

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, review of incidents and accident policy, review of hospital documentation, and review of emergency medical services (EMS) reports, the facility failed to provide assessments, care planning, and monitoring for two residents (#2 and #3) identified with a substance abuse history and failed to investigate incidents when two residents were discovered to have experienced an overdose. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries, and/or negative health outcomes when Resident #2 and Resident #3 were able to obtain and consume drugs they did not have prescriptions for resulting in Resident #2 having three episodes of being found unresponsive within a 32-hour timeframe requiring the administration of Narcan (medication to reverse opioid overdose), transfer to the emergency department (ED), and a resulting hospital admission. Furthermore, Resident #3 was discovered unresponsive with no pulse, required cardiopulmonary resuscitation (CPR), Narcan administration, and transfer to the ED where the resident was intubated and placed on mechanical ventilation prior to hospital admission. This affected two (#2 and #3) of five (#1, #2, #3, #9, #16) residents reviewed for substance use disorder. The facility identified a total of 16 residents with history of substance use disorder in a facility census of 64. On [DATE] at 3:04 P.M., the Administrator and Director of Nursing (DON) were notified the Immediate Jeopardy began on [DATE] at 2:36 P.M. when Licensed Practical Nurse (LPN) #303 was called into Resident #2's room due to the resident having low blood pressure, not responding to a sternal rub, and her pupils were pinpointed. The staff administered two doses of Narcan and EMS was contacted. Resident #2 tested positive for benzodiazepines, which were not prescribed for her. On [DATE] at 11:30 A.M., Resident #2 was found unresponsive, was transported by EMS to the ED, was administered Narcan, and returned to the facility. Again on [DATE] at 10:24 P.M., Resident #2 was found unresponsive. The resident was administered Narcan, was transported by EMS to the ED, and was admitted to the hospital. Resident #2 again tested positive for benzodiazepines. Eight days later, on [DATE], Resident #3 was discovered unresponsive without a pulse or respirations. CPR was performed, Narcan was administered, and EMS transported the resident to the ED. The resident was intubated, placed on mechanical ventilation and admitted to the hospital. After Resident #3 left the facility, a small baggie containing a white powder was discovered in Resident #3's room. Following these instances with Resident #2 and Resident #3, the facility did not complete any type of investigation into how the residents obtained the substances ingested during their overdoses, did not complete any care planning for the residents' substance use disorder, and did not provide any increase in supervision/monitoring levels for either resident. The Immediate Jeopardy was removed on [DATE], when the facility implemented the following corrective actions: On [DATE], Resident #2 was discharged from the facility. On [DATE], the DON, Assistant Director of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365488 If continuation sheet Page 1 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Nursing (ADON) #600, Licensed Social Worker (LSW) #800, and Administrator reviewed all resident medical records to identify any substance use disorder. Sixteen residents were identified. On [DATE], LSW #800, Minimum Data Set (MDS) Coordinator/Licensed Practical Nurse (LPN) #300, the Administrator, and ADON #600 completed social history assessments for the sixteen identified residents with substance use disorder. On [DATE], the facility drafted and implemented a new policy titled Illegal Drug Possession and Use by Residents Policy. The policy identifies illegal drugs, directs staff to an immediate response if drug use or possession is suspected, directs staff not to destroy or dispose of suspected evidence, what to do if a visitor is suspected of bringing in drugs, instructs the facility to conduct an investigation, and report any suspected criminal activity to the local law enforcement. The policy addresses resident care following stabilization, prevention of illegal drug possession and use, and documentation of any incidents. On [DATE] at 1:53 P.M., the DON and ADON #600 completed education to all staff related to substance use disorder. Information covered included: disorder explanation, how to identify potential sources, monitoring resident signs and symptoms, response to suspected substance, and implementation of the new policy Illegal Drug Possession and Use by Residents Policy. On [DATE], the Administrator educated the DON regarding discarding potential evidence or illegal contraband discovered in the facility. On [DATE], the facility began a new protocol on admission of new residents. The interdisciplinary team (IDT), which includes the DON, ADON #600, MDS Coordinator/LPN #300, Administrator, and social services, will review the social and medical history of residents and ensure appropriate interventions and screens are