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	07/14/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff and resident interview, review of Self Reported Incidents, and review of facility policy, the facility failed to immediately report an allegation of staff to resident physical abuse immediately to the administrator. This affected one (#3) of seven residents reviewed for staff to resident care and treatment in a facility census of 87. Findings include:Review of the medical record revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with chronic obstructive pulmonary disease, type 2 diabetes mellitus, cerebral infarction, hypertension, congestive heart failure, major depressive disorder, chronic viral hepatitis C, anxiety disorder, systemic lupus erythematosus, alcohol abuse, opioid abuse, and cognitive communication deficit. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #3 had severe cognitive impairment, no recorded behaviors, and required substantial to maximal assistance with activities of daily living.On 07/09/25 at 8:15 A. M. interview with Administrator and Director of Nursing (DON) revealed Resident #3's responsible party had made an allegation of staff to resident abuse. Resident #3's responsible party was unable to articulate when or what alleged incident took place until 07/08/25. The DON stated an alleged nurse resigned on date of alleged event of 07/05/25 in the early morning during the 6:00 P.M. to 6:00 A.M. shift. On 07/09/25 at 8:58 A. M. interview with Resident #3 revealed she was hit with bed controller in the chest by a nurse aide. Resident #3 was unable to stated the date or provide any additional information. Telephone interview on 07/09/25 at 12:23 P.M. with the alleged nurse, Licensed Practical Nurse (LPN) #200, revealed she assumed care of Resident #3 on 07/04/25 at 6:30 P.M. and was scheduled to work until the morning of 07/05/25 at 7:00 A.M. Between 11:30 P.M. and 12:00 A.M. LPN #200 went to administer medications to Resident #3. Resident #3 requested the medications crushed. LPN #200 proceeded to crush the medications, placed them in applesauce, and returned to Resident #3's bedside. LPN #200 obtained the electric bed controller from Resident #3's chest, raised the head of the bed, and placed the controlled next to the resident on the mattress. Resident #3 then became agitated and started yelling LPN #200 had hit her in the chest with the bed remote. LPN #200 attempted to calm Resident #3 and denied hitting her. Resident #3 continued yelling and Certified Nurse Aide (CNA) #400 entered the room. Once CNA #400 entered the room LPN #200 left the room and contacted her supervisor (Registered Nurse (RN) #201) via telephone and reported Resident #3 was accusing her of hitting her and this was an allegation of physical abuse. LPN #200 informed RN #201 she was leaving the facility and turned her medication cart keys over to LPN #202. At approximately 12:30 A. M. Resident #3's son came to the facility and proceeded to Resident #3's room. Resident #3's son then approached LPN #200 at the nurses station and began cursing and threatening LPN #200. LPN #200 turned over care of her residents to LPN #202 until RN #201 reported to the facility. Interview on 07/10/25 at 5:15 A. M. with CNA #400 revealed she was assigned to Resident #3's care on 07/04/25. She was walking down the hall when she heard yelling coming from Resident #3's room. CNA #400 went to check on the resident. Upon entering the room LPN #200 was standing outside the room and told CNA #400 Resident #3 was alleging she hit her with the bed remote. Resident #3 was yelling out and LPN #200 stated she was leaving the facility due to the allegation or physical abuse. CNA#400 provided Resident #3 with incontinence care and observed no potential injury and exited the room. Following care LPN #200 was observed at her medication cart and told CNA #400 she had notified the supervisor RN and she was leaving due to the allegation of physical abuse. Approximately 10 minutes later RN #201 was observed counting the medication cart and assuming care to the residents on the hall. LPN #200 proceeded to leave the facility. On 07/10/25 at 5:19 A. M. interview with CNA #401 revealed on 07/04/25 she was working in a resident room on the 400 Hall and came out seeing LPN #200 packing her bag at the nursing station. LPN #200 was stating she would not be coming back to the facility. LPN #200 stated Resident #3 alleged LPN #200 