

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2025
NAME OF PROVIDER OR SUPPLIER Wexner Heritage House		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - 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 medical record review, hospital document review, interview, and facility policy and procedure review, the facility failed to ensure laboratory testing and timely follow-up was completed to diagnose and treat a urinary tract infection (UTI). Actual harm occurred beginning on 12/10/25 when Resident #94 exhibited signs/symptoms of a UTI (burning) without evidence of adequate intervention. On 12/11/25 a plan for a urine culture (due to complaints of burning on urination and elevated temperature) was noted; however, the facility failed to send the urine specimen to the laboratory. On 12/16/25 (five days later) the facility recognized the urinalysis was not completed, and a urine specimen was obtained for testing. However, the results of the urinalysis were not available on 12/17/25 before Resident #94 became unresponsive, was intubated, and was transferred to the hospital where the resident was diagnosed with acute respiratory failure, septic shock likely due to bacteria in the urine, and a UTI. This affected one resident (#94) of one resident reviewed for UTIs. The census was 85. Review of the medical record for Resident #94 revealed the resident was admitted to the facility on [DATE] with diagnoses including legal blindness, traumatic subarachnoid hemorrhage, repeated falls, and muscle weakness. Review of Resident #94's physician's orders revealed an order dated 12/06/25 to record Foley (urinary catheter) output every shift. Review of a plan of care dated 12/08/25 revealed Resident #94 was prone to alterations in bladder function related to urine retention and urinary incontinence. Interventions included to monitor urine for color, clarity, foul odor, changes in level of consciousness, obtain urine specimens as ordered, and notify the physician/certified nurse practitioner (CNP) and family of significant changes in condition. Review of Resident #94's nursing progress notes revealed on 12/10/25 at 5:55 P.M., the resident complained of burning from his penis area and Foley catheter and CNP (#1001) was notified for possible urinalysis and culture and sensitivity. Further review of the progress note revealed the CNP reviewed the resident's medical record and saw the resident stated he had urinary retention with new orders to remove the Foley catheter, encourage the resident to void, perform bladder scans and if the resident had (urinary) retention more than 300 (milliliters) to perform a straight catheterization. CNP #1001 also ordered Pyridium, a medication to treat pain or burning, increased urination, and increased urge to urinate, but did not order any laboratory testing as the note revealed the resident had a current urinalysis completed in the hospital. Review of the December 2025 medication administration record (MAR) revealed Resident #94's Foley catheter was removed on 12/10/25 at 5:46 P.M. Further review of the December 2025 MAR revealed the resident's urinary voiding was monitored every four hours daily between 12/10/25 and 12/16/25 with no expended periods of no voiding documented. Review of Resident #94's nursing progress note revealed on 12/11/25, the resident was seen by the CNP for elevated temperature and burning on urination. The assessment and plan revealed to obtain a urinalysis with culture and sensitivity and encourage fluids and hygiene. It was noted the resident was in the hospital between 12/01/25 and 12/05/25, and on 12/03/25 a urine culture in the hospital was negative. A complete blood count (CBC) laboratory test dated 12/11/25 revealed the resident had an elevated white blood cell (WBC) count (indicative of possible infection). Review of a nursing (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 0690 Level of Harm - Actual harm Residents Affected - Few	progress note dated 12/11/25 at 11:26 A.M. revealed Resident #94 had a low-grade temperature and also had a low-grade temperature from the previous shift. The note revealed the resident continued to have bouts of confusion and the CNP ordered a urinalysis with culture and sensitivity. However, review of Resident #94's physician's orders revealed no actual physician order for the urinalysis or culture and sensitivity were written on this date. Review of a nursing progress note dated 12/11/25 at 5:48 P.M. revealed Resident #94's WBC laboratory value was elevated, and urine was obtained and awaiting pick up. Further review of the progress notes revealed no evidence the resident's urine sample was picked up for testing. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 11. The resident was assessed to require self-care assistance. Review of a physician's order dated 12/16/25 at 6:15 P.M. revealed Resident #94 was ordered a urinalysis and culture and sensitivity as a one-time order. Review of Resident #94's December 2025 medication administration record (MAR) revealed the resident's urine was obtained for a urinalysis and culture and sensitivity on 12/16/25 at 10:49 P.M. Review of a laboratory values document revealed Resident #94 had a urine sample collected on 12/17/25 at 12:00 A.M., it was received on 12/17/25 at 5:54 A.M., and reported on 12/17/25 at 11:01 P.M. Resident #94's urine was noted to be extra turbid, was positive for blood, leukocytes, nitrates, WBC, mucous, WBC clumps, and had moderate bacteria present. The urine culture was pending at the time of the laboratory report. The facility received a subsequent facsimile (fax) document which indicated the resident had Escherichia coli (E. coli) in his urine. Review of a nursing progress note dated 12/17/25 at 2:52 A.M. revealed Resident #94 was walked to the bathroom with (nurse) aides, and once the resident was in the bathroom, he went unresponsive on the toilet. A sternal rub was completed by the nurse and was not successful and abnormal abdominal breathing with noted with a weak radial pulse. Emergency medical services (EMS) were contacted, and Resident #94 was transferred to the hospital. Review of a hospital document dated 12/17/25 revealed Resident #94 arrived at the hospital with unresponsiveness and was intubated by EMS staff in the field. Assessment of Resident #94 in the emergency room (ER) revealed the resident had acute respiratory failure with significant encephalopathy; however, there was question for aspiration pneumonia. The resident was noted with shock related to unclear etiology though UTI was likely and potential aspiration pneumonia. The resident had pyuria (pus in the urine) and positive leukocytes on urinalysis and symptoms of painful urination prior to hospitalization. The resident was also noted with lactic acidosis related to severe shock and elevated troponin. Review of a hospital document dated 12/21/25 revealed Resident #94 was extubated on 12/20/25. On imaging, Resident #94's acute respiratory failure was ruled out to be caused by clinically significant pulmonary embolism but may have a component of aspiration pneumonia. The resident was assessed with septic shock in nature due to E. coli bacteremia, with a likely urinary source. The resident had a UTI with E. coli bacteremia and leukocytosis was improving. The resident was also assessed with elevated troponin level, lactic acidosis, acute kidney injury, and elevated sodium levels, all which received treatment. Resident #94's acute metabolic encephalopathy was found with unclear etiology; however, there was suspicion for dementia not previously diagnosed. The resident remained hospitalized as of 12/22/25. Interview with Licensed Practical Nurse (LPN) Unit Manager (UM) #141 on 12/18/25 at 10:46 A.M. revealed Resident #94's urine specimen was obtained on 12/11/25; however, she was not able to recall which member of the nursing staff obtained the specimen. She revealed she was told by the laboratory that they never received Resident #94's urine specimen, she also indicated the specimen was also never recovered at the facility and there were no laboratory results available for the urine specimen from 12/11/25. Interview on 12/18/25 at 2:49 P.M. with CNP #1001 revealed her intention was, after assessing Resident #94 on 12/11/25, to wait and see if removing the resident's indwelling urinary catheter resolved the discomfort rather than potentially ordering an unnecessary urine specimen and laboratory testing. CNP #1001 revealed she expected laboratory specimens be obtained within 48 hours of the order. CNP #1001 stated she never got the results of Resident #94's (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	urinalysis and on 12/15/25 she inquired with LPM UM #141 about the resident's urine sample. CNP #1001 revealed a delay in obtaining results of Resident #94's urinalysis and expressed concerns about the delay in diagnosis and treatment of Resident #94's UTI. Review of the facility's procedure titled, Laboratory Services and Reporting, dated 04/2022, revealed the facility was responsible for obtaining laboratory services when ordered by a medical practitioner. The facility was directly responsible for the timeliness of the applicable services. Review of a facility policy titled, Infection Surveillance Policy, dated 03/10/25, revealed registered nurses (RNs) and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff. Examples included a resident develops signs and symptoms of an infection or a microbiology test is ordered.