in place with staff education if substance use disorder is identified. Additionally, a social history assessment will be complete by social services upon admission within the first 24 to 48 hours, at readmission, and as needed. On [DATE], the IDT will begin monitoring the findings of the social and medical histories during their weekly risk meeting to ensure appropriate follow up. On [DATE], the facility implemented the baseline care plan will also include interventions/monitoring for substance use disorder history. The DON will monitor this for all new admission on an ongoing basis. On [DATE], the facility's Quality Assurance Performance Improvement (QAPI) met and implemented a QAPI monitoring tool used following every resident admission and readmission to monitor residents identified with substance use disorder have updated care plans, intervention/monitoring, a behavior contract as needed, and an order in place for monitoring. This will be reviewed daily by the Administrator and DON during clinical morning meeting. The Administrator is responsible to ensure the QAPI monitoring tool is completed following each admission/readmission. On [DATE], the Administrator and DON will complete, and review investigations are completed following any incidents involving resident use or possession of an illegal substance. This includes notifying any law enforcement. The Administrator will be responsible for monitoring the investigations are completed. All monitoring listed will be reviewed during facility QAPI reviews to ensure compliance. On [DATE], interview with LPN #302, Certified Nurse Aide (CNA) #203 and CNA #204 verified they had received education on [DATE] related to residents identified with polysubstance abuse and a new facility illegal drug possession policy. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included cervical disc displacement, quadriplegia, central cord syndrome, altered mental status, conversion disorder with seizures, psychoactive substance abuse, major depression, and hypertension. Review of the hospital community referral documentation dated [DATE] noted a hospital admission on [DATE] due to concerns for episode of unresponsiveness, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	potentially secondary to cerebral vascular event versus seizure like activity. The resident was found to have magnetic resonance imaging (MRI) findings suggestive of toxic metabolic encephalopathy as well as drug screen positive for cocaine. Hospital diagnoses included polysubstance abuse dating from [DATE]. Laboratory blood testing on [DATE] noted Resident #2 tested positive for the use of fentanyl. Review of the nursing admission assessment dated [DATE] revealed Resident #2 was admitted to the facility from the hospital due to being found unresponsive. The assessment documented Resident #2 was assessed with intact cognition, used drugs regularly, had a withdrawn mood, and required staff assistance with activities of daily living. Review of the MDS assessment dated [DATE] revealed Resident #2 had no upper or lower extremity range of motion deficit, was independent with eating, required assistance by staff for mobility and used a manual wheelchair. Review of a clinical nursing note dated [DATE] at 2:36 P.M. revealed LPN #303 was called into the room due to Resident #2 having a low blood pressure, Resident #2 was not responding to a sternum rub and her pupils were pinpointed. The Nurse Practitioner (NP), LPN #303 and two other nurses were at bedside during this time. LPN #303 called emergency transport (911) and then administered Narcan to Resident #2 twice, five minutes apart. Once EMS arrived, Resident #2's vital signs were stable, but the resident was still not responding to any stimuli. After about two to three minutes, EMS gave the resident another sternum rub and Resident #2 woke up. EMS decided not to transport Resident #2 due to being back at baseline. LPN #303 and another nurse obtained a urine sample to run a toxicology screen and obtained vital signs every two hours for 24 hours. Review of the EMS Run Report dated [DATE] at 2:44 P.M. revealed Resident #2 was assessed and returned to baseline. Resident #2 remained in the facility. Review of the laboratory (lab) urine drug screen results dated [DATE] at 3:03 P.M. revealed Resident #2's urine tested positive for benzodiazepines and cannabinoids. Resident #2's record revealed no physician orders for benzodiazepine medications or cannabinoids. Review of the physician orders on [DATE] at 4:00 P.M. revealed an order for the administration of Narcan Nasal Liquid four milligrams (mg)/milliliter (ml). One application alternating nostrils as needed for opioid overdose. Review of the clinical nursing note dated [DATE] at 11:31 A.M. documented LPN #303 entered Resident #2's room to take vital signs and noticed the resident was drooling and not responding to verbal stimuli. The resident's blood pressure (BP) was 87/65, heart rate was 206 beats per minute, and oxygen (O2) level was at 96 % on room air. The resident's pupils were dilated and non-reactive to light. LPN #303 and the ADON #600 were present in room. ADON #600 called the NP who gave a verbal