

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 01/07/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37452</p> <p>Based on observation, staff interview, medical record review, and policy review, the facility failed to administer medications as ordered to ensure a medication error rate of not greater than five (5) percent (%). A total of three medication errors were observed out of 37 opportunities for a medication error rate of 8.11%. This affected one (#60) of three residents reviewed for medication administration. The census was 78.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #60 revealed the resident was admitted on [DATE] and had diagnoses that included major depressive disorder and alcohol-induced dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #60, dated [DATE], revealed the resident had intact cognition.</p> <p>Review of physician orders dated [DATE] revealed Resident #60 was ordered dorzolamide hydrochloride two (2) % solution with instructions to instill one drop in both eyes two times daily for glaucoma and was ordered a multivitamin one tablet once daily for supplementation.</p> <p>Review of a physician order dated [DATE] revealed Resident #60 was ordered an anticonvulsant medication Lamictal 25 milligrams (mg) with instructions to give 2 tablets by mouth two times daily for mood or behaviors.</p> <p>Observation on [DATE] at 8:35 A.M. revealed Registered Nurse (RN) #20 prepared and administered 5 medications to Resident #60 which included including one multivitamin tablet and one 25 mg tablet of Lamictal in addition to other medications. During preparation, it was observed the bottle of multivitamins from which one tablet was given to Resident #60 included a manufacturer's expiration date of [DATE].</p> <p>Interview during the observation of RN #20 preparing Resident #60's medications, the nurse stated a second type of eye drop, dorzolamide hydrochloride 2% solution, should have also been administered, but the drops were unavailable. Following administration of the other medications, RN #20 reordered the dorzolamide eye drops from the pharmacy after the nurse found no indication a refill had been requested up to that point.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Throughout the medication administration observation on [DATE] between 8:20 A.M. and 8:50 A.M., a total of 37 opportunities for medications errors were observed between three (#32, #60, and #77) residents with three medication errors identified for Resident #60 resulting in a medication error rate of 8.11%.</p> <p>Interview on [DATE] at 2:40 P.M. with RN #20 confirmed the nurse administered an expired multivitamin to Resident #60. The nurse confirmed, in accordance with Resident #60's orders, two 25 mg tablets of Lamictal should have been given, but only one tablet was administered. Further, RN #20 confirmed Resident #60 did not receive the dorzolamide eye drops as ordered, because nursing staff had failed to reorder more drops.</p> <p>Review of a policy titled, Administering Medications, last revised [DATE], confirmed all medication shall be administered in accordance with orders. The policy further stated the individual administering the medication should check the label for the expiration date prior to administering the medication.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00160845.</p>		