

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Heritage Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 24613 Broadway Avenue Oakwood Village, OH 44146	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of hospital records, review of the National Pressure Injury Advisory Panel (NPIAP) guidelines and facility policy review, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to ensure necessary and effective interventions were in place to prevent the development and/or worsening of pressure ulcers for Resident #5 and to ensure wound treatments were completed as ordered for Resident #3. This affected two residents (#3 and #5) of three residents reviewed for pressure ulcers. The facility census was 30. Actual Harm occurred on 07/06/26 when Resident #5, who was assessed to be at risk for skin breakdown, dependent on staff for all activities of daily living (ADL) and incontinent of bowel and bladder was first identified with seven new pressure injuries staged as either a Stage III (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough or eschar may be present but does not obscure the depth of tissue loss), unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed), or suspected deep tissue injuries (a type of pressure injury that develops from the inside out and originates deep within the soft tissue or muscle near a bone, presenting as a localized area of non-blanchable deep red, maroon, or purple skin discoloration). Resident #5 was subsequently hospitalized on [DATE] for sepsis and dehydration and did not return to the facility. Findings include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with a severe cognitive impairment, diabetes, abnormal gait and mobility, and chronic pain. Review of Resident #5's admission nursing assessment revealed the resident had intact skin. Review of Resident #5's baseline care plan dated 03/04/26 revealed the resident had the potential for alteration in skin integrity. Listed interventions included to educate the resident and family on skin breakdown risk factors and preventative measures, encourage the resident to float (offload) heels while in bed, encourage to turn and reposition every two hours and as needed, to utilize a pressure reducing cushion to the chair and a pressure reducing mattress to the bed, and to provide assistance with hygiene as needed. Review of Resident #5's physician orders revealed on 03/05/26, the physician ordered a pressure redistribution mattress, offloading of heels, and frequent repositioning. Review of Resident #5's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident had severely impaired cognition. The assessment revealed Resident #5 was not noted to have behaviors and was assessed to be dependent on staff for ADL's including eating, transfers, toileting hygiene. The assessment also noted Resident #5 was always incontinent of bladder and frequently incontinent of bowel. Resident #5 required partial/moderate assistance from staff for bed mobility. At the time of the MDS assessment, Resident #5 was not noted to have any areas of skin impairment or pressure injuries. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from March 2026 through June 2026 revealed nursing staff were recording once per shift they were encouraging the resident to offload his heels and to turn and reposition, with no frequency specified in the order or records. There was no evidence nursing staff were recording the pressure reducing devices to the bed and the chair were in place as ordered. Review of Resident #5's clinical record for the month of June 2026 revealed only one weekly skin observation was completed for the month on 06/01/26. No further skin assessments were completed by facility nursing staff until 07/03/26. Review of Resident #5's clinical record revealed a quarterly Braden scale assessment dated [DATE] indicated Resident #5 was at moderate risk for developing pressure injuries. Record review revealed no new corresponding interventions implemented to prevent Resident #5 from developing pressure ulcers at that time. Review of the shower sheet dated 07/03/26 completed by Certified Nursing Assistant (CNA) #786 revealed Resident #5's skin was not intact, and the resident was identified to have red buttocks with skin tears. Review of a progress note dated 07/03/26 at 7:41 P.M. authored by Licensed Practical Nurse (LPN) #790 revealed during resident care, a wound was noted on Resident #5's sacrum. The resident was assessed, the affected area was cleansed with normal saline, padded dry, and a pad-and-protect dressing was applied until the wound team could assess. The note included the physician, the resident's spouse, and the Director of Nursing (DON) were recorded as being notified with no new orders provided. Review of a non-pressure skin grid assessment dated [DATE] authored by LPN #790 revealed Resident #5 had a new skin tear to his sacrum measuring 6.5 cm in length by 5.0 cm in width with no recorded depth. There was no odor or drainage to the wound. There was no description of the condition of the periwound. Further review of