order to send the resident to the hospital. LPN#303 called 911, the EMS arrived and the resident was transported to the local hospital ED. Review of the EMS Run Report dated [DATE] at 11:45 A.M. revealed Resident #2 was slumped over in the chair and lethargic. Facility staff reported the resident had a similar episode the prior day. The resident had pinpoint pupils, responded verbally occasionally, but would nod back off. The resident was moved to the ambulance and received Narcan 4 mg nasally. Approximately five minutes later the resident was considerably more alert, and her pupil's were now normal size. The resident's care was transferred to the hospital ED staff. Review of hospital ED documentation dated [DATE] noted Resident #2 arrived at 12:11 P.M. and was evaluated for altered mental status. Resident #2 reportedly awakened with a dose of Narcan from EMS technicians. The resident denied ingesting any substances. The nursing home reported the resident had an episode of unresponsiveness where she awakened with Narcan. Review of laboratory urine toxicology revealed a positive result for Cannabinoid. At 3:44 P.M. hospital progress notes revealed a suspect unintentional overdose, resident with history of polysubstance abuse. Resident to discharge back to nursing home and follow-up with neurology and psychiatry on an outpatient basis. Review of the clinical nursing notes on [DATE] at 5:09 P.M. revealed Resident #2 returned from the local (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	hospital. No new orders were given. The resident was given intravenous (IV) fluids in the ED. The resident had returned to normal baseline. Review of EMS Run Report dated [DATE] at 10:00 P.M. revealed Resident #2 was found sitting in her wheelchair with an altered level of consciousness and constricted pupils. The resident was alert to verbal stimulation but unable to appropriately answer questions. The resident was known to have a history of narcotic abuse and reportedly overdosed both yesterday and earlier this morning while at the nursing facility. EMS administered Narcan 4 mg intranasally, resulting in improvement in level of consciousness. The resident was transported to the local hospital. Review of the clinical nursing notes dated [DATE] at 10:24 P.M. documented LPN #304 was alerted by Certified Nurse Aide (CNA) that while moving Resident #2 from the nurse's station to her room and bed the resident was stiff as a board. LPN #304 entered the room to find Resident #2 unresponsive, drooling, had weak hand grasps, and her pupils were pinpoint and non-reactive to light. Nine-one-one (911) was called at 10:24 P.M. and arrived at 10:30 P.M. EMS gave the resident Narcan twice, causing the resident to have slight movement again. The resident continued to be unresponsive to name being called. EMS transferred the resident to the local hospital. Review of EMS Run Report dated [DATE] at 2:20 A.M. documented the hospital called the facility and spoke with the nurse regarding Resident #2's appropriateness and baseline. The hospital staff reported the resident's urine was positive for cannabinoid and benzodiazepine. Review of the hospital history and physical dated [DATE] at 5:42 A.M. revealed Resident #2 presented to the ED with chief complaint of drug overdose. Urine drug screen in the ED and laboratory toxicology screen showed positive for benzodiazepine and cannabinoids. A computed tomography (CT) scan of the chest showed multiple pulmonary emboli (PE), including saddle embolus and emboli in the main and segmental branches. The resident was admitted to the hospital, administered blood thinners and vascular surgery was consulted. Review of the medical record revealed there was no care plan for the resident's substance use disorder. The record revealed no new interventions or increased monitoring/supervision was implemented following the incidents of overdose. The facility had not completed any investigation into Resident #2's ingestion of benzodiazepine medications. Interview on [DATE] at 2:55 P.M. the DON verified Resident #2 had a history of illegal drug use prior to being admitted to the facility; however, no plan of care or interventions had been implemented to prevent or monitor for illegal drug use while she was a resident at the facility. The DON verified no investigation had been documented following Resident #2's overdoses requiring Narcan administration to return to baseline. The DON stated on [DATE] the DON and ADON #600 searched Resident #2's room and found no illegal contraband or drugs. The local police were not contacted regarding the resident use of illegal drugs or related overdoses. Resident #2 remains in the hospital due to unrelated issues. The DON confirmed Resident #2 did not have a physician order for a benzodiazepine medication. Interview on [DATE] at 3:05 P.M., MDS Coordinator/LPN #300 verified Resident #2's medical record, including the plan of care, did not contain substance abuse prevention, monitoring or treatment interventions to prevent further occurrences. 2) Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included type 2 diabetes mellitus, open wound left upper arm, arthrodesis, altered mental status, convulsions, and psychoactive substance abuse with intoxication. Review of hospital community referral dated [DATE] revealed Resident #3 reported social history of drug use including heroin and marijuana. Review of the MDS assessment dated [DATE] revealed Resident #3 had intact cognition, range of motion impairment to bilateral upper extremities, and was dependent on staff for the provision of activities of daily living. Review of the physician orders revealed an order dated [DATE] at 12:00 P.M. for the administration of Narcan Nasal Liquid 4 mg/0.1 ml one spray alternating nostrils every three minutes as needed for opioid overdose. Review of the clinical nursing notes dated (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[DATE] at 6:59 P.M. revealed at approximately 6:15 P.M Registered Nurse (RN) #400 was notified by the CNA Resident #3 was unresponsive. RN #400 immediately responded with an additional nurse, Nurse #1. The resident was unresponsive, apneic, and pulseless. CPR was initiated immediately and the facility emergency/code response was activated. The CNA was instructed to call 911. Nurse #1 administered Narcan 4 mg intranasally at 6:16 P.M. per emergency protocol. Resident #3 was lowered safely to the floor to facilitate continued CPR. A second dose of Narcan 4 mg intranasally was administered at 6:18 P.M. due to continued unresponsiveness. At approximately 6:19 P.M. there was a return of spontaneous circulation (ROSC), and the resident had a palpable pulse. EMS arrived at approximately 6:21 P.M. and assumed care of the resident. On [DATE] at 7:00 P.M., RN #400 and another staff found a small, opened baggie containing a white substance on Resident #3's tray table. Review of EMS run report dated [DATE] at 6:22 P.M. documented upon arrival Resident #3 was assessed as unresponsive. EMS took over care and inserted an advanced airway. EMS placed an Intraosseous (IO) needle (needle that goes directly into the bone marrow for fluid delivery) to left distal femur and the resident now had agonal respirations. The resident was administered Narcan 2mg via the IO needle. The resident's respiratory effort improved a few minutes later, the airway was removed, and the resident was placed on 10 liters of oxygen per minute via a non-rebreather mask and transported to the hospital. Review of the hospital adult intensive care unit history and physical admission note dated [DATE] at 6:54 P.M. documented Resident #3 presented to the ED after a suspected overdose. She was found at the nursing facility without a pulse, not breathing, and was receiving CPR. She also received Narcan and woke up. Upon arrival she was confused and there was concern about her ability to protect her airway, so she was intubated emergently in the ED. The note documented Resident #3 reported current drug use of heroin. Review of the clinical nursing notes dated [DATE] at 3:13 P.M. documented Resident #3 returned to the facility. The note documented the resident stated I don't know what happened to me. All I remember is waking up in the hospital. Resident #3 admitted to using an illicit street drug prior to hospitalization but stated she did not remember who supplied it or what substance it was. Resident verbalized she has used illicit drugs in the past and stated, I should have talked to someone instead of taking the drugs when I felt the urge to use again. Per facility order, the resident was placed on a no-visitation restriction due to concerns unauthorized substances had previously been brought to the resident by visitors. Resident was informed of the restrictions and verbalized understanding. Review of the physician progress notes dated [DATE] at 8:44 A.M. documented Resident #3 was hospitalized on [DATE] for unresponsiveness and respiratory failure secondary to fentanyl overdose. She required intubation and mechanical ventilation, with Narcan administered emergently at the facility prior to transfer to the hospital. The resident has no acute withdrawal symptoms noted. She denies interest in formal addiction treatment but agreed to ongoing psychiatric and talk therapy follow-up. Review of the medical record revealed there was no care plan for the resident's substance use disorder. The record revealed no new interventions or increased monitoring/supervision was implemented following the incident of overdose. The facility had not completed any investigation into Resident #3's overdose. Interview on [DATE] at 7:39 A.M., LPN #301, identified to be assigned to Resident #3, was unaware of any resident utilizing illegal drugs or experiencing a drug overdose. LPN #301 was unable to provide any interventions utilized to prevent resident related illegal drug consumption. Interview on [DATE] at 1:10 P.M., CNA #200 and on [DATE] at 6:08 A.M. with CNA #201, who were assigned to Resident #3, both were unaware of any residents consuming illegal drugs or with a history of overdose. Interview on [DATE] at 2:55 P.M., the DON verified no plan of care was implemented to address Resident #3's history of illegal drug use. The DON could not provide any investigation related (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	to