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy, the facility failed to ensure the dishwasher and three compartment sink was in a working order. Additionally, the facility failed to maintain the kitchen in a sanitary manner and store and prepare foods in a sanitary manner. This had the potential to affect 83 out of 85 residents residing in the facility with two residents on a nothing by mouth (NPO) diet. the facility census was 85. During observation of the kitchen area on 12/15/25 at approximately 9:40 A.M. with Regional Dietary Manager (RDM) #601, upon entering the kitchen and performing hand hygiene, the surveyor observed the paper towel dispenser at the handwashing sink was broken and nonfunctional. RDM #601 confirmed at 9:40 A.M. that the dispenser had been broken for awhile and that maintenance had not repaired it. The surveyor was required to obtain napkins from a back storage area to dry hands. During the same observation, the surveyor observed the front kitchen area near the dishwasher and noted a large strip of broken and missing floor tile, as well as a dishwasher that was leaking water onto the floor. A large puddle of standing water was present in the dishwashing area. RDM #601 confirmed at 9:44 A.M. that the dishwasher had been experiencing issues since approximately September 2025 and had not yet been replaced. Observation on 12/15/25 at 9:48 A.M., of the walk-in refrigerator revealed multiple food items that were expired, deteriorated, or improperly labeled, including cilantro past its use-by date of 12/06/25, wilted spring mix lettuce with a use-by date of 12/06/25, coleslaw dated 12/10/25, [NAME] dated 12/08/25, prepped carrots dated 12/06/25, cabbage received 10/13/25, green onions dated 12/13/25, asparagus cut and prepped dated 12/10/25 and dehydrated, two large boxes of assorted lettuce with no open or use-by dates, washed broccoli dated 12/13/25, cucumbers dated 12/09/25, celery dated 12/13/25 containing a container of dark sauce, spring mix lettuce dated 12/10/25, bell peppers dated 12/10/25, parsnips expired 11/13/25, fresh herbs dated 12/13/25, green beans dated 12/10/25, additional asparagus dated 12/13/25, carrots dated 12/10/25, and a degraded box of watermelon with yellow/brown fruit and no date. Two large containers of cornflakes and one container of Cheerios were observed stored under a prep table without any open or use-by dates. RDM #601 confirmed at the time of the observations the above items. At 10:02 A.M. on 12/15/25, observation of the freezer revealed a large amount of ice buildup on the floor, creating a slip hazard and potential for thawing of frozen food items. On 12/17/25 at 2:56 P.M., the surveyor again observed the handwashing sink and noted the paper towel dispenser remained broken and there was no trash receptacle available for disposal of paper towels. The only available trash cans required lifting lids to discard waste. This was confirmed by Assistant Dietary Manager (ADM) #550. During further observation on 12/17/25 at approximately 3:08 P.M., the surveyor observed extensive dirt and grease buildup on exhaust fans above food preparation areas, food splatter and residue on walls behind the stove, heavily soiled hood vents, and an ice machine with rust and calcified water dripping from a screw into the ice storage area, along with a black substance visible inside the ice bin. These observations were confirmed with ADM #550. On 12/17/25, the surveyor observed the dishwasher in operation and noted it only reached 170 degrees Fahrenheit, below expected sanitizing temperatures of 180. The dishwasher continued to leak water, resulting in pooled water and white calcified residue on the floor. At 4:35 P.M., pooled water remained beneath the dishwasher and had not been removed. The ADM #550 stated the water should be mopped after each meal and confirmed the dishwasher had not been used since lunch and the water had not been mopped. On 12/18/25 at 11:51 A.M., ADM #550 stated they switched to the three compartment sink to clean all dishes due to the dishwasher not working properly. Testing of the three-compartment sink sanitizing solution revealed sanitizer levels of 50 parts per million (PPM), below the required 200 PPM, per ADM #550. ADM #550 confirmed that dishes used throughout the day had been washed using this sanitizer concentration. The sink was drained and refilled; however, at (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12:00 P.M., sanitizer levels remained at 100 PPM, still below required levels, and the sink was drained again. Review of sanitization logs revealed no documented sanitizer level monitoring after the morning of 12/17/25, with lunch and dinner entries missing, and no sanitizer levels documented for 12/18/25. At 12:50 P.M., ADM #550 confirmed sanitizer levels should be 200 PPM, while logs reflected readings as high as 400 PPM and 500 PPM on prior dates, indicating inconsistent and inaccurate monitoring. During observation of the service line on 12/18/25 at 12:02 P.M., the surveyor observed multiple hand hygiene and glove use failures by [NAME] #602. [NAME] #602 grabbed the glove dispenser while already wearing gloves, then handled meal tickets and tray racks without changing gloves or performing hand hygiene. The cook was observed handling multiple food items, including fish, potato chips, and vegetables, repeatedly with the same gloves after contacting non-food-contact surfaces such as tray racks and meal tickets. [NAME] #602 also grabbed a hot dog bun from an opened bag using the same gloves and then used a tong to place the bun on the tray without changing gloves. Additionally, [NAME] #602 used gloves to handle cleaning rags to wipe down surfaces immediately prior to handling the fish, then placed the fish on trays with the same gloves, and subsequently used those same gloves to move potato chips and reposition vegetables on the trays. At no point did the cook perform hand hygiene or change gloves between touching surfaces and food items. [NAME] #602 confirmed all above details at the time of the observations. Interview on 12/18/25 at 11:24 A.M., ADM #550 confirmed that a trash can was added near the handwashing sink and cleaning behind the stove was completed after surveyor identification of concerns. The dishwasher remained nonfunctional, and the facility had transitioned to handwashing dishes due to equipment failure. Interview on 12/18/25 at 11:48 A.M. with Maintenance Director (MD) #901, revealed that the freezer had icicles approximately eight inches long due to being left open over time, allowing heat from the kitchen to cause condensation and subsequent ice buildup that had not been cleaned for an extended period. MD #901 confirmed that the dishwasher was broken and leaking, and repairs had been delayed, contributing to ongoing concerns. Interview on 12/17/25 at 3:42 P.M. with Maintenance #900, revealed that freezer doors were being left open improperly, causing water accumulation that refroze into blocks and icicles, and that staff were not following proper procedures. Maintenance #900 also confirmed that the dishwasher was broken, leaking, and not consistently reaching proper sanitization temperatures, with repairs delayed and temporary measures in place. Review of the facility policy titled Food Storage, dated 06/24 storage areas are sequenced, neat, clean, organized and kept at proper temperature. All food products should be correctly labeled with the receive date for product rotation and for the freezer, specifically, all ice build up should be removed from surfaces.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, resident interview, staff interview, and facility policy review, the facility failed to ensure Mantoux Tuberculosis (TB) testing and annual assessments were completed in a timely manner which had the potential to affect all 85 residents residing in the facility. Additionally, the facility failed to ensure oxygen tubing was replaced after the nasal cannula fell on the ground for Resident #105, and failed to ensure Enhanced Barrier Precautions (EBP) were followed during medication administration via a gastrostomy feeding tube for Resident #44. The facility census was 85.1. Review of the personnel file for Licensed Practical Nurse (LPN) #141 revealed a hire date of 07/08/25, however, there was no documentation verifying whether the staff actually began providing resident care on or after this date. Review of the initial first step for the Mantoux Tuberculosis (TB) test was administered on 07/08/25 but was not read until 07/10/25, occurring after the staff member's date of hire Review of the personnel file for LPN #350 revealed a hire date of 05/16/25, however, there was no documentation verifying whether the staff actually began providing resident care on or after this date. Review of the initial first step for the Mantoux Tuberculosis (TB) test was administered on 05/16/25 but was not read until 05/18/25, occurring after the staff member's date of hire Interview on 12/22/25 at 9:26 A.M. with Human Resource Manager #905 confirmed that she could not verify the start of care date was prior to LPN #141 and #350's date of hire and that the first reading for the initial TB test was prior to their date of hire. Review of the personnel file for LPN #112 revealed a date of hire date of 04/09/24. Review of the personnel file for LPN #112 revealed there was no evidence that an annual TB questionnaire was completed at the time of the survey. Review of the personnel Certified Nursing Assistant (CNA) #125 revealed a date of hire date of 10/23/18. Review of the personnel file for CNA #125 revealed the most recent annual TB questionnaire was completed on 02/08/24 with no evidence a more recent questionnaire had been completed. Review of the personnel file for CNA #309 revealed a date of hire date of 08/15/17. Review of the personnel file for CNA #309 revealed the most recent annual TB questionnaire was completed on 01/31/24 with no evidence a more recent questionnaire had been completed. Review of the personnel file for CNA #315 revealed a date of hire date of 05/19/21. Review of the personnel file for CNA #315 revealed the most recent annual TB questionnaire was completed on 02/02/24 with no evidence a more recent questionnaire had been completed. Interview on 12/22/25 at 9:26 A.M. with Human Resource Manager #905 confirmed the above personnel did not have an annual TB questionnaire completed timely. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the TB control plan and TB risk assessment revealed the facility will test for tuberculosis infections on hire and annually. 