STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365030	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Care Center of Toledo	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)
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** 49742 Based on record review and staff interview, the facility failed to ensure a physician was notiifed of a resident not receiving antipsychotic medications as ordered by the physician. This affected two (#36 and #53) of four residents reviewed for notification. The facility census was 79. Findings include: 1. Review of Resident #36's medical revealed an admitted [DATE], with diagnoses of schizophrenia, obesity, pseudobulbar affect (PBA), vitamin D deficiency, asthma, bipolar disorder, difficulty in walking, hypokalemia, constipation, and weakness. Review of Resident #36's orders revealed Clozapine (an antipsychotic medication) 100 milligrams (mg) was ordered by the physician to be administered two times a day (BID) by mouth (PO) beginning 01/15/19. Review Resident #36's electronic medication administration record (eMAR) for November 2024 revealed Resident #36 did not receive her physician-ordered dose of Clozapine 100 mg in the evening on 11/08/24, 11/09/24, or 11/10/24. Review of a progress note dated 11/15/24 at 4:24 P.M., which revealed the physician and guardian were aware that Clozapine 100 mg cannot be dispensed until a Patient Services Form (PSF) is completed. (A PSF is a form that is completed in the Clozapine Risk Evaluation and Mitigation (REMS) system to link a patient who is prescribed Clozapine with their prescribing provider to reduce the risk of occurrence or severity of an adverse event. If a resident is linked to a different prescribing provider in the REMS system, the pharmacy will not fill the prescription.) Review of the Pharmacy Manifest of Delivery, dated 11/27/24, revealed Resident #36 had 60 tablets (30-day supply) of Clozapine 100 mg delivered. Review of the eMAR for December 2024 revealed Resident #36 did not receive any of her physician-ordered doses of Clozapine 100 mg on 12/29/24, 12/30/24, and 12/31/24. Review of the eMAR for January 2025 revealed Resident #36 did not receive her ordered evening doses of Clozapine 100 mg on 01/01/25, 01/02/25, and 01/03/25. Concurrent review of the eMAR revealed Resident #36 did not receive her ordered morning doses of Clozapine 100 mg on 01/02/24 and 01/03/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed no evidence of the physician being notified of the medication not being administered per orders. Interview on 01/30/25 at 10:10 A.M., with Regional Director of Clinical Services (RDNC) #200 verified Resident #36 did not receive the missing doses of Clozapine listed above for the months of November 2024, December 2024, and January 2025. Interview on 02/05/25 at 1:00 P.M., with RDNC #200 verified there was no documentation of physician notification of Resident #53's not receiving medications as ordered. 2. Review of Resident #53's medical record revealed an admitted [DATE] with diagnoses including: cognitive social or emotional deficit following unspecified cerebrovascular disease, benign prostatic hyperplasia (BPH), vitamin D deficiency, tachycardia, morbid obesity, hypertension (HTN), pulmonary embolism, dysphagia, bipolar disorder, violent behavior, mild intellectual disabilities, other sexual dysfunction, anemia, personal history of diseases of the skin and subcutaneous tissues, personal history of COVID-19, paranoid schizophrenia, unspecified psychosis not due to a substance or known physiological condition, anxiety, and insomnia. Review of Resident #53's monthly physician orders for November, December 2024 and January 2025 revealed physician orders for Clozapine 100 mg by mouth every morning, for psychosis and Clozapine 200 mg by mouth every evening, for psychosis. Review of the eMAR for Resident #53 for November 2024 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 11/23/24 or 11/26/24. Concurrent review revealed he did not receive his physician-ordered 200 mg dose of Clozapine on 11/08/24, 11/09/24, and 11/10/24. Review of the eMAR for Resident #53 for December 2024 revealed he did not receive is physician-ordered 100 mg dose of Clozapine on 12/16/14 and 12/30/24. Concurrent review revealed he did not receive his physician-ordered 200 mg dose of Clozapine on 12/28/24, 12/29/24, and 12/30/24. Review of the eMAR for Resident #53 for January 2025 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 01/06/25 and 01/07/25. Review of the medical record revealed no evidence of the physician being notified of the medication not being administered per orders. Interview on 02/04/25 at 10:19 A.M. with RDNC #200 verified the medication was not administered per orders and there was no documentation of physician notification of Resident #53's not receiving medications as ordered.