the resident's drug overdoses or preventive measures implemented to prevent further illegal drug overdoses. The DON stated when the bag of white substance was discovered in Resident #3's room, the substance was wasted by the DON in a controlled substance waste kit. Law enforcement was not notified regarding Resident #3's drug overdoses and the unidentified substance in the resident's room. Interview on [DATE] at 3:05 P.M., MDS Coordinator/LPN #300 verified Resident #3's medical record did not contain a plan of care to address history of substance abuse or interventions to prevent further occurrences. Interview on [DATE] at 6:01 A.M., LPN #302, who was sometimes assigned to Resident #3, was aware Resident #3 experienced a drug overdose; however, LPN #302 was unaware of any resident specific interventions to prevent further occurrences. LPN #302 verified no care plan with interventions was in place to prevent illegal drug use and confirmed there was no information indicating Resident #3 was not to have visitors or was to have monitored visitation. Interview on [DATE] at 8:21 A.M., Resident #3 stated on [DATE] she contacted a person in the community to obtain fentanyl and subsequently consumed the substance. Resident #3 stated prior to residing in the facility she had previously consumed fentanyl. Review of the facility policy titled Incidents and Accidents, with a date of 2025, revealed it is the policy of the facility for staff to utilize point click care management report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Licensed staff will utilize point click care risk management to report incidents/accidents and assist with completion of any investigative information to identify root causes. If necessary, law enforcement may be contacted for specific events. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator. This deficiency represents non-compliance investigated under Master Complaint Number 3084200.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure develop a baseline care plan at admission to address substance use disorder. This affected one (#2) out of five residents reviewed for resident care plan development. The facility identified 16 residents with a history of substance use disorder in a facility census of 64. Findings include: Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included cervical disc displacement, quadriplegia, central cord syndrome, altered mental status, conversion disorder with seizures, psychoactive substance abuse, major depression, and hypertension. Review of the hospital community referral documentation dated 06/12/26 noted a hospital admission on [DATE] due to concerns for episode of unresponsiveness, potentially secondary to cerebral vascular event versus seizure like activity. The resident was found to have a drug screen positive for cocaine. Hospital diagnoses included polysubstance abuse dating from 12/07/25. Laboratory blood testing on 06/06/26 noted Resident #2 tested positive for the use of fentanyl. Review of the nursing admission assessment dated [DATE] revealed Resident #2 was admitted to the facility from the hospital due to being found unresponsive. The assessment documented Resident #2 was assessed with intact cognition and used drugs regularly. Review of the record revealed no baseline care plan was developed to identify Resident #2's substance use prevention, monitoring or treatment interventions to prevent further occurrences of substance abuse. Interview on 07/20/26 at 3:05 P.M. the Minimum Data Set (MDS) Coordinator Licensed Practical Nurse (LPN) #300 verified Resident #2's medical record had no plan of care related to her substance abuse. This deficiency represents non-compliance investigated under Master Complaint Number 3084200.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4420 South Avenue Toledo, OH 43615	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to develop a comprehensive plan of care to address a resident's substance use disorder. This affected one (#3) of five residents reviewed for care plan development. The facility identified 16 residents with a history of substance use disorder in a facility census of 64. Findings include: Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included type 2 diabetes mellitus, open wound left upper arm, arthrodesis, altered mental status, convulsions, and psychoactive substance abuse with intoxication. Review of hospital community referral dated 07/12/25 revealed Resident #3 reported social history of drug use including heroin and marijuana. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had intact cognition, range of motion impairment to bilateral upper extremities, and was dependent on staff for the provision of activities of daily living. Review of the medical record lacked a plan of care to address Resident #3's history of substance use. Interview on 07/20/26 at 3:05 P.M. MDS Coordinator Licensed Practical Nurse #300 verified Resident #3's medical record did not contain a plan of care to address history of substance abuse or interventions to prevent further occurrences. This deficiency represents non-compliance investigated under Master Complaint Number 3084200.		