2. Review of the medical record for Resident #105 revealed an admission date of 12/16/25 with diagnoses including acute posthemorrhagic anemia, gastrointestinal hemorrhage, acute respiratory failure with hypoxia, and acute pulmonary edema. Review of orders revealed continuous oxygen via nasal cannula at three liters per minute every shift related to chronic obstructive pulmonary disease, initiated on 12/17/25. Review of the care plan revealed no indication of oxygen use. Observation on 12/18/25 at 1:20 P.M. revealed CNA #910 passing meal trays when she accidentally kicked the resident's oxygen tubing, which became wrapped around her leg and was dragged across the floor. At the time, the nasal cannula was not on the resident. CNA #910 handed the oxygen tubing to the resident's daughter. The nasal cannula was then placed back on the resident without being cleaned or sanitized. Interview on 12/18/25 at 1:30 P.M. with CNA #910 confirmed that the nasal cannula was placed back on Resident #105 without cleaning or changing after being dragged across the floor. She acknowledged that she did not explain to the resident or daughter that the tubing should have been replaced due to contamination. She also confirmed that the tubing should have been replaced and that the resident uses continuous oxygen at this time. 3. Review of the medical record for Resident #44 revealed admission date 05/18/16 with diagnoses including but not limited to anoxic brain damage, contractures of bilateral elbows, wrists, hands, and knees, tracheostomy dependent and percutaneous endoscopic gastrostomy (PEG tube for feeding) dependent. A review of Resident #44 physician orders dated 12/01/25 to 12/31/25 revealed an order dated 04/21/25 for Baclofen tablet 20 milligrams (mg) give one tablet via PEG tube three times a day for muscle spasm and an order dated 04/22/25 Resident is on Enhanced Barrier Precautions (EBP), EBP are required with high contact resident activities. An observation on 12/17/25 at 1:19 P.M. revealed on the wall outside Resident #44's room an EBP notification sign. Further observation revealed Licensed Practical Nurse (LPN) #206 preparing the medication Baclofen for administration. LPN #206 completed the preparation, sanitized hands and entered Resident #44's room. LPN #206 washed hands and put on gloves. LPN #209 then flushed Resident #44's PEG tube and checked for placement of the PEG tube. LPN #206 continued to administer the medication Baclofen via the PEG tube, completed the administration, removed gloves and washed hands. LPN #209 did not place personal protective equipment (PPE) gown prior to the PEG tube flush and administration of medication for Resident #44. An interview on 12/17/25 at 1:30 P.M. with LPN #209 confirmed when LPN #209 administered Resident #44's medication via the PEG tube and did not put a PPE gown on prior to working with Resident #44's PEG tube and administering medication via the PEG tube. Review of the Enhanced Barrier Precautions (EBP) notification sign revealed providers, and staff must also wear gloves and a gown for the following including device care or use central line, urinary catheter, feeding tube, tracheostomy. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled Isolation Precautions revised 06/2021 revealed enhanced barrier precautions are used in conjunction with standard precautions and expand the use of PPE to donning of gown and glove during high-contact care activities that could expose healthcare worker hands/clothing to Multi-Drug-Resistant Organisms (MDRO).		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to follow physician orders related to obtaining daily weights. This affected Resident #01 and #10 out of five residents ordered to receive daily weights. Additionally, the facility failed to ensure that physician orders for double portions were followed, which affected Resident #18. The facility also failed to obtain a timely self-medication administration assessment for Resident #01 who was receiving tube feeding. The facility census was 85. 1. Review of the medical record for Resident #18 revealed an admission date of 06/03/25 with diagnoses of metabolic encephalopathy, type one diabetes mellitus, cognitive communication deficit, gastroesophageal reflux disease (GERD), and obesity. Review of quarterly Minimum Data Set (MDS) 3.0 assessment completed 12/08/25 revealed Resident #18 is cognitively intact, independent with eating, and has not had a weight gain or loss in the past month. Review of care plan dated 06/10/25 revealed Resident #18 has a nutritional problem or potential related to type one diabetes mellitus, hypertension, hyperlipidemia, GERD, urinary tract infection, seizures, long-term insulin use, transient ischemic attack, and history of falls. Resident also has vitamin D and B12 deficiency and requires double portions with meals. Staff interventions include providing and serving diet as ordered. Review of nutrition/dietary note dated 11/06/25 revealed updated diet order to reflect double portions and request daily sugar-free ice cream with dinner. Doubling portions was intended to aid in desired weight maintenance. Review of physician order dated 11/06/25 revealed Resident #18 was to receive a certified kosher diet, regular texture, regular/thin consistency with double portions. Review of meal ticket dated 12/18/25 for breakfast service for Resident #18 revealed regular diet with thin liquids. The resident was served cranberry juice, one half cup oatmeal, two hard-boiled eggs, orange cranberry muffin, four-ounce fresh fruit cup, eight ounces milk, and six ounces coffee. Review of meal ticket dated 12/18/25 for lunch service for Resident #18 revealed regular diet with thin liquids. The resident was served three ounces crunchy baked fish, one half cup house-made chips, four ounces coleslaw, one half cup banana pudding, six ounces coffee, and eight ounces water. Observation on 12/18/25 at 8:13 A.M. of Resident #18 breakfast tray confirmed he did not receive double portions as required. Resident #18 confirmed his meal tray ticket did not include the double portion requirement. Observation on 12/18/25 at 12:29 P.M. of Resident #18 lunch tray confirmed he did not receive double portions as required. He voiced needing additional food for lunch and dinner service and confirmed his meal tray ticket did not include the double portion requirement. Interview and observation on 12/18/25 at 12:31 P.M. with Certified Nursing Assistant (CNA) #309 and Registered Nurse (RN) #360 confirmed Resident #18 meal ticket did not include the double portion requirement and the resident did not receive double portion sizing for lunch service. CNA #309 and RN #360 denied knowledge the resident was to receive double portions but confirmed physician orders were present in the record for the requirement. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/18/25 at 12:33 P.M. with Licensed Practical Nurse #350 confirmed current physician order for Resident #18 to receive double portions during meal times. Review of therapeutic diets policy dated 11/2016 revealed a tray identification system is established to ensure each resident receives their diet as ordered. 2. Review of the medical record for Resident #01 revealed an admission date of 09/07/20 with a re-entry date of 01/17/23 and diagnoses of malignant neoplasm of the base of the tongue, laceration without foreign body of the scalp (subsequent encounter), extended spectrum beta-lactamase resistance, and bacteremia. Review of the quarterly MDS assessment completed on 11/06/25 revealed Resident #01 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, no mood or behavioral concerns, and independence with activities of daily living, including eating. The MDS indicated the resident had a feeding tube, consumed a mechanically altered diet, and reported no weight gain or loss since the prior assessment. Review of physician orders dated 04/04/25 through 11/20/25 revealed Resident #01 was ordered enteral nutrition via gastrostomy tube, including TwoCal HN bolus feedings. Orders included an enteral feeding regimen every four hours (six times daily) that was discontinued on 11/20/25, and a revised order initiated on 11/20/25 at 9:00 P.M. for TwoCal HN, one carton (237 mL) via gastrostomy tube five times daily with prescribed water flushes. Review of physician orders also revealed multiple orders to obtain weights and re-weigh the resident when weight changes of five pounds or greater occurred, including re-weigh orders dated 08/05/25, 09/11/25, 09/17/25, 10/07/25, and 11/03/25, each requiring completion within one day to confirm accuracy. A physician order dated 08/11/25 required weekly weights every Monday for monitoring. Review of the care plan initiated on 01/04/21 and revised most recently on 11/19/25 revealed Resident #01 required tube feeding via gastrostomy tube related to dysphagia and inconsistent oral intake and was permitted to self-administer bolus feedings and medications through the gastrostomy tube. Review of assessments revealed a self-administration medication assessment was completed on 02/02/24, with no evidence of a subsequent reassessment completed thereafter, despite the resident continuing to self-administer medications and enteral feedings. Review of dietary progress notes dated 11/26/25 documented a current body weight of 130.8 pounds on 11/24/25, reflecting a 17.2-pound (11.6 percent) weight loss from 148.0 pounds recorded on 11/03/25. Dietary documentation recommended daily weights for five days to establish accurate weight status; however, review of the medical record revealed daily weights were not completed as recommended. Review of dietary documentation dated 12/12/25 revealed continued significant weight loss over 30 days, with a decrease from 148.0 pounds to 134.2 pounds, representing a nine percent loss. Dietary documentation dated 12/17/25 revealed discrepant weights obtained on 12/15/25, including 143.4 pounds and 134.4 pounds, and requested additional weekly weights to verify accuracy. Review of documented weights revealed Resident #01 weighed 143.4 pounds on 12/15/25 and 134.3 (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pounds on 12/19/25, reflecting a 9.1-pound (approximately 6.3 percent) weight loss in four days. Review of the medical record revealed no re-weigh was completed until 12/22/25 to confirm the significant weight change, despite physician orders requiring confirmation re-weighs within one day when weight changes of five pounds or greater occurred. Interview on 12/22/25 at 11:19 A.M. with the Director of Nursing (DON) confirmed the re-weigh completed on 12/22/25 was not timely. The DON confirmed the facility policy required confirmation re-weighs when a resident experienced a significant weight change of a 5 pound weight loss/gain. The DON further confirmed the re-weigh ordered for 09/18/25 was not completed and acknowledged dietary recommendations for daily weights following the significant weight loss identified on 11/24/25 were not completed. The DON also confirmed self-administration medication assessments should be completed at least annually and acknowledged Resident #01's self-administration medication assessment had not been completed timely. Review of the facility policy titled, Self-Administration of Medications, dated 12/01, revealed residents who wish to self-administer medications may be subject to periodic assessment for appropriateness by the interdisciplinary team (IDT) based on changes to the residents medical and decision-making status. Nursing staff will check the resident at each administration time to ensure that the medication was self-administered and indicate self-administration was monitored on a medication administration record (MAR) maintained by the nursing staff. 