Resident #5's record from 07/04/26 and 07/05/26 revealed no evidence of new treatments, nutritional supplements, or pressure-reducing interventions or assistive devices were implemented. Continued review of Resident #5's record revealed no indication of any decline in the resident's condition or level of functioning during this time. Review of the progress note dated 07/06/26 revealed during morning wound care, Resident #5 was noted with several new in-house acquired pressure injuries. New skin areas were noted to the (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The surrounding skin was normal with no signs of infection. Review of email communication provided by the facility revealed Director of Nursing (DON) #764 sent an email to Dietitian #833 on 07/06/26 at 11:01 A.M. The email included that Resident #5 had new in-house acquired pressure injuries. DON #764 stated the resident would need supplements to assist with wound healing, the physician and family would be notified regarding a hospice consult, a wheelchair review would be completed, and the resident was being set up for a low air loss mattress (a specialized mattress that uses a constant stream of air to provide active pressure redistribution to help heal pressure injuries). Interview on 07/07/26 at 12:11 P.M. with the facility Wound Nurse (WN) #766 revealed Resident #5's sacral wound was first identified as a skin tear on 07/03/26. WN #766 reported she had been first notified of the skin tear wound on 07/06/26 and stated she added Resident #5 to the list of residents to be seen by contracted Wound Nurse Practitioner (WNP) #832 on 07/06/26. During wound rounds (on 07/06/26), WN #766 stated Resident #5's skin tear to the sacrum was assessed to be an unstageable pressure injury. WN #766 reported she then wanted to do a full body assessment with WNP #832, and they identified six additional unhealed pressure injuries. Upon identification of the seven newly identified pressure injuries, WN #766 stated she had concerns with care and felt the situation with Resident #5's newly identified wounds were not right. At the time of the interview, Resident #5 was observed sleeping in bed, positioned with a wedge cushion behind and positioned on his right side, slightly facing the wall. Resident #5 was observed with a bandage and boot present to his left foot. Resident #5 was lying on a standard pressure reduction mattress. Interview on 07/07/26 at 12:38 P.M. with DON #764 revealed skin checks were to be completed weekly in the electronic medical record as a skin observation. DON #764 confirmed only one skin assessment was completed for Resident #5 in June 2026 on 06/01/26 and confirmed the next recorded skin observation was not completed until 07/06/26 upon the identification of seven newly identified pressure injuries. Interview on 07/07/26 at 4:08 P.M., LPN #790 revealed Resident #5 could not verbalize his needs and needed staff assistance with all ADL care. LPN #790 stated if the facility had more staff, she felt better care would be provided, but staff tried their best. LPN #790 reported she was notified Resident #5 had an area to his sacrum on 07/03/26. LPN #790 reported she completed a change in condition report, a skin assessment, and a pain assessment in Resident #5's electronic medical record. She reported Resident #5 appeared to be in pain, so she gave him a dose of as-needed Tylenol. LPN #790 reported she checked Resident #5's whole body and did not identify any other areas of skin impairment. LPN #790 revealed Resident #5 stayed in bed, but she reported he was repositioned more often (Resident #5's clinical record did not include indication that a change in the frequency of repositioning was increased). During an interview on 07/07/26 at 5:16 P.M., WNP #832 revealed he saw Resident #5 from 06/15/26 to 06/22/26 related to a shoulder abrasion that healed well. WNP #832 indicated he was asked to see Resident #5 on 07/06/26 and noted multiple, newly identified in-house acquired pressure injuries. WNP #832 stated he recommended an air mattress, to limit time in the chair, and getting nutrition on board. However, as of 07/07/26, Resident #5 remained on a standard pressure reduction mattress and (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	no new nutritional or other interventions to aid wound healing had been implemented. Review of a progress note dated 07/07/26 at 5:26 P.M. revealed a change in condition was reported and included a functional decline, increased confusion, and changes in skin color or condition. The note referenced Resident #5 had fatigue and pressure injuries and had pain. Resident #5 was noted to have an altered level of consciousness and the note concluded by referencing the resident would be sent to a local emergency room for evaluation. Review of Resident #5's hospital records dated 07/08/26 revealed Resident #5 was admitted to a local hospital on [DATE]. He arrived from a local nursing home and presented to the emergency department with lethargy. The note referenced Resident #5 was ill-appearing, had dry mucous membranes