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on record review, review of policies, review of hospital records, and staff interviews, the facility failed to ensure the mental health of a resident was met when antipsychotic medications were not administered per physician orders. This affected two (#36 and #53) of four residents reviewed for behavioral services. The facility census was 79. Findings include: 1. Review of Resident #36's medical revealed an admitted [DATE], with diagnoses of schizophrenia, obesity, pseudobulbar affect (PBA), vitamin D deficiency, asthma, bipolar disorder, difficulty in walking, hypokalemia, constipation, and weakness. Review of the most recent Quarterly Minimum Data Set (MDS) assessment, dated 10/29/24, revealed a Brief Interview of Mental Status (BIMS) Score of 15, indicating Resident #36 was cognitively intact. Review of the most recent care plan for revealed Resident #36 used psychotropic medications related to schizophrenia. The goal was for the resident to remain free of psychotropic-related drug complications. Interventions include administering psychotropic medications as ordered by the physician. a. Review of Resident #36's orders revealed Clozapine (an antipsychotic medication) 100 milligrams (mg) was ordered by the physician to be administered two times a day (BID) by mouth (PO) beginning 01/15/19. Review Resident #36's electronic medication administration record (eMAR) for November 2024 revealed Resident #36 did not receive her physician-ordered dose of Clozapine 100 mg in the evening on 11/08/24, 11/09/24, or 11/10/24. Review of the electronic medical record (EMR) revealed no documentation on why the evening doses of Clozapine 100 mg for 11/08/24, 11/09/24, and 11/10/24 for Resident #36 was not administered. Review of the EMR for Resident #36 revealed a progress note dated 11/15/24, at 4:24 P.M. which revealed the physician and guardian were aware that Clozapine 100 mg cannot be dispensed until a Patient Services Form (PSF) is completed. (A PSF is a form that is completed in the Clozapine Risk Evaluation and Mitigation (REMS) system to link a patient who is prescribed Clozapine with their prescribing provider to reduce the risk of occurrence or severity of an adverse event. If a resident is linked to a different prescribing provider in the REMS system, the pharmacy will not fill the prescription.) rems Review of the eMAR for December 2024 revealed Resident #36 did not receive any of her physician-ordered doses of Clozapine 100 mg on 12/29/24, 12/30/24, and 12/31/24. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note for Resident #36, dated 12/29/24 at 11:01 A.M., revealed Resident #36's morning dose of physician-ordered Clozapine 100 mg was not administered due to not having medication and medication will need to be ordered. Review of a progress note for Resident #36, dated 12/29/24 at 7:47 P.M., revealed Resident #36's evening dose of physician-ordered Clozapine 100 mg was not administered due to being on order. Review of a progress note for Resident #36, dated 12/30/24 at 11:08 A.M., revealed Resident #36's morning dose of physician-ordered Clozapine 100 mg was not administered due to waiting on pharmacy to fill the prescription. Review of a progress note for Resident #36, dated 12/30/24 at 8:39 P.M., revealed Resident #36's evening dose of physician ordered Clozapine 100 mg was not administered due to being on back order. Review of a progress note for Resident #36, dated 12/31/24 at 10:01 A.M., revealed Resident #36's morning dose of physician ordered Clozapine 100 mg was not administered as it had been re-ordered from the pharmacy and the facility was awaiting delivery. Review of a progress note for Resident #36, dated 12/31/24 at 7:58 P.M., revealed Resident #36's evening dose of physician ordered Clozapine 100 mg was not administered due to being on back order. Review of the eMAR for January 2025 revealed Resident #36 did not receive her ordered evening doses of Clozapine 100 mg on 01/01/25, 01/02/25, and 01/03/25. Concurrent review of the eMAR revealed Resident #36 did not receive her ordered morning doses of Clozapine 100 mg on 01/02/24 and 01/03/24. Review of a progress note for Resident #36, dated 01/01/25 at 11:49 A.M., Resident #36 is experiencing alter mental status, cannot answer what her name is or where she is. Review of the progress note for Resident #36, dated 01/01/25 at 7:36 P.M., revealed Resident #36's evening dose of