3. Review of the medical record for Resident #10 revealed an admission date of 05/10/22 with diagnoses including encephalopathy, acute kidney failure, Dieulafoy lesion of the intestine, and hypotension. Review of the quarterly MDS assessment completed on 11/10/25 revealed Resident #10 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The MDS indicated the resident experienced weight loss within the last six months. The assessment further reflected extensive dependence for activities of daily living, use of a wheelchair for mobility, and reliance on staff for eating set-up and personal care. Review of documented weights revealed Resident #10 experienced a clinically significant and sustained weight decline beginning in June 2025. Review of weights dated 06/10/25 reflected a weight of 138.6 pounds. Subsequent weights dated 09/09/25 reflected a weight of 128.9 pounds, demonstrating a 9.7 pound weight loss over approximately three months. Review of documented weights further revealed continued weight decline following September 2025. Weights dated 11/08/25 reflected a weight of 124.9 pounds, and weights dated 12/16/25 reflected a weight of 116.8 pounds. This represented a total weight loss of approximately 21.6 pounds from June 2025 to December 2025, equating to an approximate 15.6 percent loss over six months. Review of weights also revealed a one-month weight loss from 123.0 pounds on 11/15/25 to 116.8 pounds on 12/16/25, reflecting a 6.2-pound (approximately five percent) loss, and a three-month weight loss from 128.9 pounds on 09/13/25 to 116.8 pounds on 12/16/25, reflecting a 12.1-pound (approximately 9.4 percent) loss. Review of nutrition and dietary documentation dated 07/16/25, 07/23/25, 08/19/25, and 09/19/25 reflected ongoing identification of nutrition risk and continued provision of Nepro oral nutritional supplement three times daily related to weight loss and dialysis needs. Review of dietary documentation dated 09/19/25 identified declining dry weights and low laboratory values but did not (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflect any adjustment to the nutritional supplement regimen or physician orders despite the clinically significant weight loss identified by September 2025. Review of physician orders revealed Nepro oral nutritional supplement was ordered three times daily beginning on 07/15/25 and remained unchanged until 12/11/25. Review of the medical record revealed no changes to nutritional supplement orders or calorie provision were implemented between July 2025 and December 2025, despite ongoing documented weight loss and repeated triggers for significant weight loss during that period. Review of nutrition assessments revealed no comprehensive nutrition assessment was completed after 09/11/24, despite the resident experiencing multiple episodes of significant weight loss between June 2025 and December 2025. Review of the Medication Administration Record for November 2025 revealed Nepro eight ounces by mouth three times daily for weight loss was administered with zero percent intake documented on multiple occasions, including administration at 8:00 A.M. on 11/16/25, 11/18/25, and 11/22/25; at 2:00 P.M. on 11/14/25, 11/18/25, 11/21/25, and 11/23/25; and at 9:00 P.M. on 11/14/25, 11/18/25, 11/20/25, and 11/24/25. Review of the medical record revealed no documented adjustment to the nutrition plan or physician orders during this period of non-consumption. Review of physician orders dated 12/10/25 revealed a change in oral nutritional supplement from Nepro to Glucerna three times daily, indicating the first documented adjustment to supplement orders since July 2025. Interview on 12/17/25 at 4:16 P.M. with Dietician #500 confirmed dietary services transitioned to the facility on [DATE]. Dietician #500 confirmed the resident was being followed weekly with weights and dialysis coordination and stated the resident's weight had stabilized in the three weeks prior to the interview. The Dietician #500 confirmed that no changes to nutritional supplements or physician orders occurred between July 2025 and December 2025 despite ongoing weight decline and triggers for significant weight loss identified in September 2025. Interview on 12/18/25 at 2:43 P.M. with Resident #10 revealed the resident stated he did not like Nepro or Glucerna supplements and expressed dissatisfaction with facility food, which he believed contributed to his weight loss. The resident stated he preferred not to continue losing weight. Review of the facility policy titled, Weight Change Policy, dated 08/25, revealed a significant weight loss is identified as 5% in one month, 7.5% in three months, or 10% loss in six months. Additionally, stated recheck weights are to be obtained for a 5-pound (five) loss or gain if resident weighs over 100 pounds. A 5-pound gain or loss on a resident weighing 100 pounds or more will be reported to the dietitian and the physician. The dietitian or the registered dietetic technician will review the weight changes and make recommendations to the neighborhood nurse for follow-up with the physician as needed. Weekly weights, weight every 3 days, or as needed will be done as ordered and recorded in Point Click Care (PCC).		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, staff interview, and facility policy, the facility failed to ensure foods were at a palatable temperature. This had the potential to affect 83 out of 85 residents in the facility with two residents receiving a nothing by mouth (NPO) diet. The facility census was 85. During interview on 12/16/2025 at 2:12 P.M., Resident #30, stated that the food was terrible, arrived cold, and lacked flavor. Review of additional interviews conducted during the survey revealed that multiple residents reported concerns regarding food being served cold. During observation related to tray service on 12/18/2025, a test tray was not observed on the meal cart at 1:18 P.M. Staff stated that the test tray was not present because it had been left in the kitchen. At 1:23 P.M., staff confirmed that the test tray had been sitting in the kitchen for approximately 15 minutes after being prepared and was not placed on the meal cart prior to service. The temperatures of the lunch items were around 60-80 degrees Fahrenheit (F) and the items were not tasted at that point. During a breakfast meal pass observation on 12/22/2025 from 8:27 A.M. to 8:45 A.M., temperatures of plated food items were obtained. Pancakes were measured at 107 degrees F, sausage at 108 degrees F, and oatmeal at 133 degrees F. At 8:45 A.M., Dietary Assistant Manager #550 was interviewed at the time of the observation and confirmed that the pancakes and sausage were cold, stating that he would not want to eat those items cold for breakfast. Review of the facility policy titled, Food Temperatures, dated in 2023, revealed all hot food items must be cooked to appropriate internal temperatures and held and served at a temperature of at least 135 degrees F, with required cooking temperatures reached and maintained in accordance with regulations, laws, and standardized recipes; hot food items may not fall below 135 degrees F after cooking unless they are intended to be rapidly cooled to below 41 degrees F and reheated to at least 165 degrees F for a minimum of 15 seconds prior to serving, and caution must be taken to avoid serving food and liquids at temperatures that could cause burns. All cold food items must be stored at a temperature of 41 degrees F or below. Food temperatures should be taken periodically to ensure hot foods remain above 135 degrees F and cold foods remain below 41 degrees F during holding, plating, and until food leaves the service area. Foods should be transported as quickly as possible to maintain required temperatures, and when transportation time is extensive, appropriate methods such as hot or cold carts, pellet systems, or insulated plate bases and domes must be used. Foods sent to units for distribution, including meals, snacks, nourishments, and oral supplements, must be transported and delivered to unit storage areas in a manner that maintains cold foods at or below 41 degrees F and hot foods at or above 135 degrees F, and unit refrigerators must be monitored to ensure temperatures maintain foods at or below 41 degrees F.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation and staff interview, the facility failed to ensure purred foods were at the appropriate consistency which had the potential to affect Residents #1, #2, #96, #53, #64 who received a pureed diet. The facility census was 85. During observation on 12/18/2025 at 11:26 A.M., the surveyor observed the pureed food preparation process with [NAME] #600. The surveyor observed the fish item intended for residents on a pureed diet and noted the consistency was stringy and not smooth. The fish was described as having separable strands when processed with broth, and the surveyor observed that the texture was not appropriate for residents prescribed a pureed diet. [NAME] #600 stated she was attempting to remove the fish item from the pureed menu due to it not pureeing correctly and further stated that residents did not like the consistency and confirmed the consistency was not correct, however, she confirmed that the item would continue to be served. Review from the International Dysphagia Diet Standardization Initiative (IDDSI), Level 4 foods, which are considered pureed, must be smooth with no lumps, hold their shape on a spoon, and require no chewing to swallow. Pureed foods also must not be stringy or require tongue manipulation to break apart, as these characteristics increase the risk of choking or aspiration. Pureed food should be tested before service to ensure it meets these criteria and is safe for residents with swallowing difficulties to consume.