had hit the resident with the bed remote. RN #201 had assumed care of her residents. On 07/10/25 at 5:46 A.M. interview with RN #201 revealed on 07/05/25 at 12:37 A.M. she received a phone call from LPN #200 stating Resident #3 accused her of throwing a bed remote at her and LPN #200 was reporting the alleged incident to her supervisor. RN #201 stated she phoned the DON immediately after speaking with LPN #200. RN #201 told the DON Resident #3 alleged LPN #200 threw the bed remote and hit her in the face. RN #201 took another phone call and returned a phone call to the DON at 12:45 A.M. on 07/05/25. RN #201 informed the DON LPN #200 was going to leave and RN #201 was going in to assume care. Approximately 20-25 minutes later RN #201

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview and facility policy, the facility failed to thoroughly investigate an allegation of staff to resident physical abuse. This affected one (#3) of seven residents reviewed for staff to resident care and treatment in a facility census of 87. Findings include:Review of the medical record revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with chronic obstructive pulmonary disease, type 2 diabetes mellitus, cerebral infarction, hypertension, congestive heart failure, major depressive disorder, chronic viral hepatitis C, anxiety disorder, systemic lupus erythematosus, alcohol abuse, opioid abuse, and cognitive communication deficit. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #3 had severe cognitive impairment, no recorded behaviors, and required substantial to maximal assistance with activities of daily living. The medical record contained no documentation of Resident #3 making any allegation of abuse from a staff member. On 07/09/25 at 8:15 A.M. interview with Administrator and Director of Nursing (DON) revealed Resident #3's responsible party had made an allegation of staff to resident abuse. Resident #3's responsible party was unable to articulate when or what alleged incident took place until 07/08/25. The DON stated an alleged nurse resigned on date of alleged event of 07/05/25 in the early morning during the 6:00 P.M. to 6:00 A.M. shift. On 07/09/25 at 8:58 A.M. interview with Resident #3 revealed she was hit with bed controller in the chest by a nurse aide. Resident #3 was unable to stated the date or provide any additional information. Telephone interview on 07/09/25 at 12:23 P.M. with the alleged nurse, Licensed Practical Nurse (LPN) #200, revealed she assumed care of Resident #3 on 07/04/25 at 6:30 P.M. and was scheduled to work until the morning of 07/05/25 at 7:00 A.M. Between 11:30 P.M. and 12:00 A.M. LPN #200 went to administer medications to Resident #3. Resident #3 requested the medications crushed. LPN #200 proceeded to crush the medications, placed them in applesauce, and returned to Resident #3's bedside. LPN #200 obtained the electric bed controller from Resident #3's chest, raised the head of the bed, and placed the controlled next to the resident on the mattress. Resident #3 then became agitated and started yelling LPN #200 had hit her in the chest with the bed remote. LPN #200 attempted to calm Resident #3 and denied hitting her. Resident #3 continued yelling and Certified Nurse Aide (CNA) #400 entered the room. Once CNA #400 entered the room LPN #200 left the room and contacted her supervisor (Registered Nurse (RN) #201) via telephone and reported Resident #3 was accusing her of hitting her and this was an allegation of physical abuse. LPN #200 informed RN #201 she was leaving the facility and turned her medication cart keys over to LPN #202. At approximately 12:30 A.M. Resident #3's son came to the facility and proceeded to Resident #3's room. Resident #3's son then approached LPN #200 at the nurses station and began cursing and threatening LPN #200. LPN #200 turned over care of her residents to LPN #202 until RN #201 reported to the facility. LPN #200 proceeded to leave the facility at 1:00 A.M. LPN #200 stated she did not provide a statement regarding the incident or document the incident in Resident #3's medical record. Interview on 07/10/25 at 5:15 A.M. with CNA #400 revealed she was assigned to Resident #3's care on 07/04/25. She was walking down the hall when she heard yelling coming from Resident #3's room. CNA #400 went to check on the resident. Upon entering the room LPN #200 was standing outside the room and told CNA #400 Resident #3 was alleging she hit her with the bed