STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365026	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexner Heritage House	1151 College Avenue Columbus, OH 43209

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 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 closed record review, self-reported incident review, facility investigation review, interviews, and policy review, the facility failed to complete a thorough investigation regarding an alleged sexual assault of Resident #85. This affected one (Resident #85) of three residents reviewed for abuse. The facility census was 84. Findings Include: Review of the closed medical record revealed Resident #85 was admitted on [DATE] with diagnoses that included a urinary tract infection, Parkinson ' s disease, fibromyalgia, and dystonia. The resident was discharged on 09/05/25.The hospital Discharge summary dated [DATE] revealed Resident #85 had a fall and was treated for a urinary tract infection. An admission summary dated [DATE] at 9:00 P.M. revealed Resident #85 had a hematoma to the left lateral scalp, bruising to the right arm, bruising to the left hip, and bruising to the back of the left shoulder. Review of the progress notes dated 09/03/25 and 09/04/25 revealed no evidence of Resident #85 having loose stools or report of a change in Resident #85's condition. The Medicare 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #85 had severely impaired cognitive skills. The MDS also revealed Resident #85 had no hallucinations or delusions and no behaviors. Resident #85 was incontinent of bowel and bladder. Review of a Self-reported incident (SRI) #264911, created on 09/05/25 at 5:36 P.M., revealed an alleged incident occurred on 09/03/25 in Resident #85's room. The incident was reported by staff on 09/05/25 at approximately 5:30 P.M. Resident #85 had whispered to her daughter that she had been raped the night before last night, 09/03/25. Resident #85 was interviewed and stated a short man with short black hair helped her up on bed when she told him she had to use the bathroom, took Resident #85's clothes off, assaulted her, and then washed Resident #85 with soap. Resident #85 was incontinent of bowel and bladder and did not notify staff of the need to void. Resident #85 was assessed by staff, and no signs of abuse were apparent. Resident #85 was not tearful or frightened during the assessment. Resident #85's daughter reported she did not feel the resident had been raped but did want Resident #85 sent to the hospital for examination. CNA #201 was assigned to care for Resident #85 on 09/03/25 and 09/04/25. CNA #201 did not match the description provided and no other males were present. CNA #201 reported on 09/03/25 he noticed Resident #85 had declined and notified the nurse. CNA #201 stated Resident #85 had trouble swallowing medication, was mumbling, gurgling, and stated she did not feel well. New orders were written for Ensure (supplement) with meals, liquid protein twice a day, monitor deep tissue injury to sacrum, and antifungal medication for thrush. CNA #201 reported on 09/04/25 he had to spend extra time performing incontinence care due to Resident #85 had loose stools. An incident note dated 09/05/25 at 6:02 P.M. revealed Resident #85's daughter reported Resident #85 stated she had been sexually assaulted. The daughter stated it happened last night (09/04/25). The daughter stated the incident actually happened the evening on 09/03/25. A full body assessment was completed on 09/05/25, and Resident #85 had a hematoma on the left front scalp, scattered bruising on both arms, bruising to the left hip, and bruising to the back of both legs, and a bruise to the back of the left shoulder. Resident #85 also had a pressure sore to the buttocks. Resident #85 answered questions and did not appear fearful during questioning. Resident #85 was transported to the hospital for examination. Review of the schedules for 09/03/25 and 09/04/25 revealed Certified Nursing Assistant (CNA) #201 was the only male working. Review of the employee list revealed no males with the name Resident #85 provided. The list was also reviewed for names beginning with the same letter and names similar to the one provided. However, none were identified.A handwritten statement (no date) written by Registered Nurse (RN) #204 revealed Resident #85 reported something happened the night before. Resident #85 stated a black, short haired man of normal size had provided care for Resident #85 before and had taken the trash out. Resident #85 had to go to the bathroom and believed the male helped Resident #85 on the bed, forced Resident #85's clothes off, made Resident #85 lie down and got on top of her and tried to put his penis in her. The male left on his own and Resident #85 was washed up with soap. A skin assessment revealed Resident #85 had a hematoma to the left side of upper head, bruising to bilateral arms, left upper hip area, back of the left shoulder, and to the bilateral back of the knees. A name provided by the resident was written on the statement, but a different spelling. A handwritten statement (no date) written by LPN #207 revealed Resident #85's daughter stated Resident #85 told her, You would not believe what goes on at night. I was raped. Resident #85 stated she did not want to cause trouble and was over it. Resident #85 stated it was not last night but the night before (Wednesday, 09/03/25). A typed statement by the Director of Nursing (DON) of a telephone interview with LPN #202 on 09/05/25