physician-ordered Clozapine 100 mg was not administered due to being on back order. Review of the progress note for Resident #36, dated 01/02/25 at 1:02 P.M., revealed Resident #36's morning dose of physician-ordered Clozapine was not administered due to her having altered mental status and does not understand how to take this medication. Review of the progress note for Resident #36, dated 01/03/25 at 9:21 A.M. revealed Resident #36's morning dose of physician-ordered Clozapine 100 mg, was not administered due to not being available. Review of the progress note for Resident #36, dated 01/03/2/5 at 7:17 P.M., revealed Resident #36's evening dose of physician-ordered Clozapine 100 mg, was anticipated to be delivered to the facility on [DATE]. Review of Resident #36's EMR revealed no documentation the facility notified the physician on 01/01/25, 01/02/25 and 01/03/25, the doses of Clozapine 100 mg were not administered. b. Review of Resident #36's orders revealed Nuedexta (a medication used to treat PBA) 20-10 mg was ordered by the physician to be administered two times a day (BID) by mouth (PO) beginning on 01/15/19. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's EMR revealed no documentation the facility notified the physician on 11/08/24, 11/09/24, or 11/10/24, the doses of Nuedexta 20-10 mg were not administered. Review Resident #36's eMAR for January 2025 revealed Resident #36 did not receive her physician-ordered dose of Nuedexta 20-10 mg in the evening on 01/02/25, and she did not receive any doses of this medication on 01/08/25. The MAR does not have any documentation for the evening of 01/02/25 and there are no progress notes as to why it was not administered. On 01/08/25, the morning dose was documented in the MAR as refused and there are no progress notes as to why this dose was not administered. On 01/08/25, the MAR does not have any documentation for the evening dose and there are no progress notes as to why it was not administered. Review of Resident #36's EMR revealed no documentation the facility notified the physician on 01/01/25, or 01/08/25, the doses of Nuedexta 20-10 mg were not administered. Review of a progress note, dated 01/02/25 at 11:49 A.M., revealed Resident #36 had altered mental status and was transported to the emergency room (ER) for further evaluation. Review of a progress note, dated 01/02/25 at 10:13 P.M., revealed Resident #36 would be returning from the ER at that time. Review of the hospital discharge records for Resident #36, dated 01/02/25, revealed at 6:42 P.M., the consulting neurologist determined the cause of Resident #36's current state was her not receiving her medications at the facility. At 9:24 P.M., psychiatry evaluated Resident #36 who was showing improvement after medications were administered, and at this time she was able to speak a few words at the time. At this time, psychiatry stated Resident #36's AMS and dystonia were secondary to PBA and her not having her medications. At 9:28 P.M., Resident #36's medication dosing was reviewed with the pharmacies who recommended titrating Resident #36's Clozapine 25 mg twice a day for the first three days; then 50 mg twice a day for the next three days; then 75 mg twice a day for three days and finally back to 100 mg twice a day. Review of a progress note, dated 01/02/25 at 11:28 P.M., revealed Resident #36 returned to the facility via stretcher with a flat facial effect and stated she was glad to be home. Review of the eMAR for January 2025 revealed Clozapine administration was documented in the eMAR as follows: on 01/03/25: both doses were not available; on 01/04/25: AM dose: spit out meds, PM dose: refused; on 01/05/25: both doses were administered; on 01/06/25: AM dose: refused, PM dose: administered on 01/07/25: AM dose: administered, PM dose: refused; and on 01/08/25: AM dose: refused, PM dose: no documentation of administration. Review of progress note for Resident #36 dated 01/06/25 at 4:20 P.M., documented Resident #36 is confused and walking around, and she had never been like this before. Review of progress note, dated 01/08/25 at 5:30 P.M., revealed Resident #36 was refusing to take her medications and is currently taking off her clothes, yelling, and standing on one leg in the hall with no clothes in a statues position staring. Due to Resident #36's changing mental status, causing these behaviors, it was decided at this time to send Resident #36 to the ER again for evaluation. At 6:26 P.M., the progress notes documented transportation arrived to pick up Resident #36 to go to the ER. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of hospital discharge summary dated 01/09/25 revealed Resident #36 was admitted due to not eating or drinking, carrying for herself and appeared internally stimulated. Resident #36 was observed to be exit seeking, disrobing and non-verbal. Resident #36 has history of Catatonia. Resident #36 was seen a week ago, stabilized and discharged . It was noted Resident #36 progressively decompensated, due to non-availability of her medications for being on back order. At this time of this interview, Resident #36 presents as disorganized, irritable, notably nonverbal and uncooperative with assessment, noted that Resident #36 was nonsensical, yelling and screaming out loud at the emergency department. She was very incoherent, and noncompliance with evaluation. Resident #36 paces the hallway appears somewhat lethargic and irritable. Unable to fully assess due to Resident #36's refusal to engage. Requested medical consultation and a higher level of care to evaluate possible neurological co-mobility. Interview on 01/20/25 at 7:30 A.M., with the Regional Director of Nursing Compliance (RDNC) #200 revealed the facility has a plan for Resident #36's missing doses of Clozapine. Concurrent interview with RDNC #200 verified Resident #36 was transferred to the ER and returned to the facility on [DATE] and was again transferred to the ER [DATE]. Further interview with RDNC #200 revealed Resident #36 had not returned to the facility after her transfer to theER on [DATE]. Interview on 01/30/25 at 10:10 A.M., with RDNC #200 verified Resident #36 did not receive the missing doses of Clozapine and Nuedexta listed above for the months of November 2024, December 2024, and January 2025. Interview on 01/30/25 at 11:35 A.M., with Registered Nurse (RN) #202 revealed he worked the morning shift (6:30 A.M. - 2:30 P.M.) on 01/08/25 and verified Resident #36 was sent to the ER that day as she was walking around the halls naked and was unable to be redirected. Interview on 01/30/25 at 11:50 A.M., via telephone, with the Director of Nursing (DON) revealed that on 01/08/25 Resident #36 was not behaving at her baseline. Concurrent interview with the DON revealed Resident #36 had not returned to her baseline since 01/02/25 ER encounter. Interview on 01/30/25 at 1:07 P.M., with the Administrator revealed Resident #36 was no longer at The University of [NAME] Medical Center (UTMC) and was at an inpatient psychiatric facility in Lorain, OH. Interview on 01/30/25 at 3:04 P.M., with Physician Assistant (PA) #205 was revealed at the time of the mix-up with Resident #36's Clozapine, there was disorganization due to a new DON, Assistant DON (ADON), and psychiatry provider. Concurrent interview with PA #205 revealed he was not aware of the ER's discharge order to titrate Resident #36's Clozapine and she was started on her baseline physician-ordered dose of 100 mg twice a day. Resident #36 was still registered to the previous prescribing provider in the REMS system, so the pharmacy was unable to refill her Clozapine prescriptions that he wrote for. Interview on 02/04/25 at 3:32 P.M., with Regional Director of Clinical Operations (RDCO) #206 verified Resident #36 returned to the facility on [DATE]. RDCO #206 states she spoke to the Nurse Practitioner (NP) with the admitting group on 01/03/25 who stated she did not want to implement the titration orders from the ER for Resident #36's Clozapine. Concurrent interview with RDCO #206 revealed she spoke to PA #205 on 01/04/25 and he stated to resume Resident #36's Clozapine at 100 mg by mouth and twice and did not want to implement the ER recommendations. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/25 at 3:38 P.M., with PA #205 revealed he spoke to RDCO #206 on 01/04/25 but was not aware of the ER's discharge order to titrate Resident #36's Clozapine. 2. Review of the electronic medical record for Resident #53 revealed an admitted [DATE], with diagnoses including cognitive social or emotional deficit following unspecified cerebrovascular disease, benign prostatic hyperplasia (BPH), vitamin D deficiency, tachycardia, morbid obesity, hypertension (HTN), pulmonary embolism, dysphagia, bipolar disorder, violent behavior, mild intellectual disabilities, other sexual dysfunction, anemia, personal history of diseases of the skin and subcutaneous tissues, paranoid schizophrenia, unspecified psychosis not due to a substance or known physiological condition, anxiety, and insomnia. Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS Score of 10, indicating Resident #53's cognition was moderately impaired. Review of Resident #53's orders revealed physician orders for Clozapine 100 mg by mouth every morning, for psychosis and Clozapine 200 mg by mouth every evening, for psychosis. Review of the eMAR for Resident #53 for November 2024 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 11/23/24 or 11/26/24. Concurrent review revealed he did not receive his physician-ordered 200 mg dose of Clozapine on 11/08/24, 11/09/24, and 11/10/24. Review of a progress note for Resident #53, dated 11/26/24 at 5:22 A.M., revealed the medication (Clozapine 100 mg) was not available. Review of the eMAR for Resident #53 for December 2024 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 12/16/14 and 12/30/24. Concurrent review revealed he did not receive his physician-ordered 200 mg dose of Clozapine on 12/28/24, 12/29/24, and 12/30/24. Review of a progress note for Resident #53, dated 12/16/24 at 5:04 A.M., revealed Clozapine 100 mg has not arrived from the pharmacy. The medication was not available, and the facility was awaiting drop ship (expedited delivery) of this medication. Review of a progress note for Resident #53, dated 12/28/24 at 3:31 P.M., revealed Clozapine 200 mg was on order. Review of a progress note for Resident #53, dated 12/29/24 at 3:35 P.M., revealed Clozapine 200 mg was on order. Review of the progress note for Resident #53, dated 12/30/24 at 6:00 A.M., revealed Clozapine 100 mg was on order. Review of the progress note for Resident #53, dated 12/30/24 at 6:55 P.M., revealed Clozapine 100 mg was on order. Review of the eMAR for Resident #53 for January 2025 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 01/06/25 and 01/07/25. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's EMR revealed no documentation the facility notified the physician on 11/08/24, 11/09/24, 11/10/24, 11/23/24, 11/26/24, 12/16/24, 12/28/24, 12/29/24, 12/30/24, 01/06/25 and 101/07/25, the doses of Clozapine were not administered as ordered. Interview on 02/04/25 at 10:19 A.M., with RDNC #200 verified Resident #53's physician-ordered Clozapine 100 mg was not administered on 11/23/24, 11/26/24, 12/16/24, 12/30/24, 01/06/24, and 01/07/24. Concurrent interview with RDNC #200 verified Resident #53's physician-ordered Clozapine 200 mg was not administered on 11/08/24, 11/09/24, 11/10/24, 12/28/24, 12/29/24, and 12/30/24. Interview on 02/04/25 at 10:19 A.M., with RDNC #200 verified there was no documentation of physician notification for Resident #53's physician ordered Clozapine 100 mg on 11/23/24, 11/26/24, 12/16/24, 12/20/24, 01/06/25, and 01/07/25; and no documentation of physician notification for Resident #53's physician ordered Clozapine 200 mg on 11/08/24, 11/09/24, 11/10/24, 12/28/24, 12/29/24, and 12/30/24, were not administered. Review of the facility policy titled, Administering Medications, revised December 2012, revealed medications shall be administer in a safe and timely manner, and as prescribed. Review of the policy titled, Adverse Consequences and Medication Errors, revised February 2023, revealed the interdisciplinary team monitors medication usage. An interview on 02/05/25 at 8:29 A.M. with RDNC #200 verified there was no documentation of physician notification for Resident #36's physician-ordered Clozapine 100 mg PO BID not being administered on the evenings of 11/08/24, 11/09/24, 11/10/24, 12/29/24, 12/30/24, 12/31/24, 01/01/25, 01/02/25, 01/03/25, and the mornings of 12/29/24, 12/20/24, 12/31/24, and 01/02/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on m medical records review, review of pharmacy records, and staff interviews, the facility failed to ensure that physician-ordered medications were available and administered per physcian orders. This affected two residents (#36 and #53) of four residents reviewed for pharmaceutical services. The facility census was 79. Findings include: 1. Review of Resident #36's medical revealed an admitted [DATE], with diagnoses of schizophrenia, obesity, pseudobulbar affect (PBA), vitamin D deficiency, asthma, bipolar disorder, difficulty in walking, hypokalemia, constipation, and weakness. Review of Resident #36's orders revealed Clozapine (an antipsychotic medication) 100 milligrams (mg) was ordered by