medications removed for Resident #63 were Aricept (cognition-enhancing medication) 10 milligrams (mg), lamotrigine (anticonvulsant) 25 mg, sertraline (antidepressant) 25 mg, sertraline 50 mg, and a multivitamin. The medication cup of pills for Resident #63 sat on the top of the medication cart as RN #305 started to prepare medications for Resident #34.</p> <p>Continuous observation of medication administration on 04/24/24 from 9:25 A.M. to 9:30 A.M. revealed RN #306 removed ability (antipsychotic) 5.0 mg, Lipitor (treats high cholesterol) 10 mg, Remeron (antidepressant) 15 mg, prednisone (steroid) one mg, sertraline 50 mg, Flomax (treats urinary retention) 0.5 mg, buspirone (treats anxiety) 10 mg, Norvasc (treats high blood pressure) 10 mg, Latuda (antipsychotic) 40 mg, Lopressor (treats high blood pressure) 25 mg, memantine hydrochloride extended release (treats dementia) 28 mg, Aldactone (treats high blood pressure) 25 mg and a multivitamin placed each pill in the medication cup labeled with Resident #34's room number on the top of the medication cart. At 9:30 A.M., RN #305 picked up the medication cups labeled with Resident #63's and #34's room number and placed them in a bin in the top drawer of the medication cart. Locked the medication cart and wheeled the medication cart to the doorway of Resident #63 and #34's room. At 9:34 A.M., RN #305 unlocked the medication cart, removed the cup of pills labeled Resident #63's room number and proceeded to the bedside of Resident #63, handed the resident the cup of pills along with a cup of water from Resident #63's table. At 9:36 A.M., RN #305 returned to the medication cart, removed the cup of pills labeled with Resident #34's room number and proceeded to Resident #34's bedside and handed Resident #34 the cup of pills.</p> <p>Interview on 04/24/24 at 10:50 A.M. with the Assistant Director of Nursing #500 verified medications were to be prepared and administered one resident at a time.</p> <p>3. Additional observation on 04/24/24 at 11:00 A.M. with Assistant Director of Nursing #500 of RN #305 administering medications in the dining room to two unidentified residents revealed medications were prepared as medication cups with pills inside were pulled from the top drawer of the medication cart upon RN #305 entering the dining room. Interview with the Assistant Director of Nursing #500 at the time of the observation revealed medications were prepared ahead of time and should not have been to prevent the potential for medication errors.</p> <p>Review of the facility undated policy titled Administering Medications, revealed medications will be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required timeframe.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152519.</p>