remote. Resident #3 was yelling out and LPN #200 stated she was leaving the facility due to the allegation or physical abuse. CNA#400 provided Resident #3 with incontinence care and observed no potential injury and exited the room. Following care LPN #200 was observed at her medication cart and told CNA #400 she had notified the supervisor RN and she was leaving due to the allegation of physical abuse. Approximately 10 minutes later RN #201 was observed counting the medication cart and assuming care to the residents on the hall. LPN #200 proceeded to leave the facility. CNA #400 stated she did not provide a statement following the incident. On 07/10/25 at 5:19 A.M. interview with CNA #401 revealed on 07/04/25 she was working in a resident room on the 400 Hall and came out seeing LPN #200 packing her bag at the nursing station. LPN #200 was stating she would not be coming back to the facility. LPN #200 stated Resident #3 alleged LPN #200 had hit the resident with the bed remote. RN #201 had assumed care of her residents. On 07/10/25 at 5:46 A.M. interview with RN #201 revealed on 07/05/25 at 12:37 A.M. she received a phone call from LPN #200 stating Resident #3 accused her of throwing a bed remote at her and LPN #200 was reporting the alleged incident to her supervisor. RN #201 stated she phoned the DON immediately after speaking with LPN #200. RN #201 told the DON Resident #3 alleged

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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** Based on medical record review, staff interview, and review of facility policy, the facility failed to administer a diuretic and insulin as ordered within a specified time frame for one (#3) out of seven patients reviewed in a census of 87. Findings include: Review of the medical record revealed Resident #3 admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with chronic obstructive pulmonary disease, type 2 diabetes mellitus, cerebral infarction, hypertension, congestive heart failure, major depressive disorder, chronic viral hepatitis C, anxiety disorder, systemic lupus erythematosus, alcohol abuse, opioid abuse, and cognitive communication deficit. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #3 had severe cognitive impairment, no recorded behaviors, and required substantial to maximal assistance with activities of daily living.Review of the medication administration record and physician orders revealed orders for diuretic hydralazine 100 milligram (mg) tablet three times daily at 8:00 A.M., 2:00 P.M. and 10:00 P.M. and Insulin Aspart Flexpen sliding scale- blood sugar (bs) 151-200 give (=) 3 units, bs 201-250= 6 units, 251-300= 9 units, 301-350= 12 units, 351-400= 15 units, 401-450= 20 units, call physician (MD) if bs above 400 or below 70, administer subcutaneous before meals and at bedtime scheduled 7:00 A. M., 11:00 A.M., 4:00 P.M., and 9:00 P.M.Review of medication administration audit report revealed the hydralazine 100 mg and Insulin Aspart Flexpen three (3) units were scheduled for 07/04/25 at 9:00 P.M. The medications were not administered until 07/05/25 at 12:28 A.M.Telephone interview on 07/09/25 at 12:22 P. M. with Licensed Practical Nurse (LPN) #200 verified she was assigned to administer medications to Resident #3 on 07/04/25 evening (P.M.). Resident #3 was sleeping and the medications were not administered within prescribed timeframes. LPN #200 verified the physician was not notified of the medications being given outside of prescribed timeframes and no entry was made in the medical record indicating the reason the medications were provided late. Review of facility policy titled Medication Administration revealed medications will be administered within the time frame of one hour before up to one hour after ordered time. Medications that are refused or withheld or not given will be documented. Critical medications that are refused including insulin or anticoagulants will be followed up with physician contact. Documentation of medications will follow accepted standards of nursing practice. On 07/10/25 at 8:34 A.M. interview with the Director of Nursing confirmed Resident #3's medications were documented to be administered outside of prescribed time frames. No documentation was contained in the medical record indicating a reason for late medication administration. This deficiency represents non-compliance investigated under Complaint Number OH00167398/ iQIES Complaint Number 1326898.