with ulcers noted. The assessment and plan indicated Resident #5 had diagnoses including but not limited to severe sepsis, metabolic encephalopathy, and pressure injuries, all with a designation indicating the conditions were present upon the resident's admission to the hospital. Continued review of the hospital record revealed Resident #5 was seen by an infectious disease specialist on 07/09/26 related to the sepsis diagnosis. The specialist noted Resident #5 was a frail gentleman with sepsis present upon admission who had multiple potential sources of sepsis including a urinary tract infection, cellulitis of the right hip and buttock area, and the presence of dry gangrene to his left foot. Empiric antibiotics were initiated. The note indicated Resident #5 was considered an immunocompromised host at high risk of deterioration without appropriate antimicrobial coverage. Interview on 07/09/26 at 8:17 AM. with Dietitian #833 revealed she had not been made aware of any skin breakdown for Resident #5. Telephone interview on 07/13/26 at 3:05 P.M. with Resident #5's spouse revealed she had been notified the resident had one wound but was unaware the resident had multiple other newly identified wounds. Resident #5's spouse questioned how the resident could have developed seven new pressure wounds and stated it had to be related to lack of care. Resident #5's spouse reported Resident #5 remained in the hospital and would not be returning to the facility, citing care concerns. Review of the facility policy titled Pressure Injury Prevention and Management, revised 06/01/26, revealed the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate. 2. Review of Resident #3's medical record revealed the resident was admitted on [DATE] with diagnoses including vascular dementia with mood disturbance, shortness of breath and cerebral infarction. Review of Resident #3's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem. Review of Resident #3's Wound Care progress note dated 07/06/26 revealed the resident had a left hip Kennedy terminal ulcer with full-thickness depth which measured 5.6 cm (centimeters) length by (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3.2 cm width by undetermined (UDT) depth with fluctuant, adhered eschar (black necrotic skin). Review of Resident #3's physician orders revealed an order dated 05/19/26 (discontinued 06/23/26) to cleanse the left hip with 0.25% Dakin's (an antibacterial solution used to cleanse wounds, kill bacteria, and reduce infection risk without damaging healthy tissue) solution, pat dry, apply Dakin's moistened gauze (squeeze out excess Dakin's), cover with a super absorbent dressing every shift for wound care; and an order dated 06/23/26 to cleanse the left hip with normal saline (NS), pat dry, apply Santyl (enzymatic debriding ointment at nickel thick) then calcium alginate (maintains moist wound environment) and cover with a super absorbent dressing every day shift for wound care and as needed. Review of Resident #3's medication administration records (MARS) from 06/01/26 to 07/07/26 revealed no evidence wound care to the left hip was completed on 06/12/26, 06/14/26, 06/23/26 and 06/24/26. Review of Resident #3's Wound Care progress note dated 07/06/26 revealed the resident had a right ischium [NAME] Terminal ulcer with full-thickness depth which measured 5.9 cm length by 3.9 cm width by UTD depth with odor and fluctuance. Review of Resident #3's physician orders revealed an order dated 06/23/26 to cleanse the right ischium with NS, pat dry, apply Santyl (nickel thick) then calcium alginate and cover with a super absorbent dressing every day shift for wound care and as needed. Review of Resident #3's MARS from 06/01/26 to 07/07/26 revealed no evidence wound care to the right ischium was completed on 06/24/26. Review of Resident #3's Wound Care progress note dated 07/06/26 revealed the resident had a sacrum [NAME] (combined with the left buttock) Terminal Ulcer with full-thickness which measured 8.8 cm length by 6.1 cm width by UTD depth with fluctuance and odor. Review of Resident #3's physician orders revealed an order dated 05/26/26 (discontinued 06/23/26) to cleanse the left buttock with NS, pat dry, apply collagen and cover with a super absorbent dressing every day shift for wound care and as needed; an order dated 06/23/26 to cleanse the sacrum (along with the left buttock) with NS, pat dry, apply Santyl debridement cream (nickel thick) then calcium alginate and cover with a super absorbent dressing every shift and as needed; Review of Resident #3's MARS from 06/01/26 to 07/07/26 revealed no evidence wound care to the sacrum and left buttock were completed on 06/01/26, 06/12/26, 06/14/26, 06/23/26 and 06/24/26. Interview on 07/07/26 at 9:50 A.M. with Licensed Practical Nurse (LPN) Wound Nurse #766 confirmed Resident #3's wound care was not completed as ordered Interview on 07/07/26 at 11:15 A.M. with Resident #3's granddaughter revealed she had visited the facility on 06/26/26 around 11:00 A.M. and the resident did not have dressings on her wounds on the arms, legs and