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and facility policy review the facility failed to maintain safe and comfortable temperatures in Resident #36's room. This affected one (#36) of three residents reviewed for environment. The census was 85. Review of Resident #36's medical record revealed an admission date of 12/03/24. Diagnoses include type II diabetes mellitus with other specified complication, morbid obesity, unsteadiness on feet, need for assistance with personal care, lymphedema, essential (primary) hypertension, muscle weakness, chronic pain syndrome, bilateral primary osteoarthritis of hip, low back pain, and left bundle branch block. Review of Resident #36's Minimum Data Set 3.0 (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Observation on 12/15/25 at 2:20 P. M of Yazz 4 hallway revealed Certified Nursing Assistant (CNA) wearing winter coat in hallway. Observation on 12/15/25 at 2:24 P.M. reveals maintenance in Resident #36's room regarding heater. Interview on 12/15/25 at 2:35 P.M. with Resident #36 revealed her heater had stopped working and she needed extra blankets to keep warm. Resident #36's stated they moved some items off of the heater near the window sill. Observation on 12/15/25 at 2:36 P.M. reveals thermostat reading room as 69 degrees Fahrenheit (F) with heat set at 80 degrees F. Review of the facility's work order log confirmed a work order labeled as high priority dated 12/15/25 at 1:56 P.M. stating the issue as heat not working in Resident #36's room with notes stating checked heat, verified it works, changed and order was closed at 2:26 P.M. Observation on 12/15/25 at 3:39 P.M. reveals thermostat reading as 69 degrees F in Resident #36's room. Observation on 12/15/25 at 4:30 P.M. reveals thermostat reading as 69 degrees F in Resident #36's room. Interview on 12/16/25 at 8:40 A.M. with CNA #257 confirmed Resident #36's thermostat in room was reading at 69 degrees F. Interview on 12/16/25 at 8:41 A.M. with Licensed Practical Nurse (LPN) #280 confirmed they will place an expedited work order for maintenance regarding Resident #36's heat. Review of the facility's work order log confirmed a work order labeled as a high priority on 12/16/25 at 8:42 A.M. stating heat not working in Resident #36's room. Interview on 12/16/25 at 9:27 A.M with Maintenance Member #110 confirmed the temperature range using an infrared thermometer in different locations in Resident #36's room ranged from 65 to 67 degrees Fahrenheit. Maintenance Member #110 stated housekeeping would be coming to assist Resident #36 with clearing armoire (dresser) to move it away from heater to allow for better airflow. Maintenance Member #110 confirmed Resident #36 should have been temporarily moved to another room if the heater was not working properly overnight. Interview on 12/16/25 at 10:12 A.M. with Maintenance Member #109 revealed Resident #36's window was cracked therefore preventing the room from heating up and they also changed the thermostat in the room. Observation on 12/16/25 at 1:47 P.M. revealed Resident #36's thermostat in room reading 71 degrees F. Interview on 12/16/25 at 1:47 P.M. with Resident #36 confirmed the temperature in the room felt warmer and was comfortable with the thermostat reading at 71 degrees F. Observation on 12/16/25 at 4:37 P.M. revealed Resident #36's thermostat reading at 72 degrees F. Observation on 12/17/25 at 9:50 A.M. revealed Resident #36's thermostat reading at 71 degrees F. Interview on 12/18/25 at 10:51 A.M. with Unit Manager #350 confirms she was not aware of Resident #36's room being cold and would've temporarily moved Resident #36 to another room if they were unable to fix the heater. Review of the facility's policy titled, Extreme Heat/Extreme Cold Policy effective date 04/2025, confirms the facility will provide as comfortable environment as possible for our residents and staff by monitoring temperatures in all areas of the building. In the event of temperatures (i.e. 71 degrees Fahrenheit or below) in resident rooms, these residents will be moved to another area or room that has heat.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to complete a baseline abnormal involuntary movement scale (AIMS) scale for one resident (#12) who was admitted on psychotic medication. This affected one resident (#12) of five residents reviewed for unnecessary medications. The facility census was 85. Review of the medical record for Resident #12 revealed an initial admission date of 08/22/25 with the diagnoses including but not limited to bipolar disorder, catatonic disorder, dementia with behavioral disturbances, protein calorie malnutrition, hypertension, hypothyroidism, depression, spinal stenosis, anemia, hyperlipidemia, urge incontinence, insomnia, voice and resonance disorder, constipation, adult failure to thrive and intra-abdominal and pelvic swelling, mass and lump. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had indicators of depression and displayed no behaviors including rejection of care. The assessment indicated the resident received antipsychotic, antidepressant, opioid and anticonvulsant. The resident received antipsychotic medications on a routine basis and a gradual dose reduction (GDR) was not attempted and the physician had not documented the GDR was contraindicated. Review of the plan of care dated 08/22/25 revealed the resident used psychotropic medications. Interventions included administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly, discuss with physician, family regarding ongoing need for use of medication, review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication drugs being given, monitor/document/report as needed any adverse reactions of psychotropic medications. Review of the resident's physician's orders for December 2025 identified an order dated 11/02/25 for Abilify 10 milligrams (mg) to be given by mouth daily for bipolar disorder. Review of the medical record revealed no AIMS scale completed on admission. Further review revealed the first AIMS completed was on 11/24/25 by the facility contracted psychiatric company. On 12/18/2025 9:42 A.M., interview with Director of Nursing (DON) verified no baseline AIMS was completed on admission. Review of the facility policy titled, Antipsychotic/Psychotropic Drugs, last revised on 03/25 revealed antipsychotic/psychotropic drug therapy shall be used only when it is necessary to treat a specific condition. An AIMS test will be completed every six months at minimum.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to ensure routine shaving was provided for Resident #12, who was dependent on staff. This affected one resident (#12) of five residents reviewed for activities of daily living (ADL). The facility census was 85. Review of the medical record for Resident #12 revealed an initial admission date of 08/22/25 with the diagnoses including but not limited to bipolar disorder, catatonic disorder, dementia with behavioral disturbances, protein calorie malnutrition, hypertension, hypothyroidism, depression, spinal stenosis, anemia, hyperlipidemia, urge incontinence, insomnia, voice and resonance disorder, constipation, adult failure to thrive and intra-abdominal and pelvic swelling, mass and lump. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had indicators of depression and displayed no behaviors including rejection of care. The assessment indicated the resident was dependent on staff for bathing and personal hygiene. Review of the plan of care dated 08/22/25 revealed the resident was prone to ADL/functional deficits related to acute on chronic health conditions. Resident requires assistance with ADL's related to bipolar disorder, catatonic disorder, dementia, malnutrition, hypertension, hypothyroidism, spinal stenosis, anemia, hyperlipidemia, urge incontinence, insomnia, adult failure to thrive, cardiac pacemaker and intra-abdominal/pelvis swelling/mass. Interventions included assist with daily bathing, hygiene, dressing and grooming cares resident is unable to complete independently as needed daily, maintain call light within reach, encourage use for assistance answering promptly daily, Occupational and Physical Therapy to evaluate and treat as ordered, set up, assist as needed with oral care every am, after meals and at bedtime per resident personal preference and shower bathe per residents personal preference. On 12/17/25 at 8:30 A.M., observation of Resident #12 revealed she had long chin hairs. On 12/17/25 at 3:35 P.M., observation of the resident revealed the resident was resting quietly in bed and she continued to have long chin hair. On 12/17/2025 at 3:39 P.M., an interview with Certified Nursing Assistant (CNA) #372 verified the resident had a scheduled shower this date and the resident's long chin hair was not shaved. The CNA revealed she just didn't have time to shave the resident's chin hair. Review of the facility policy titled, Shaving a Resident, dated 01/05/03 revealed residents are to be shaved on shower days and as needed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview this facility failed to ensure prescribed splint orders were transcribed and implemented correctly. This affected one (Resident #75) of the two residents reviewed for splints. The facility census was 85. Review of the medical record for Resident #75 revealed an admission date of 06/02/2025. Diagnoses included cerebral palsy, contracture of the right and left hand, and muscle weakness. Review of Resident #75's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed this resident experienced long and short-term memory problems with a severely impaired cognition for daily decision-making abilities. Review of the plan of care dated 07/07/25 revealed Resident #75 was at risk for or prone to the development of contractures. Interventions included to provide Resident #75 with gentle range of motion (ROM) to affected joint as tolerated when providing daily care, application of a Royan Hand Brace apply brace to right hand in the morning, take off at night every day and night shift for contracture of right hand. Review of Resident #75's physician orders revealed an order to apply a right-hand palm protector as tolerated to prevent skin integrity issues one time only for right hand tightness for 12 months. Ordered on 07/08/2025. Review of the nursing progress note dated 07/07/2025 created by Licensed Practical Nurse (LPN) #317 revealed, new order for a right-hand brace due to contractures. Interview on 12/18/2025 at 1:00 P.M. with Director of Therapy #902 revealed this resident had orders for two different splints, a palm protector to the right hand as tolerated daily for 12 months along with the splint that is to be on during the day and off at night. He confirmed the order had been written incorrectly when it said to apply a right-hand palm protector as tolerated to prevent skin integrity issues one time only for right hand tightness for 12 months. order date of 07/08/2025. Claimed that he planned to go into the system and fix the order now to daily as tolerated for 12 months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2025
NAME OF PROVIDER OR SUPPLIER Wexner Heritage House		STREET ADDRESS, CITY, STATE, ZIP CODE 1151 College Avenue Columbus, OH 43209	