the physician to be administered two times a day (BID) by mouth (PO) beginning 01/15/19. Review of the Pharmacy Manifest of Delivery, dated 10/21/24, revealed Resident #36 had 60 tablets (30-day supply) of Clozapine 100 mg delivered. Review Resident #36's electronic medication administration record (eMAR) for November 2024 revealed Resident #36 did not receive her physician-ordered dose of Clozapine 100 mg in the evening on 11/08/24, 11/09/24, or 11/10/24. Review of a progress note dated 11/15/24 at 4:24 P.M., which revealed the physician and guardian were aware that Clozapine 100 mg cannot be dispensed until a Patient Services Form (PSF) is completed. (A PSF is a form that is completed in the Clozapine Risk Evaluation and Mitigation (REMS) system to link a patient who is prescribed Clozapine with their prescribing provider to reduce the risk of occurrence or severity of an adverse event. If a resident is linked to a different prescribing provider in the REMS system, the pharmacy will not fill the prescription.) Review of the Pharmacy Manifest of Delivery, dated 11/27/24, revealed Resident #36 had 60 tablets (30-day supply) of Clozapine 100 mg delivered. Review of the eMAR for December 2024 revealed Resident #36 did not receive any of her physician-ordered doses of Clozapine 100 mg on 12/29/24, 12/30/24, and 12/31/24. Review of a progress note for Resident #36, dated 12/29/24 at 11:01 A.M., revealed Resident #36's morning dose of physician-ordered Clozapine 100 mg was not administered due to not having medication and medication will need to be ordered. Review of a progress note for Resident #36, dated 12/29/24 at 7:47 P.M., revealed Resident #36's evening dose of physician-ordered Clozapine 100 mg was not administered due to being on order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365030	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Care Center of Toledo	3121 Glanzman Rd Toledo, OH 43614

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note for Resident #36, dated 12/30/24 at 11:08 A.M., revealed Resident #36's morning dose of physician-ordered Clozapine 100 mg was not administer due to waiting on pharmacy to fill the prescription. Review of a progress note for Resident #36, dated 12/30/24 at 8:39 P.M., revealed Resident #36's evening dose of physician ordered Clozapine 100 mg was not administered due to being on back order. Review of a progress note for Resident #36, dated 12/31/24 at 10:01 A.M., revealed Resident #36's morning dose of physician ordered Clozapine 100 mg was not administered as it had been re-ordered from the pharmacy and the facility was awaiting delivery. Review of a progress note for Resident #36, dated 12/31/24 at 7:58 P.M., revealed Resident #36's evening dose of physician ordered Clozapine 100 mg was not administered due to being on back order. Review of the eMAR for January 2025 revealed Resident #36 did not receive her ordered evening doses of Clozapine 100 mg on 01/01/25, 01/02/25, and 01/03/25. Concurrent review of the eMAR revealed Resident #36 did not receive her ordered morning doses of Clozapine 100 mg on 01/02/24 and 01/03/24. Review of the progress note for Resident #36, dated 01/01/25 at 7:36 P.M., revealed Resident #36's evening dose of physician-ordered Clozapine 100 mg was not administered due to being on back order. Review of the progress note for Resident #36, dated 01/02/25 at 1:02 P.M., revealed Resident #36's morning dose of physician-ordered Clozapine was not administered due to her having altered mental status and does not understanding how to take this medication. Review of the progress note for Resident #36, dated 01/03/25 at 9:21 A.M., revealed Resident #36's morning dose of physician-ordered Clozapine 100 mg, was not administered due to not being available. Review of the progress note for Resident #36, dated 01/03/2/5 at 7:17 P.M., revealed Resident #36's evening dose of physician-ordered Clozapine 100 mg, was anticipated to be delivered to the facility on [DATE]. Review of the Pharmacy Manifest of Delivery, dated 01/03/25, revealed Resident #36 had 60 tablets (30-day supply) of Clozapine 100 mg delivered. Interview on 01/30/25 at 10:10 A.M., with Regional Director of Clinical Services (RDNC) #200 verified Resident #36 did not receive the missing doses of Clozapine listed above for the months of November 2024, December 2024, and January 2025. Interview on 01/30/25 at 3:04 P.M., with Physician Assistant (PA) #205 revealed at the time of the mix-up with Resident #36's Clozapine, there was disorganization due to a new DON, Assistant DON (ADON), and psychiatry provider. Interview on 02/05/25 at 1:00 P.M., with RDNC #200 verified a delivery of 60 tablets of Clozapine 100 mg on 11/27/24, which is enough for 30 days for Resident #36. Further interview with RDNC #200 verified Resident #36 did not receive any more deliveries of Clozapine 100 mg until 01/03/25. (continued on next page)

