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	01/29/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure one resident's indwelling urinary catheter was maintained in a sanitary manner. This affected one (#37) of three residents reviewed for indwelling urinary catheters. The facility census was 83. Findings include: Review of the medical record for Resident #37 revealed an admission date of 09/23/25, diagnoses included metabolic encephalopathy, severe protein calorie malnutrition, benign prostatic hyperplasia, obstructive and reflux uropathy, hydronephrosis, hypertension, dementia, myocardial infarction, and resistance to Vancomycin. According to the most current Minimum Data Set (MDS) assessment dated [DATE], Resident #37 had severely impaired cognition, had physical and verbal behavioral symptoms one to three days, rejected care one to three days, was dependent on staff for the completion of activities of daily living including transfers and bed mobility, utilized an indwelling urinary catheter, was incontinent of bowel, and was at risk for pressure ulcer development with no current skin breakdown. On 09/25/25 a plan of care was implemented and on 11/28/25 the plan of care was revised to address Resident #37's indwelling urinary catheter due to obstructive uropathy and benign prostatic hypertrophy. Interventions included to position the catheter bag and tubing below the level of the bladder, to provide privacy bag, and to secure the drainage catheter to the resident's leg with securement device. Review of a physician order dated 10/31/25 revealed a urinary indwelling catheter was to placed to continuous drainage. On 01/14/26 a physician order was written for the administration of Levofloxacin (antibiotic) 750 milligrams (mg) each morning due to a urinary tract infection of bacteremia. Observation on 01/26/26 at 6:42 P.M. Resident #37 was in bed with the indwelling urinary catheter drainage bag laying on the floor under the bed.Observation on 01/26/26 at 9:15 P.M. the indwelling urinary catheter drainage bag was observed to remain on the floor under Resident #37's bed. Interview on 01/26/26 at 9:16 P.M. with Certified Nurse Aide (CNA) #398 stated Resident #37 was in contact isolation due to an infection in his urine (methicillin resistant staphylococcus aureus). CNA #398 also verified the indwelling urinary catheter drainage bag was laying on the floor under the bed and stated the drainage bag should be secured to the bed frame. Observation on 01/27/26 at 3:09 P.M. Resident #37 was in bed with the indwelling urinary catheter drainage bag laying on the floor next to the bed.Observation on 01/29/26 at 6:05 A.M. Resident #37 observed in bed with the indwelling urinary catheter drainage bag on end of bed at the level of his bladder.On 01/29/26 at 6:08 A.M. interview with CNA #398 verified the urinary catheter bag was not below the level of Resident #37's bladder and it should be to prevent the backflow of urine into the resident's bladder.On 01/29/26 at 10:34 A.M. interview with Registered Nurse #342 verified the facility indwelling urinary catheter policy included for staff to ensure the collection bag is not on the floor, was draining properly and secured to the bed, below the level of the bladder so there is no reflux of urine back into the bladder. Review of the (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	undated facility policy titled Catheter Care stated staff are to ensure the drainage collection bag is not on the floor, urine is draining properly, and the urinary drainage bag secured below the level of the resident's bladder to prevent reflux of urine back to the bladder. This deficiency represents non-compliance investigated under Complaint Number 2715485.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, and staff interview the facility failed to ensure resident rooms were clean and equipment was adequately maintained. This affected three (#11, #37, and #30) of 24 residents reviewed for environmental services, The facility census was 83. Findings include:1. Observation on 01/26/26 at 6:42 P.M. revealed an area of Resident #37's wall with gouges in the drywall and exposed drywall underlayment behind the head of the bed. The area measured approximately five foot by five foot. Additional observation on 01/28/26 at 6:15 A.M. noted the wall located to the right of Resident #37's bed with a liquid appearing splatter debris covering the wall and to the right of the bed a maroon mat on the floor with the same debris. On 01/28/2026 at 8:15 A.M. observation with Maintenance Director #319 of Resident #37's room verified the gouges in the wall behind Resident #37's head of the bed. On 01/28/2026 at 8:21 A.M. observation with the Director of Environmental Services (ES) #499 verified the debris on the wall and next to Resident #37's bed. ES #499 stated resident has a behavior of spitting. ES #499 was unable to indicate the most recent time the wall or floor matt were cleaned. 2. Observation on 01/28/2026 at 8:41 A.M. noted Resident #11's room wall to the left of the bed with gouges in the drywall and white unpainted drywall patches. The area measured approximately five foot by three foot. On 01/28/26 at 8:43 A.M. interview with the Maintenance Director #319 verified the gouges and unpainted patches to the wall inside Resident #11's room. 3. Observation on 01/27/26 at 10:55 A.M. revealed a tube feeding pump mounted on a pole next to Resident #30's bed, the legs of the pole had a puddle of fresh tube feeding on the legs along with older dried tube feeding covering the legs of the pole. Under the pole on the floor there was a small puddle, approximately two inches in diameter of tube feeding. Interview on 01/27/26 at 11:02 A.M. with the Director of Risk Management #500 verified the tube feeding on the legs of the pole and floor.