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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 medical record review, observation, staff interview and policy review, the facility failed to implement interventions to prevent resident falls for Residents #20 and #94. This effected two of three residents reviewed for falls with injuries. The facility census was 85.1. Review of the medical of Resident #20 revealed she was admitted to the facility on [DATE] with diagnoses of osteoarthritis, muscle weakness, and history of falls. The resident's care plan dated 12/08/25 indicated she was at increased risk for falls. Interventions included maintaining the call light within reach. A review of the fall incident on 09/26/25 revealed the resident was found on the floor face down in her room between 4:00 A.M and 5:00 A.M. The nursing assessment noted injuries including a laceration to the left lower leg, edema to the head and eye, and pain upon touch. The resident was sent to the emergency room for evaluation and returned later that day with sutures to the left lower leg. After the fall, the interdisciplinary team met and decided to update the resident's care plan with new interventions included maintaining the bed in the lowest position. An interview on 12/18/25 at 4:15 P.M. with Licensed Practical Nurse, (LPN) #388, who completed the fall report, revealed when Resident #20 was found, she explained she was reaching for her call light on the floor and rolled out of the bed. Observation on 12/18/25 at 4:37 P.M. revealed the bed was not in the lowest position. LPN #388 confirmed this and immediately lowered the bed. A review of the Interdisciplinary Team (IDT) note dated 09/29/25 confirmed the care plan was updated following the fall, and interventions included maintaining the bed in the lowest position. A review of the facility's falls policy revised on 04/01/25 revealed all safety interventions must be immediately implemented after a fall occurs. 2. Review of the medical record of Resident #94 revealed he was admitted to the facility on [DATE] with diagnoses of traumatic subarachnoid hemorrhage, muscle weakness, depression, and legal blindness. Review of Resident #20's care plan dated 12/08/2025 indicated he was at increased risk for falls related to impaired strength and endurance, visual impairment, cognitive impairment, use of psychotropic and opioid medications, and history of falls. Interventions included maintaining the call light within reach and providing staff assistance with mobility and transfers. A review of the fall incident, which occurred 12/05/2025, revealed the resident was found on the floor after attempting to get up to use the bathroom. The nursing assessment noted the resident stated he hit his head, but no new bruises were observed. The resident had a pre-existing hematoma on the left side of his head. An interview on 12/17/2025 at 4:30 P.M. with the Resident #20's family member revealed she informed staff at the time of Resident #20's admission and orientation that the resident was blind and could not see his call light. She affirmed he was likely trying to get to the restroom when he fell. An interview on 12/18/2025 at 10:46 A.M. with the Unit Manager revealed the intervention to move the resident closer to the nurses' station was not implemented until 11/08/25. She acknowledged that in his first room, which was in the second to furthest position from the nurses' station, staff would have had difficulty hearing him if he called them. She confirmed that she was not aware of staff implementing any additional interventions to ensure the resident could properly use his call light to call for staff assistance. A review of the facility's falls policy revised on 04/01/2025 revealed a fall risk assessment will be completed on admission, in consideration of a resident's medications, vision and activities of daily living functional status.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and review of facility policy, the facility failed to label oxygen tubing for Resident #09, #14, and #44. This affected three of five residents reviewed for respiratory care. The census was 85. 1. Record review of Resident #09's medical record revealed an admission date of 12/31/24. Diagnoses include chronic obstructive pulmonary disease, heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart disease with heart failure, dependence on supplemental oxygen, chronic respiratory failure with hypoxia, and type II diabetes mellitus with diabetic neuropathy. Review of Resident #09's Minimum Data Set 3.0 (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09, indicating moderately impaired cognition and that Resident #09 required oxygen therapy. Review of Resident #09's care plan dated 12/02/25 revealed Resident #09 is prone to cardio-pulmonary complications related to acute on chronic health conditions with a goal for Resident #09 to be free from cardio-pulmonary complications through goal date and interventions include, administer oxygen therapy as ordered, and change oxygen tubing weekly. Review of Resident #09's physician orders revealed an order for oxygen at two liters via nasal cannula to maintain oxygen saturation above 92 percent. Observation on 12/15/25 at 4:01 P.M. of Resident #09's room revealed Resident #09's nasal cannula tubing was not labeled and was stuck under her bedside table. Interview on 12/15/25 at 4:06 P.M. with Licensed Practical Nurse (LPN) #280 confirmed Resident #09's nasal cannula tubing was not labeled. 2. Record review for Resident #14's medical record revealed an admission date of 09/21/22. Diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unsteadiness on feet, dependence on supplemental oxygen, chronic respiratory failure with hypercapnia, atherosclerosis heart disease of native coronary artery with unspecified angina, paroxysmal atrial fibrillation, contracture right hand and elbow, chronic obstructive pulmonary disease (COPD), need for assistance with personal care, muscle weakness, and essential (primary) hypertension. Review of Resident #14's Minimum Data Set 3.0 (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating Resident #14 had moderate cognitive impairment. Resident #14 required oxygen therapy. Review of Resident #14's care plan dated 11/24/25 revealed Resident #14 is prone to cardio-pulmonary complications related to acute on chronic health conditions with a goal for Resident #14 to be free from cardio-pulmonary complications through goal date and interventions include, administer oxygen therapy as ordered, and change oxygen tubing weekly and change nebulizer tubing weekly when in use. Review of Resident #14's physician orders revealed an oxygen order for 2.5 liters via nasal cannula to maintain oxygen saturation between 88 and 92 percent. Due to COPD , notify the provider if oxygen (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saturation is less than 92%. Order for oxygen tubing to be changed every seven days (every night shift every Saturday). Observation on 12/15/25 at 12:50 P.M. revealed Resident #14's uncovered nebulizer mask on top of night stand. Observation on 12/15/25 at 4:05 P.M. revealed Resident #14's uncovered nebulizer mask on top of night stand and unlabeled nasal cannula tubing. Interview on 12/15/25 at 4:05 P.M. with LPN #280 confirmed Resident #14's nebulizer mask should be in a bag when not in use and nasal cannula tubing should be labeled. 3. Review of Resident #44's medical record revealed admission date 05/18/16 with diagnoses including but not limited to anoxic brain damage, respiratory failure and tracheostomy dependent. Review of Resident #44's physician orders dated 12/01/25 to 12/31/25 revealed an order dated 04/22/25 for supplemental oxygen six liters (L) via tracheostomy mask with humidified air. Further review revealed no physician orders for oxygen tubing to be changed. An observation on 12/16/25 at 9:45 A.M. revealed Resident #44's oxygen concentrator located in the bathroom and set at six L of oxygen with oxygen tubing attached to the concentrator. The oxygen tubing went from the concentrator across the room to the humidifier for the tracheostomy mask. There was no date on the oxygen tubing to reflect when the tubing had been recently changed. An interview on 12/16/25 at 9:55 A.M. with Unit Manager (UM) #350 verified there were no dates on the oxygen tubing to reflect being recently changed. UM #350 also verified Resident #44 did not have physician orders for the oxygen tubing to be regularly changed. Review of the facility's policy titled, Oxygen Therapy and Storage, effective date 09/2025, the purpose is to establish policies and procedures to store and administer oxygen safely.		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based record review, staff interview and review of facility policy, the facility failed to ensure physician ordered daily weights were collected timely, this affected one (#54) of residents reviewed for physician orders. The facility census was 85. Review of the medical record for Resident #54 revealed an admission date of 11/18/25 with diagnoses of hypocalcemia, cognitive communication deficit, atrial fibrillation, muscle weakness, chronic combined systolic and diastolic heart failure, hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery with angina, hyperlipidemia, and pulmonary embolism. Review of admission Minimum Data Set assessment dated [DATE] revealed Resident #54 is cognitively intact, has active heart and circulation diagnoses of atrial fibrillation, coronary artery disease, heart failure, and hypertension, and is currently taking an antiplatelet and anticoagulant. Review of care plan dated 11/24/25 revealed the resident has a nutritional problem or potential related to cognitive communication deficit, atrial fibrillation, chronic heart failure, heart disease, hyperlipidemia, and weight gain prior to admission. Interventions include obtaining and monitoring weight per policy. Review of physician order dated 11/21/25 revealed instructions to obtain daily weights and notify physician or nurse practitioner for an increase of three pounds or more in one day for chronic heart failure. Review of weight summaries revealed Resident #54 weighed 235.9 pounds (lbs.) on 11/18/25, 233 lbs. on 12/08/25, and 217 lbs. on 12/16/25. Review of progress notes dated 11/21/25, 12/09/25, and 12/16/25 revealed Resident #54 was to resume home regimen except for Lasix due to soft blood pressure, monitor weight changes, weigh daily, and notify nurse practitioner or physician of weight gain of three pounds or more in one day. Review of daily weight task from 11/22/25 through 12/22/25 revealed weights were obtained on 12/16/25 and 12/18/25 with Resident #54 weighing 217 lbs. Review of nutritional assessment dated [DATE] revealed Resident #54 typical weight is between 213 and 215 lbs. The resident had recent history of weight gain related to eating more and a sedentary lifestyle, with a plan to provide diet as ordered and monitor weights and intake per protocol. Review of Treatment Administration Record (TAR) and Medication Administration Record (MAR) for November 2025 and December 2025 revealed no recorded daily weights. Interview conducted on 12/18/25 at 2:45 P.M. with the Director of Nursing (DON) confirmed Resident #54 had an order for daily weights in place since 11/22/25 and daily weights had not been obtained as ordered. The DON stated the physician order was placed incorrectly and triggered as a no documentation order, therefore a prompt to complete daily weights was not initiated. The DON confirmed only three weights were taken during Resident #54's admission. Interview conducted on 12/18/25 at 3:01 P.M. with the Administrator confirmed physician-ordered daily weights for Resident #54 were not obtained as ordered. Interview conducted on 12/18/25 at 3:34 P.M. with Licensed Practical Nurse Unit Director #141 confirmed she was unaware Resident #54 had a physician order for daily weights related to chronic heart failure therefore they were not completed. Interview conducted on 12/18/25 at 4:08 P.M. with Dietician #500 denied concerns regarding weight loss or signs and symptoms of poor fluid management. Dietician #500 stated they spoke with Resident #54 and attributed the weight loss to increased activity and improved food quality intake, and noted the resident expressed interest in losing more weight. Review of physician order policy dated 10/31/21 revealed the nurse who takes the physician order will be responsible for executing the order or providing a safe hand-off to the next nurse, which includes MAR/TAR updates and notifying internal staff of changes or updates.