STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365704	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Healthcare Center	955 Garden Lake Pkwy 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, review of facility investigations, staff interview, and review of the facility policy the facility failed to ensure medications were administered to the correct resident. This affected one resident (#89) reviewed for medication errors. The facility census was 92. Findings include: Review of the medical record for Resident #89 revealed an admitted [DATE] with diagnoses of follow-up for joint replacement surgery, depression, anxiety, alcohol abuse, and cocaine abuse. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #89 revealed he was cognitively intact and he was not ordered any opioid medication (narcotic pain medication). Review of the current physician orders for April 2025 for Resident #89 revealed no orders for Gabapentin (medication used for nerve pain), Doxycycline (antibiotic), Metoprolol (used to treat high blood pressure), Norco (narcotic (opioid) pain medication), and Oxycodone (narcotic (opioid) pain medication. Review of the listed drug allergies for Resident #89 revealed he had an allergy to Aspirin only. Review of the care plan revised 02/14 for Resident #89 revealed the resident had substance use disorder history of smoking, marijuana, cocaine abuse and alcohol abuse and he now uses his past experiences to help share with others in rehabilitation. Review of the nursing progress notes for Resident #89 dated 01/31/25 revealed he was administered medication in error the following medications: Gabapentin 100 milligrams (mg), Doxycycline 100 mg, Metropolol 25 mg, and Norco 5/325 mg. Interview on 03/31/25 at 10:39 A.M. with Resident #89 stated he was involved in two medication errors where he received medication that was not prescribed to him. Review of the internal investigation for the medication error dated 01/31/25 for Resident #89 revealed Licensed Practical Nurse (LPN) #378 prepared medication for administration and administered the medication to the wrong resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 04/02/25 at 4:01 P.M. with LPN #378 stated she was working on 01/31/25 and was passing her medications when there were many different events happening with residents requesting to go out to smoke, Certified Nursing Assistants (CNA) reporting different items to her and two residents with the same name. LPN #378 amidst the distractions she prepared medications for administration and delivered the medication to the wrong resident, Resident #89. LPN #378 further stated Resident #89 requested some Tylenol and she returned to the medication cart and discovered the medication she prepared was for a different resident based on the computer screen that she was working on and then returned to Resident #89 and he had already taken the medication she delivered to him. Review of the nursing progress notes for Resident #89 dated 03/27/25 revealed he was administered medication in error, Resident #89 was administered Oxycodone five milligrams. Review of the internal investigation for the medication error dated 03/27/25 for Resident #89 revealed LPN #309 prepared medication for administration and administered the medication to the wrong resident. Phone interview on 04/02/25 at 4:32 P.M. with LPN #309 stated she was working on 03/27/25 and was overwhelmed with distractions with a new resident and her family with anxiety and a resident that was sent out by ambulance and she began her medication administration late. LPN #309 stated during her medication administration she misread the room and administered medication to the wrong resident. LPN #309 further stated she administered Oxycodone five milligrams, two pills, a medication for acid reflux and upon entering the room for Resident #89 he requested Tylenol and she returned to the medication cart, obtained the Tylenol and then returned to Resident #89 and administered the medication. LPN #309 stated Resident #89 inquired about the medication, she explained the medication he was receiving and LPN #309 then stated Resident #89 shrugged his shoulders and took the medication. LPN #309 then stated Resident #89 then reported to her immediately after taking the medication those aren't my pills. LPN #309 stated she returned to the medication cart and discovered she administered the wrong medication to the wrong resident. Interview on 03/31/25 at 5:10 P.M. with the Director of Nursing (DON) identified only one resident with medication errors in the past three months was Resident #89. Review of the incident and accident log for past three months revealed there was only one resident with medication errors, Resident #89. Review of the facility policy titled Medication Administration, undated revealed general procedure for medication administration include observation of the five rights in giving medication, the right resident, the right time, the right medication, the right dose, and the right route. Full attention should be given during preparation of medications avoiding distractions is important for infection prevention and reducing errors. This deficiency represents non-compliance investigated under Complaint Number OH00162741.