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 closed record review, interview, and policy review, the facility failed to complete treatments, provide medications and obtain laboratory testing as ordered by the physician. This affected one (#86) of three residents reviewed for condition change. The facility census was 84. Findings include: Review of the closed medical record revealed Resident #86 was admitted on [DATE] with diagnoses that included but not limited to acute osteomyelitis to the left ankle and foot, anorexia, sepsis due to Methicillin-resistant Staphylococcus aureus (MRSA), aftercare following surgical amputation, type 2 diabetes mellitus, peripheral vascular disease, congestive heart failure, atrial fibrillation, dementia, and an open wound on the left foot. The resident was discharged on 09/03/25.a. Review of the Plan of care dated 08/24/25 revealed Resident #86 was at risk for skin breakdown and development of pressure injury related to hospitalization, and left foot wound due to partial second metatarsal amputation. Review of physician order dated 08/24/25 revealed Resident #86's left foot was to be cleansed with normal saline, have betadine (antiseptic) applied to the wound bed, covered with a four-inch by four-inch dry sterile gauze, and a single four-inch by four-inch gauze placed at the dorsal food and anterior ankle, then wrapped with a gauze roll and a four-inch elastic bandage with very light compression every day shift. A Skin and Wound evaluation dated 08/25/25 revealed Resident #86 had a surgical wound with seven sutures to the left plantar second digit toe (amputation) that was present upon admission. The wound measured 4.1 centimeters long and 0.5 cm wide. Review of the treatment administration record (TAR) revealed no evidence of the treatment being completed on 08/27/25, 08/28/25, 09/01/25, and 09/03/25. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 had severe cognitive impairment. The MDS also revealed Resident #86 had an infection of the foot/surgical wound.An interview on 10/23/25 at 10:51 A.M. with the Director of Nursing (DON) verified there was no documentation of the treatments being completed to Resident #86's left foot on 08/27/25, 08/28/25, 09/01/25, and 09/03/25.Wound care treatment guidelines policy dated 03/31/22 revealed documentation of the treatment should be done immediately after the treatment. b. A comprehensive metabolic panel (CMP) laboratory test dated 08/27/25 revealed Resident #86's potassium level was 4.0 milliequivalents (mEq) per Liter (L). The normal reference range for Potassium was 3.5 mEq/L to 5.3 mEq/L. Review of CMP results dated 09/01/25 revealed Resident #86's Potassium was 2.6 mEq/L which was critically low. An order dated 09/02/25 was received for a STAT (immediate) basic metabolic panel (BMP). The BMP dated 09/02/25 revealed Resident #86's potassium was 2.7 mEq which was critically low. A general nurse's note dated 09/02/25 at 10:43 P.M. authored by Licensed Practical Nurse (LPN) #209 revealed Resident #86 potassium was 2.7 mEq. The physician called the supervisor and ordered potassium two bid (twice a day), a day and 1 at 10pm , 3pm, and 1 at 7 pm dose was administered resident tolerated the drugs.A general nurse's note dated 09/03/25 at 12:10 A.M. authored by Registered Nurse (RN) #208 revealed the physician called regarding Resident #86's low potassium level. Resident #86 received evening medication at approximately 9:00 P.M. and vomited soon after. The physician ordered Resident #86 be given Zofran (anti-nausea) four milligrams sublingually. After 30-minutes, Resident #86 was to be administered 40 mEq of potassium. If Resident #86 was able to tolerate these medications 40 mEq of potassium was to be administered at 3:00 A.M. and 7:00 A.M. If Resident #86 was unable to tolerate the medication, the physician needed to be notified, and Resident #86 may need sent to the hospital. RN #208 relayed the orders to LPN #209 to place the orders and order the labs. LPN #209 verbalized understanding. Review of the medical record revealed no evidence of Zofran or Potassium 40 mEq being administered. There was no evidence the medications were removed from the facility emergency stock medications.Further review revealed a BMP was completed on 09/03/25 