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	365030	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Care Center of Toledo	3121 Glanzman Rd Toledo, OH 43614

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #53's medical record revealed an admitted [DATE] with diagnoses including: cognitive social or emotional deficit following unspecified cerebrovascular disease, benign prostatic hyperplasia (BPH), vitamin D deficiency, tachycardia, morbid obesity, hypertension (HTN), pulmonary embolism, dysphagia, bipolar disorder, violent behavior, mild intellectual disabilities, other sexual dysfunction, anemia, personal history of diseases of the skin and subcutaneous tissues, personal history of COVID-19, paranoid schizophrenia, unspecified psychosis not due to a substance or known physiological condition, anxiety, and insomnia. Review of Resident #53's monthly physician orders for November, December 2024 and January 2025 revealed physician orders for Clozapine 100 mg by mouth every morning, for psychosis and Clozapine 200 mg by mouth every evening, for psychosis. Review of the Pharmacy Manifest of Delivery, dated 11/02/24 revealed Resident #53 had 30 tablets (30-day supply) of Clozapine 200 mg delivered. Review of the eMAR for Resident #53 for November 2024 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 11/23/24 or 11/26/24. Concurrent review revealed he did not receive his physician-ordered 200 mg dose of Clozapine on 11/08/24, 11/09/24, and 11/10/24. Review of a progress note for Resident #53, dated 11/26/24 at 5:22 A.M., revealed the medication (Clozapine 100 mg) was not available. Review of the Pharmacy Manifest of Delivery, dated 11/26/24, revealed Resident #53 had 30 tablets (30-day supply) of Clozapine 100 mg delivered. Review of the eMAR for Resident #53 for December 2024 revealed he did not receive is physician-ordered 100 mg dose of Clozapine on 12/16/14 and 12/30/24. Concurrent review revealed he did not receive his physician-ordered 200 mg dose of Clozapine on 12/28/24, 12/29/24, and 12/30/24. Review of a progress note for Resident #53, dated 12/16/24 at 5:04 P.M., revealed Clozapine 100 mg has not arrived from the pharmacy. Review of a progress note for Resident #53, dated 12/28/24 at 3:31 P.M., revealed Clozapine 200 mg was on order. Review of a progress note for Resident #53, dated 12/29/24 at 3:35 P.M., revealed Clozapine 200 mg was on order. Review of the progress note for Resident #53, dated 12/30/24 at 6:00 A.M., revealed Clozapine 100 mg was on order. Review of the progress note for Resident #53, dated 12/30/24 at 6:55 P.M., revealed Clozapine 100 mg was on order. Review of the eMAR for Resident #53 for January 2025 revealed he did not receive his physician-ordered 100 mg dose of Clozapine on 01/06/25 and 01/07/25. (continued on next page)

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Concord Care Center of Toledo	3121 Glanzman Rd Toledo, OH 43614

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pharmacy Manifest of Delivery, dated 01/03/25, revealed Resident #54 had 30 tablets (30-day supply) of Clozapine 100 mg delivered and had 30 tablets (30-day supply) of Clozapine 200 mg delivered. Interview on 02/04/25 at 10:19 A.M., with RDNC #200 verified Resident #53's physician-ordered Clozapine 100 mg was not administered on 11/23/24, 11/26/24, 12/16/24, 12/30/24, 01/06/24, and 01/07/24. Concurrent interview with RDNC #200 verified Resident #53's physician-ordered Clozapine 200 mg was not administered on 11/08/24, 11/09/24, 11/10/24, 12/28/24, 12/29/24, and 12/30/24. Interview on 02/05/25 at 1:00 P.M., with RDNC #200 verified a delivery of 30 tablets of Clozapine 200 mg enough for 30 days, for Resident #53 on 11/02/24 and 100 mg 30 day supply delivered on 11/26/24. Further interview with RDNC #200 verified Resident #53 did not receive any further deliveries of this medication until 01/03/25. Review of the policy titled, Administering Medications, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00161721.