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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interview, and review of facility policy, the facility failed to ensure narcotic medications were administered and maintained in a secured manner. This affected four (#64, #72, #93, and #94) of 18 residents receiving narcotic medications residing on the 400 unit. The facility census was 83. Findings include: Observation on 01/26/26 at 6:52 P.M. noted Licensed Practical Nurse (LPN) #370 and LPN #316 conducting a shift change narcotic medication and controlled substance inventory for the 400 unit medication cart. LPN #316 was observed to be removing narcotic medication cards from the 400 unit medication cart and counting the number of medications (tablets, contents) on each card and reporting the count to LPN #370. LPN #370 was observed reviewing the controlled substance inventory log for each narcotic and controlled substance contained in the 400 unit medication cart to verify with the count reported. Thirty-nine narcotic medication cards were contained in the locked narcotics drawer in the 400 unit medication cartInterview with LPN #316 at the time of the observation verified he was assuming care of the residents on the 400 unit for the 6:30 P.M. until 7:00 A.M. shift on 01/26/26. Interview with LPN #370 revealed she was finishing her shift and had been assigned to provide care to the residents on the 400 unit from 6:30 A.M. until 7:00 P.M. Continued observation noted LPN #319 removed Resident #64's medication card containing 17 Hydrocodone-acetaminophen 10-325 milligrams (mg). LPN #370 stated the controlled substance inventory log for the Hydrocodone-acetaminophen 10-325 mg noted 18 tablets. LPN #319 removed a second medication card for Resident #63 with 47 tablets of Clonazepam 0.5 mg. LPN #370 stated the controlled substance inventory log displayed a current inventory of 48 tablets. Interview with LPN #370 at the time revealed she had given the medications to Resident #64 during the shift, but did not sign the medications out as administered on the controlled substance log.Continued observation revealed LPN #319 removed Resident #72's medication card containing a physical count of 19 oxycodone 5 mg tablets. LPN #370 stated the count on the controlled substance log log stated there should be 20 tablets remaining. LPN #319 then removed a medication card containing Resident #93's oxycodone 15 mg tablets, the physical count was 18 tablets. LPN #370 reported the count on the controlled substance log was 19. Further observation revealed LPN #319 remove Resident #94's Pregabalin 150 mg medication card from the cart, there was a physical count of 54 tablets. LPN #370 reported 55 tablets were currently listed in the inventory on the controlled substance log.On 01/26/26 at 7:05 P.M. interview with LPN #370 revealed she had administered the narcotic medications to the specified residents (#72, #93 and #94) during the shift however, she was extremely busy and did not record the medications as administered on the controlled substance log at the time of the administration. LPN #370 and LPN #319 verified narcotics and controlled substances are to be signed out on the controlled substance log at the time of administration. Interview on 01/26/26 at 9:20 P.M. with the Director of Nursing verified narcotic medications are to be signed out on the Medication Administration Record and on the Controlled Substance Log at the time of administration immediately after they are removed from the medication cart. According to undated Medication Administration policy, narcotics will be signed out when administered.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to maintain a reach in refrigerator at a safe temperature, failed to date and label food items, and failed to maintain a sanitary environment. This had the potential to affect all residents in the facility receiving food from the kitchen, except for Resident's #11, #30, #76, #88, and #89 who were identified by the facility as not receiving food by mouth. The facility census was 83.Findings include:On initial tour of kitchen on 01/26/26 from 6:10 P.M. until 6:26 P.M. revealed at 6:10 P.M. the reach in refrigerator located approximately three feet across from steam table had both doors propped open by serving carts, inside the refrigerator were 15 cups of grape juice, five cups of cranberry juice, 11 cups of orange juice, 26 cups of lemonade, six cups of milk, and 18 cups of an unidentified liquid, all cups were labeled but contained no dates. The inside thermometer for the refrigerator was reading 58 degrees Fahrenheit (F). Interview with Dietary Aide #337 at the time of the observation revealed that the doors were propped open to make it easier to access the prepared cups of juice being placed on the resident's meal trays. Dietary Aide #337 confirmed the various cups of liquids should have been dated to indicated when they were prepared.Continued observation on 6:21 P.M. revealed a resident's meal tray which had been eaten from was sitting on top of a smaller reach in cooler located next to the service door. Interview on 01/26/26 at 6:21 P.M. with Dietary Aide #337 confirmed the tray containing partially eaten food was placed on the reach in cooler after being brought into the kitchen from the dining room.Continued observation of the walk in cooler at 6:26 P.M. revealed two open containers of pudding, one open container of sour cream, and one open container of chicken salad all without labels indicating the dates opened. Also observed in the walk in cooler was a package of opened and undated tortillas on the right side second shelf. Interview on 01/26/26 at 6:26 P.M. with [NAME] #339 confirmed the items listed did not have labels indicating when they were opened.Review of policy titled Food Storage: Cold Foods, with a revised date of 02/2023, revealed that all perishable foods will be maintained at a temperature of 41 degrees F, or below and that all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.Review of policy titled Environment with a revision date of 06/2025, revealed that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, resident interview, staff interview, and policy review, the facility failed to ensure vision services were provided timely. This affected one (#3) of two residents reviewed for vision services. The facility census was 83. Findings include: Review of the medical record for Resident #3 revealed an