and the resident's Potassium level returned to 4.5 mEq/L. An interview on 10/20/25 at 3:06 P.M. LPN #209 revealed she could not recall information about Resident #86's potassium being administered. An interview on 10/20/25 at 3:16 P.M. RN #208 revealed critical labs were called to the nursing supervisors. RN #208 verified she was notified of the critical labs and relayed the new orders for medications to LPN #209. RN #208 verified LPN #209 should have entered the orders and administered the Zofran and potassium as ordered. An interview on 10/23/25 at 10:51 A.M. DON verified the nurse note by LPN #209 dated 09/02/25 at 10:43 P.M. was confusing. DON verified there was no evidence in the medical record of the orders for Zofran or potassium being written or administered to Resident #86 as ordered on 09/02/25 or 09/03/25. Physician Orders policy dated 01/03/22 revealed a provider may give a medical order

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, hospital record review, policy review and interview the facility failed to implement a comprehensive, resident centered plan for the prevention and treatment of pressure ulcers.Actual Harm occurred on 09/03/25 when Resident #86, who had resided in the facility less than 30 days, was cognitively impaired and required staff assistance with activities of daily living, was assessed to have an unstageable pressure ulcer to the sacrum with necrosis requiring debridement. Resident #86 had been admitted to the facility on [DATE] with a skin alteration to the coccyx that the facility failed to complete a comprehensive wound assessment of, failed to provide appropriate/adequate interventions for and failed to ensure the facility wound physician and wound nurse were timely notified of to prevent the deterioration of the alteration to an unstageable pressure ulcer. This affected one resident (#86) of three residents reviewed for pressure ulcers. Findings include: Review of the closed medical record revealed Resident #86 was admitted to the facility on [DATE] with diagnoses including acute osteomyelitis left ankle and foot, anorexia, sepsis due to methicillin-resistant Staphylococcus aureus (MRSA), aftercare following surgical amputation, type 2 diabetes mellitus, peripheral vascular disease, congestive heart failure, atrial fibrillation, osteoarthritis of the knee, dementia, irritant contact dermatitis, and open wound on left foot. Resident #86 was discharged from the facility on 09/03/25 to the hospital and did not return to the facility following the hospitalization. Review of the hospital record dated 08/24/25 revealed the resident was being discharged to the facility and had Moisture Associated Skin Damage (MASD), skin inflammation caused by prolonged exposure to moisture, leading to skin breakdown and irritation, present to the buttocks with Triad cream (sterile, zinc-oxide base, hydrophilic paste to create a moist environment that aids autolytic debridement) ordered for treatment. Review of the resident's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 had severe cognitive impairment. The assessment revealed Resident #86 required maximal (staff) assistance with bed mobility. The MDS also revealed Resident #86 was always incontinent of bowel and bladder. The initial assessment completed did not indicate the resident was admitted to the facility with any type of skin alterations. A care plan dated 08/24/25 revealed Resident #86 was at risk for skin breakdown and development of pressure injury. The care plan included Resident #86 had a left foot wound related to partial second metatarsal amputation, moisture associated skin damage (MASD), and redness under both breasts. Interventions included assisting with turning and repositioning every two hours and as needed, assisting with maintaining skin clean and dry daily, monitoring for MASD/redness and left foot wound for signs and symptoms of infection every shift, completing treatments as ordered, weekly skin assessments as scheduled, and the wound physician/nurse to evaluate and treat as ordered. Record review revealed no documented evidence staff were encouraging or providing turning and repositioning every two hours. In addition, there was no evidence Resident #86 was noncompliant with care or interventions. A physician order dated 08/24/25 revealed Resident #86 was ordered Triad paste to buttocks for incontinence every day and night shift. The resident also had an order for HydraGuard (moisture barrier) to be applied every shift after incontinent episodes for prevention. Review of the treatment administration record (TAR) revealed the treatments were completed per orders.A Braden Scale for Predicting Pressure Sore Risk dated 08/24/25 revealed Resident #86 scored a 14 out of a possible 18 which indicated Resident #86 was at moderate risk for pressure ulcer development. A skin and wound evaluation dated 08/24/25 at 12:01 P.M. included