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	06/02/2026

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 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** Based on closed medical record review, staff interview and review of the facility policy, the facility failed to ensure timely notification for a change in condition for a resident who was cognitively impaired and had a Power of Attorney (POA) for medical decisions. This affected one resident (#12) of three residents reviewed for timely notification. The facility census was 74.Findings include:Review of the closed medical record for Resident #12 revealed an admission date of 07/31/25. Diagnoses included mild intellectual disability, adjustment disorder, dementia, and diabetes mellitus Type II. Resident #12 had a POA to make healthcare decisions. The resident discharged to another facility on 05/08/26.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was moderately cognitively intact and had no skin conditions. Review of the nursing progress note dated 05/04/26 at 6:39 P.M. revealed Resident #12 complained of pain in the lower back and upon assessment, a wound was discovered. The nurse conducted a telehealth visit with the on-call provider and orders were obtained to cleanse and dress the wound, with instructions to have wound care follow-up. Further review revealed no evidence the resident's POA was notified at the time of discovery of the wound on Resident #12's back. Further review of the nursing progress notes from 05/04/26 through 05/06/26 revealed no evidence Resident #12's POA was notified of the wound on his back. Review of the medical Nurse Practitioner's (NP) progress noted dated 05/06/26 revealed Resident #12 was seen for an acute visit/change in status for a new skin integrity wound found on the posterior lumbar back (lower back area). Resident #12 was noted to be a poor historian and the onset and clinical information was difficult to obtain from him. The NP discussed with the wound care NP, who stated she saw the wound on evaluation today and it was noted to have a significantly indurated swelling with a white center. At the time of the wound NP's visit, she did not do a sharp debridement. The NP documented the wound as a lower back abscess that measured 2.8 by (x) 2.8 centimeters (cm) with a firm, protrusive/swollen center with sloth and healthy tissue in a marble like appearance. The NP documented that, per chart review and previous documentation, it apparently started as a boil earlier in the week and the NP was not made aware of it on Monday (05/04/26). Orders included antibiotics, referral for a surgical consult, laboratory testing, and to cleanse the wound with wound cleanser, pat dry, and apply honey hydrogel to the base of the wound every Monday, Wednesday, and Friday. The note stated the NP encouraged and answered multiple questions to perceived satisfaction from the resident, staff, and/or family; however, the note did not indicate any specific contact with Resident #12's family/POA. Interview on 06/02/26 at 4:10 P.M. with the Director of Nursing (DON) verified the facility had no evidence Resident #12's POA was notified of the abscess on the resident's back. The DON stated the facility had some issues in the past contacting the POA and the POA would call back days later. Further interview with the DON confirmed that the previous nursing notes, dated 04/23/26, documented attempts to contact the POA; however, on 05/04/26, when the abscess was discovered on Resident #12's back, there was no evidence the facility attempted to contact the POA. The DON verified the facility had no evidence the POA was notified of the abscess at the time of discovery.A follow-up interview on 06/02/26 at 4:49 P.M. with (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON revealed she attempted to find an incident report for a new skin issue for Resident #12, that may have documented POA notification, but a hand written incident report was not able to be found.Observation on 06/02/25 at approximately 5:10 P.M. revealed the Administrator and the DON discussing timely notification to Resident #12's POA regarding the abscess to his lower back. The DON stated to the Administrator, It probably wasn't timely, but it happened (meaning the notification occurred). The Administrator and DON stated there was documentation of difficulty getting in touch with the POA in the past and the POA did not return calls right away. The DON verified there was not a documented attempt to contact the POA at the time of discovery of the wound on Resident #12's lower back.Review of the facility policy titled, Change in a Resident's Condition or Status, revised May 2024, revealed the facility would promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. A significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Unless otherwise instructed by the resident, a nurse would notify the resident's representative when there was a significant change in the residents physical, mental, or psychosocial status. This deficiency represents non-compliance investigated under Complaint Number 3019109.