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure physician parameters were appropriately followed. This affected three (#04, #08, and #75) of six residents selected for medication regimen review. The facility census was 85. 1. Record review of Resident #04 revealed an admission date of 10/31/25 and readmission of 11/25/25. Diagnoses included but are not limited to osteomyelitis of vertebra, discitis, low back pain, complication of internal fixation device of vertebrae, bipolar disorder, Post Traumatic Stress Disorder (PTSD), depression, gout and chronic pain. Further review of Resident #04 record revealed an order for Hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg), start date 11/25/25, with direction to give two tablets by mouth every four hours as needed for pain, and a second order for Hydrocodone-acetaminophen oral table 5-325 mg, with a start date of 11/25/25, with directions to give one tablet by mouth every four hours as needed for pain. Interview with Licensed Practical Nurse (LPN) #158 on 12/22/25 at 11:04 A.M. confirmed Resident #04 had two active orders for Hydrocodone and reported Resident #04 is given one tab for a pain between four and six, using a 0 (no pain) to 10 (worst pain) pain scale and two tabs for pain between seven and 10. LPN #158 confirmed Resident #04's medication administration record (MAR) does not have parameters listed for when Resident #04 is to receive one tab versus two tabs and was unable to provide documentation of an existing pain scale parameter. LPN #158 confirmed Resident #04 has been receiving either one or two tabs of Hydrocodone for varying pain levels between 0 to 10 on the pain scale. Interview with Unit Manager (UM) #177 on 12/22/25 at 2:02 P.M. confirmed Resident #04 had two orders for Hydrocodone and parameters were not listed on the MAR. Further interview with UM #177 on 12/22/25 at 2:30 P.M. revealed the nurses were administering one or two tabs of Hydrocodone based off of their own assessment of the resident and confirmed there was no documentation of these assessments or how the assessments were completed. UM #177 confirmed a pain scale should be present for the medication and documenting the resident's refusal or preference of a lower dose. Additional interview with UM #177 12/22/25 at 3:30 P.M. revealed Resident #04 controlled substance record for Hydrocodone had pain parameters of one tablet for pain between four and six and two tablets for pain between seven and 10 orally every four hours as needed for pain. UM #117 confirmed the nurses were not consistently following the parameters of the Hydrocodone listed on the controlled substance record. 2. Record review of Resident #08 revealed an admission date of 06/13/19 and readmission of 03/14/24. Diagnoses included but are not limited to dementia, schizoaffective disorder, congestive heart failure, tachycardia, bi-polar disorder, hypertensive heart disease with heart failure, anxiety disorder, unspecified atrial fibrillation, long QT syndrome, left bundle-branch block, orthostatic hypotension, major depressive disorder, Alzheimer's disease, other specified peripheral vascular diseases, atherosclerosis of coronary artery bypass grafts, and presence of aortocoronary bypass graft. Further review of Resident #08 record revealed an order for Hydrochlorothiazide oral tablet 12.5 mg, start date 06/24/25, with further details to give one tablet by mouth one time a day for hypertension and to hold if systolic blood pressure is less than equal to 100 or if heart rate is less than or equal to 60. Record for Resident #08 also revealed an order for Metoprolol Succinate extended release (ER) (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	24-hour 50 mg, start date 06/23/25, with further details to give one tablet by mouth one time a day for hypertension ad to hold is systolic blood pressure is below 110 or heart rate is below 60. Review of Resident #08's medication administration record (MAR) from September 2025 to December 2025 revealed Hydrochlorothiazide administered with the following blood pressure (BP) and/or heart rate (HR) values; 12/01/25 HR 56, 12/03/25 HR 58, 11/04/25 HR 57, 11/05/25 HR 60, 11/25/25 HR 59, 10/04/25 HR 54, 10/11/25 HR 54, 10/19/25 HR 57, 10/20/25 HR 57, and 09/07/25 HR 60. Further review of Resident #08's MAR from September 2025 to December 2025 revealed Metoprolol Succinate ER administered with the following blood pressure and/or HR values; 12/01/25 HR 56, 12/03/25 HR 58, 11/25/25 HR 59, 11/29/25 HR 54, 10/11/25 HR 54, 10/14/25 BP with systolic value of 108, 10/19/25 HR 57, and 10/20/25 HR 57. Interview with Unit Manager (UM) #350 12/18/25 at 12:20 P.M. revealed the nurses are instructed to hold medications when the residents' blood pressure and/or heart rate are outside of doctor ordered parameters. UM #350 further confirmed if the medication is held there should be documentation of the doctor being notified and any further direction from the doctor if applicable. UM #350 also revealed if the doctor instructed to still administer the medication there should be documentation. UM #350 confirmed per doctor parameters Resident #08 should not have received the Hydrochlorothiazide on 12/01/25, 12/03/25, 11/04/25, 11/05/25, 11/25/25, 10/04/25, 10/11/25, 10/19/25, 10/20/25, and 09/07/25 and confirmed there was no documentation of doctor notification. UM #350 further confirmed per doctor parameters Resident #08 should not have received the Metoprolol Succinate ER on [DATE], 12/03/25, 11/25/25, 11/29/25, 10/11/25, 10/14/25, 10/19/25, and 10/20/25. 3. Review of the medical record for Resident #75 revealed an admission date of 06/02/2025. Diagnosis included seizures, atrial fibrillation, and hypertension. Review of Resident #75's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed this resident experienced long and short-term memory problems with a severely impaired cognition for daily decision-making abilities. Review of Resident #75's currently physician orders revealed an order for Metoprolol tartrate oral tablet 25 mg, give one tablet via gastric feeding tube (PEG) tube twice a day at 8:00 A.M. and 8:00 P.M. for hypertension. Do not administer this medication for systolic blood pressure readings (SBP) less than 110 and/or a heart rate less than 60 beats per minute. Review of the medication administration record for August, September, November, and December 2025 revealed multiple days where Resident #75's pulse or blood pressure was not monitored prior to the administration of the ordered Metoprolol tartrate medication. Continued review revealed Resident #75 had another hypertension medication that was administered at 7:00 A.M. which this residents blood pressure was being checked for but not for the 8:00 P.M. medication administration. Interview on 12/18/2025 at 12:46 P.M. with Unit Director (UD) #350 revealed the nurses are instructed to hold medications when blood pressure and or heart rate are outside of doctor order parameters. UD #350 also confirmed if the medication is held the vital measurements should still be recorded in the MAR for the doctor to review. UD #350 confirmed Resident #75's MAR did not have pulse and blood pressures documented on multiple occasions. Review of the facility's General Dose Preparation and Medication Administration policy, revised 11/25/24, revealed facility staff should document necessary medication administration/treatment information. The policy further revealed facility staff should verify each time a medication is administered that the medication, dose, route, rate, and time for the correct resident, as well as confirming the medication administration record (MAR) reflects the most recent order.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of manufacturer guidelines, and facility policy review the facility failed to remove expired Tubersol tuberculin solution from circulation. This deficient practice had the potential to affect new resident admissions. The facility census was 85. An observation on [DATE] at 9:51 A.M. revealed in the medication storage refrigerator located at the nurses' desk on the first hallway. Inside the refrigerator was an open half-used vial of Tubersol tuberculin solution not labeled with an open date on the storage box or on the vial. Further observation revealed another open half used vial of Tubersol tuberculin solution with an open date [DATE] located on the vial. Both vials of the Tubersol tuberculin solution had an expiration date of 10/2026. A review of the manufacture guidelines for Tubersol tuberculin solution dated 10/2021 revealed a vial of Tubersol which has been entered and in use for 30 days should be discarded. Do not use after expiration date. A review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals revised [DATE] revealed once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. An interview on [DATE] at 9:30 A.M. with Licensed Practical Nurse (LPN) #194 confirmed the open undated vial of tuberculin solution and the open vial of tuberculin solution dated [DATE] were in the medication storage refrigerator. LPN #194 stated the vials should be dated when opened to use and the vial should only be used for 30 - days and then discarded.		