Resident #86 had an unstageable pressure wound to the coccyx. The evaluation noted the wound was present upon admission and measured 9.4 centimeters (cm) long and 0.94 cm wide. The author of the assessment did not sign the document or provide a description of the coccyx wound. A black and white photo dated 08/24/25 was provided for the surveyor from the medical record. No unstageable wound could be identified to the resident's coccyx or buttocks. The quality of the photograph did not support the said stage of the wound.An admission Screener dated 08/24/25 at 3:25 P.M., completed by LPN #200, revealed Resident #86 had an open area to the coccyx. There was no description or staging of the wound despite the document having an anatomical drawing, descriptions of wound staging and areas to document wound measurements. Review of hospital documentation and the facility skin assessments (MDS, skin and wound evaluation, admission screener) for this area were inconsistent at the time of admission, noting the resident had MASD, an open area and an unstageable pressure ulcer to the sacrum. No additional documentation or evidence was provided by the facility to support a comprehensive and accurate assessment, including description and

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview, and policy review, the facility failed to ensure laboratory testing was completed per physician order. This affected one (#86) of three residents reviewed for condition change. The facility census was 84. Findings include: Review of the closed medical record revealed Resident #86 was admitted on [DATE] with diagnoses that included but not limited to acute osteomyelitis to the left ankle and foot, anorexia, sepsis due to Methicillin-resistant Staphylococcus aureus (MRSA), aftercare following surgical amputation, type 2 diabetes mellitus, peripheral vascular disease, congestive heart failure, atrial fibrillation, dementia, and an open wound on the left foot. The resident was discharged on 09/03/25.A comprehensive metabolic panel (CMP) laboratory test dated 08/27/25 revealed Resident #86's potassium level was 4.0 milliequivalents per liter (mEq/L) of blood. The normal reference range for Potassium was 3.5 mEq/L to 5.3 mEq/L.Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 had severe cognitive impairment. CMP laboratory results dated [DATE] revealed Resident #86's Potassium was 2.6 mEq/L which was critically low. An order dated 09/02/25 was received for a STAT (immediate) basic metabolic panel (BMP) laboratory test. The BMP dated 09/02/25 revealed Resident #86's potassium was 2.7 mEq/L which was critically low. A general nurse's note dated 09/02/25 at 10:43 P.M. authored by Licensed Practical Nurse (LPN) #209 revealed Resident #86 potassium was 2.7 mEq/L. The physician called the supervisor and ordered potassium.A general nurse's note dated 09/03/25 at 12:10 A.M. authored by Registered Nurse (RN) #208 revealed orders were received to administer potassium chloride 40 mEq orally thirty minutes after Zofran (anti-nausea) and then again at 3:00 A.M. and 7:00 A.M. If Resident #86 was unable to tolerate the medication, the physician needed to be notified, and Resident #86 may need sent to the hospital. The physician also ordered a CMP and Magnesium level to be drawn on 09/03/25. RN #208 relayed the orders to LPN #209 to place the orders and order the labs. LPN #209 verbalized understanding. Review of the closed medical record revealed a BMP was completed on 09/03/25 and the resident's Potassium level returned to 4.5 mEq/L. However, a CMP and Magnesium were not completed.An interview on 10/20/25 at 10:51 A.M. Director of Nursing (DON) verified orders for CMP and Magnesium blood work for Resident #86 were not completed as ordered (the RN and LPN did not enter the order in the medical record). An interview on 10/20/25 at 3:06 P.M. LPN #209 revealed she could not recall information about Resident #86's potassium or ordered blood work.An interview on 10/20/25 at 3:16 P.M. RN #208 revealed critical labs were called to the nursing supervisors. RN #208 verified she was notified of the critical labs and relayed the new orders for medications and blood work to LPN #209 for the LPN to address.Physician Orders policy dated 01/03/22 revealed a provider many give a medical order over the telephone. The nurse will transcribe the order into the electronic medical record. The nurse that the physician gave the order to will be responsible for executing the order or provide for the safe hand-off to the next nurse. Contact laboratory services as required to execute the medical order. Laboratory Services and Reporting policy dated 04/2022 revealed the community provides or obtains laboratory services to meet the needs of its residents. The community is responsible for the timeliness of the services. This deficiency represents non-compliance investigated under Complaint Number 2609622.