admission date of 09/22/25. Diagnoses included hemiplegia and hemiparesis, chronic obstructive pulmonary disease, hypertension, anxiety, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Further review of the MDS assessment revealed the resident had no corrective lenses. Review of a request for services form dated 09/24/25 revealed the resident had requested to be seen for eye care. Review of the vision provider schedule dated 10/27/25 revealed the provider was in the facility and Resident #3 was not seen by the provider. Review of the progress notes dated 09/25/25 through 01/28/26 revealed no documentation the resident had been provided eye care services as requested. Interview on 01/26/26 at 8:52 P.M., Resident #3 revealed she had requested to see the eye doctor a while ago and had not seen the provider.Interview on 01/28/25 at 9:02 A.M., Social Service Designee (SSD) #404 revealed the eye care provider was last in the facility on 10/27/25 and had not seen Resident #3. SSD #404 verified Resident #3 had not been provided with vision services since her admission to the facility. SSD #404 revealed the facility changed providers at the end of 12/2025 and the new provider also had not been in the building yet to provide vision services for the residents. Review of the undated facility policy Social Services, revealed social services would help and support residents in addressing concrete service needs including referrals for eye care, dental care, podiatry, and durable medical equipment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, medical record review, staff interview and review of facility policy, the facility failed to ensure fall prevention interventions were implemented and fall occurrences were thoroughly investigated. This affected one (#4) of one resident reviewed for fall incidents and related interventions. The facility census was 83.Findings include:Review of the medical record revealed Resident #4 admitted to the facility on [DATE], diagnoses included atrial fibrillation, bipolar disorder, schizoaffective disorder, major depressive disorder, anxiety disorder, left and right knee contractures. According to the most current Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 with moderately impaired cognition, lower extremity range of motion impairment on one side, a dependency on staff for the completion of activities of daily living, and transfers. Resident #4 was incontinent of bowel and bladder, had no skin breakdown, was at risk for pressure ulcer development, and was receiving an anticoagulant, opioids, and anticonvulsant medications. On 08/09/25 a nursing plan of care was developed to address Resident #4's history of falling, the plan of care was revised on 12/04/25. Interventions included to ensure anti-tippers are in correct position on the wheelchair, to ensure the resident was wearing appropriate non-skid footwear, encourage the resident to call for help with transfers, to encourage the resident and staff to keep the wheelchair close to the side of the bed, and for non-skid strips on the floor next to bed. Review of the medical record revealed on 12/09/25 a fall follow-up assessment was completed from a fall sustained on 12/03/25. Intervention included for the the care plan updated. On 12/25/25 a fall risk assessment was completed and scored the resident at risk of falling. The assessment noted Resident #4 had previously sustained falls within the past two to six months. Review of nursing progress note dated 12/25/25 at 1:00 A.M. revealed Resident #4 was observed sitting on the floor, on his buttocks next to his bed. Resident #4 stated he was crawling on the floor to get in his wheelchair. Resident #4 denied hitting his head, had no complaints of pain or discomfort, and exhibited no signs or symptoms of distress. Resident #4 had a blood pressure of 112/72 , and a heart rate of 72. The resident was educated on the importance of using the call light and waiting for assistance. Resident #4 was assisted off the floor by two staff members and placed in the wheelchair. Review of the facility occurrence report dated 12/25/25 and timed 1:00 A.M. noted Resident #4 sustained a fall during a transfer in the resident's room. The occurrence report contained no documentation of what fall interventions were in place at the time of the fall, how long the resident had been on the floor, or any potential witnesses or resident specific interventions implemented to address fall incident.Interview on 01/29/26 at 12:45 P.M. with the Director of Nursing (DON) verified the nursing progress note, and the facility occurrence report for Resident #4's fall on 12/25/25 contained no documentation of what fall interventions were in place at the time of the fall, or the reason why the resident attempted to self transfer. Additionally, the DON verified the fall investigation was not thorough as the the missing information was not requested, no witness statements regarding the fall were obtained and there was not a review of current interventions care planned for to ensure the interventions had been effectively implemented. Observation on 01/28/26 at 6:12 A.M. Resident #4 was noted in bed with his eyes closed. The resident's head of the bed elevated, bilateral grab bars were in place, and the resident's specialized wheelchair was located at foot of bed. Both sides of the bed were open to the room, no non-skid strips were in place on the floor to the right side of the bed. At 8:58 A.M. Resident #4 was seated on the right side of the bed, with feet to floor.According to updated facility fall prevention policy, fall investigations are to include asking the resident what they were doing when they fell, identify if there were any witnesses to the fall and if so, obtain a written witness statement of what they saw. The interdisciplinary team (IDT) is to review all information from a fall at the next daily clinical meeting and discuss the fall to include potential causes, interventions in place at time of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall to determine if they were effective, and review of the resident's care to identify if interventions were appropriate or if new interventions should be added.

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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 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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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.