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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 record review, interview, and policy review, the facility failed to ensure physician ordered urine screenings were collected timely, this affected two (Resident #36 and Resident #94) out of six reviewed for physician ordered lab results. The facility census was 85. 1. Review of the medical record for Resident #36 revealed an admission date of 12/03/24 with diagnoses including type two diabetes mellitus, depression, chronic pain syndrome, constipation, anxiety and arthritis. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 is cognitively intact, dependent on staff for personal hygiene and toilet transfers, and requires substantial to maximal assistance with bed mobility. Review of care plan dated 12/03/25 revealed Resident #36 is prone to alterations in bowel and bladder function related to impaired strength and endurance, generalized weakness, unsteadiness on feet, right femur fracture/surgery, anemia, constipation, and diuretic use. Interventions include assisting with toileting and hygiene, monitoring urine, and obtaining urine specimens as ordered. Review of physician visit summary dated 11/13/25 revealed recent lab work showing leukocytosis with white blood cells at 13.3, with an order to obtain urine analysis and culture and sensitivity, encourage fluids and monitor. Review of physician order dated 11/14/25 revealed straight catheter for urine analysis and culture and sensitivity. Review of progress note dated 11/14/25 at 1:35 P.M. revealed urine analysis was not obtained due to insufficient urine for testing. Review of progress note dated 11/14/25 at 5:50 P.M. revealed urine culture was not obtained. Review of physician order dated 11/17/25 revealed straight catheter for urine analysis and culture and sensitivity. Review of physician order dated 11/18/25 revealed straight catheter for urine analysis and culture and sensitivity. Review of progress note dated 11/18/25 at 12:48 P.M. revealed staff spoke with nurse practitioner about inability to obtain urine for urine analysis and culture and sensitivity and received an order to place catheter until there was enough urine to obtain a specimen. Review of progress note dated 11/18/25 at 6:50 P.M. revealed urine was collected and stored in the unit fridge. Review of physician visit summary dated 11/18/25 revealed follow-up on leukocytosis with pending lab results. Review of lab results revealed specimen collected on 11/19/25. Review of physician visit summary dated 11/21/25 revealed follow-up on labs in context of urinary tract infection, positive result for Klebsiella Pneumoniae sensitivity, and a new order to begin Cipro for seven days. Interview on 12/22/25 at 12:26 P.M. with Licensed Practical Nurse (LPN) Unit Director #141 confirmed she is the active infection control designee, with current expectations for staff to obtain urine specimens the day the order is received from the physician, with a goal to have it in the fridge in the morning after for laboratory services to pick up. LPN Unit Director #141 confirmed the initial request for staff to obtain a urine specimen for Resident #36 was placed on 11/14/25, with two additional requests placed on 11/17/25 and 11/18/25. During this time frame, progress notes documented attempts on 11/14/25 and 11/18/25, however only on 11/8/25 did nursing staff notify the physician and obtain an order for a Foley catheter to collect the necessary amount. LPN Unit Director #141 confirmed no additional attempts were made and nursing staff did not successfully collect the urine sample until day four. 2. Record review for Resident # 94 revealed this resident was admitted to the facility on [DATE] with diagnoses including legal blindness, traumatic subarachnoid hemorrhage, repeated falls, and muscle weakness. At the time of admission, Resident #94 had an indwelling urinary catheter due to a history of urinary retention. Review of the care plan dated 12/08/25 revealed Resident #94 is prone to alterations in bladder function related to urine retention and urinary incontinence. Interventions included obtaining urine specimens as ordered. Review of Resident #94's medical record revealed that on 12/11/2025, the resident developed a low-grade fever and confusion. The resident's complete blood count test that day showed an elevated white blood count of 12.5. Certified Nurse Practitioner (CNP) #1001 ordered a urinalysis and culture, and sensitivity. Review of Resident #94's physician orders did not reveal the urinalysis or (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2025
NAME OF PROVIDER OR SUPPLIER Wexner Heritage House		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	culture and sensitivity order. During a subsequent interview with Unit Director #141 12/18/25 at 10:46 A.M., she stated the specimen was obtained on 12/11/25, as ordered. However, she was not able to recall which member of the nursing staff obtained the specimen. She confirmed she was advised by the laboratory that they never received the specimen. She also confirmed the specimen was never recovered at the facility, either. On 12/15/2025, CNP #1001 inquired about the results of Resident #94's urinalysis. At this time, Unit Director #141 learned the ordered urine specimen was missing. CNP# 1001 re-ordered the urinalysis and culture and sensitivity again. Review of the treatment administration record of Resident #94 revealed that the specimens ordered were obtained and sent to the laboratory were completed on the evening of 12/16/2025. During a subsequent interview on 12/18/25 at 2:49 P.M. with CNP #1001, she confirmed her expectation is that an ordered specimen should be completed and sent to the processing laboratory within forty-eight hours of the order being received. She expressed concern about the delay in diagnosis and treatment for Resident #94. Review of physician order policy dated 10/31/21 revealed the nurse who takes the physician order will be responsible for executing the order or providing a safe hand-off to the next nurse, which includes medication administration and treatment administration record updates and notifying internal staff of changes or updates.		

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NAME OF PROVIDER OR SUPPLIER Wexner Heritage House		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed ensure one resident had a physician's order for labs obtained. This affected one resident (#12) of five residents reviewed for unnecessary medications. The facility census was 85. Review of the medical record for Resident #12 revealed an initial admission date of 08/22/25 with the diagnoses including but not limited to bipolar disorder, catatonic disorder, dementia with behavioral disturbances, protein calorie malnutrition, hypertension, hypothyroidism, depression, spinal stenosis, anemia, hyperlipidemia, urge incontinence, insomnia, voice and resonance disorder, constipation, adult failure to thrive and intra-abdominal and pelvic swelling, mass and lump. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's current physician's orders for December 2025 identified orders dated 08/22/25 lipid panel every 12 months and 09/11/15 complete blood count (CBC), complete metabolic panel (CMP), vitamin D level, thyroid stimulating hormone (TSH) and Lamictal level every six months. Review of the resident's laboratory results revealed the facility completed a CBC, CMP, vitamin D level, TSH and Lamictal was completed on 09/05/25, 09/22/25, 09/23/25, 10/09/25, 10/31/25, 11/11/25 and 11/19/25 without a physician's order. Interview on 12/18/2025 9:42 A.M. with the Director of Nursing (DON) verified Resident #12 had unnecessary laboratory testing completed on 09/05/25, 09/22/25, 09/23/25, 10/09/25, 10/31/25, 11/11/25 and 11/19/25 without a physician's order. The DON stated there was an order entry error with how the once every 12 month and once every 6 month lab orders were entered. Review of the facility policy titled, Laboratory Services and Reporting, dated 04/22 revealed the community must provide or obtain laboratory services when ordered by a practitioner in accordance with state law.		

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NAME OF PROVIDER OR SUPPLIER Wexner Heritage House		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure antibiotic stewardship was followed. This affected one (Resident #36) out of four residents reviewed for antibiotic usage. The facility census was 85. Review of the medical record for Resident #36 revealed an admission date of 12/03/24 with diagnoses of type two diabetes mellitus, depression, chronic pain syndrome, constipation, anxiety and arthritis. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 is cognitively intact, dependent on staff for personal hygiene and toilet transfers, and requires substantial to maximal assistance with bed mobility. Review of care plan dated 12/03/25 revealed Resident #36 is prone to alterations in bowel and bladder function related to impaired strength and endurance, generalized weakness, unsteadiness on feet, right femur fracture/surgery, anemia, constipation, and diuretic use. Interventions include assisting with toileting and hygiene, monitoring urine, and obtaining urine specimens as ordered. Review of physician visit summary dated 11/13/25 revealed recent lab work showing leukocytosis with white blood cells at 13.3, with an order to obtain urinalysis and culture and sensitivity, encourage fluids and monitor. Review of physician orders dated 11/14/25, 11/17/25 and 11/18/25 revealed straight catheter for urinalysis and culture and sensitivity. Review of progress note dated 11/18/25 at 6:50 P.M. revealed urine was collected and stored in the unit fridge. Review of physician visit summary dated 11/21/25 revealed follow-up on labs in context of urinary tract infection, positive result for Klebsiella Pneumoniae sensitivity, and a new order to begin ciprofloxacin (Fluoroquinolones) for seven days. Review of physician order dated 11/21/25 and end date of 11/22/25 revealed ciprofloxacin oral tablet 500 milligrams (mg) give one tablet by mouth twice daily for urinary tract infection. Review of medication administration record for 11/21/25 and 11/22/25 revealed Resident #36 received a total of two doses one on 11/21/25 at 9:00 P.M. and 11/22/25 at 9:00 A.M. Review of laboratory results reported 11/22/25 revealed growth of Klebsiella pneumoniae (1) at 50-60,000 colony-forming units per milliliter (CFU/mL) and Escherichia coli (2) 50-60,000 CFU/mL. Review of sensitivity revealed Ciprofloxacin for bacteria 1 noted as susceptible; however, for bacteria 2 noted as resistant. Nitrofurantoin was noted as susceptible for both organisms. Review of physician order dated 11/22/25 through 11/27/25 revealed Macrobid (nitrofurantoin) 100 mg oral capsule was ordered by mouth twice daily for urinary tract infection (UTI). Review of medication administration record for 11/22/25 through 11/27/25 revealed Resident #36 received all doses of antibiotic with the first administration on 11/22/25 at 9:00 P.M. and last dose on 11/27/25 at 9:00 A.M. Interview on 12/22/25 at 12:26 P.M. with Licensed Practical Nurse (LPN) Unit Director #141 confirmed she is the current active infection preventionist in-house. She confirmed ciprofloxacin was initiated prior to receiving the full culture and sensitivity back, acknowledged that E. coli was resistant to ciprofloxacin, and confirmed the culture results were below the threshold for antibiotic initiation. She denied any abnormal vital signs or symptoms on infection while waiting for the results to come back, history of UTI with sepsis or current infectious disease or urology consult. Review of the McGeer criteria infection surveillance checklist dated 11/21/25 revealed that Resident #36 did not meet the criteria for urinary tract infection. The resident exhibited none of the required clinical signs or symptoms (such as acute dysuria, fever, leukocytosis, suprapubic pain, hematuria, or new/worsening urinary symptoms) and did not meet any microbiological criteria (no qualifying urine culture results) as defined by the McGeer surveillance definitions. Despite this, ciprofloxacin was initiated prior to full culture and sensitivity results, which is inconsistent with antibiotic stewardship principles. Review of antibiotic stewardship policy dated 05/29/25 revealed the antibiotic stewardship team are involved in antibiotic selection, dosing and monitoring for selected agents, and promote best practices reflecting CMS quality improvement recommendations and CDC guidelines regarding use of appropriate antibiotics.		