hip areas. The granddaughter confirmed the only dressing in place was the one on her (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	sacrum and the granddaughter stated the wound care was not completed as ordered. Review of the Wound Treatment Management policy revised 12/01/25 revealed to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Assessment, review of the Payroll Based Journal (PBJ), policy review, and interview, the facility failed to ensure Registered Nurse (RN) staffing coverage of at least eight consecutive hours per day, and the facility had a one-star rating on the PBJ for the second quarter of 2026. This finding had the potential to affect all 30 residents residing in the facility. Findings include: Review of the Facility assessment dated [DATE] revealed nursing services included RNs of approximately 12 hours per day; RNs with Administrative Duties approximately two hours per day Monday through Friday; Licensed Practical Nurses (LPNs) approximately six hours per day; LPNs with administrative duties one Monday through Friday; Certified Nursing Assistants (CNAs) at approximately 150 hours per day at a census of 75; and an Infection Preventionist eight hours per day Monday through Friday. Review of the PBJ Staffing Data Report for the second quarter of 2026 (01/01/26 to 03/31/26) revealed the facility had one star rating and no RN hours. Durin an interview on 07/07/26 at 10:40 A.M., Regional Human Resources (HR) #830 and Regional HR #31 confirmed the above findings. Regional HR #830 confirmed the facility has hired five RNs since 03/2026. Review of the undated list provided by the facility revealed no RN coverage on 01/10/26, 01/11/26, 01/24/26, 01/25/26, 02/07/26, 02/08/26, 02/21/26, 02/22/26, 02/28/26, 03/01/26, 03/07/26, 03/08/26, 03/14/26, 03/15/26, 03/21/26 and 03/22/26. Review of the Nursing Services and Sufficient Staff policy, dated 09/26/25, revealed it was the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to ensure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census acuity, and diagnoses of the resident population will be considered based on the facility's assessment.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review the facility failed to ensure proper infection control procedures were implemented related to glucometer use, respiratory equipment storage and sanitation of the laundry room. This affected Resident #4 and #8 and had the potential to affect all 30 residents in the facility. Findings include: 1. Review of the medical record for Resident #8 revealed an admission date 03/18/25 with diagnoses including vascular dementia, type II diabetes, hypertension, alcohol abuse, gout, chronic kidney disease stage three. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # had impaired cognition and received insulin injections. Review of the Care Plan dated 06/24/26 revealed the resident was at risk for hyperglycemia and hypoglycemia related to diabetes. Intervention included checking blood sugar level as needed and to monitor for signs and symptoms of hypo glycemic and hyperglycemic. Review of the physician orders for June 2026 revealed an order for Admelog SoloStar pen injector a rapid acting insulin based on sliding scale for blood glucose level of 161 or higher. Observation on 06/29/26 at 11:44 A.M. Registered Nurse (RN) #780 performing a blood glucose level for Resident #8 revealed she gathered supplies and donned gloves. RN #780 wiped the resident's finger with alcohol, inserted the testing strip into the glucometer (a facility glucometer), pricked the finger to draw blood and applied a drop of blood on the testing strip. The glucometer registered the glucose level at 139. RN #780 disposed of her gloves, washed her hands and threw the glucometer testing strip in the trash and placed the glucometer into a basket in the medication cart. Interview on 06/29/26 at 11:51 A.M. with RN #780 verified she threw the used testing strip in the trash and did not clean the glucometer. The contaminated testing strip should have been placed in the biohazard box. Review of the facility policy titled Glucometer Disinfection dated 03/01/26 stated glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single or multiple resident use. 2. Review of the medical record for Resident #4 revealed an admission date 09/09/25 with diagnoses including vascular dementia, bipolar, chronic obstructive pulmonary disease (COPD), type 2 diabetes, osteomyelitis, chronic kidney disease, syncope, and post traumatic stress disorder (PTSD). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 4 had impaired moderate cognitive impairment and required supervision for activities daily living. Review of the Care Plan dated 05/29/26 revealed the was at risk for altered respiratory status related to dx of COPD. Intervention included giving aerosol or bronchodilators as ordered and to give oxygen as ordered. (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 physician order dated July 2026 revealed orders for Albuterol Sulfate Inhalation by nebulization Solution to administer 3 millimeter (ml) via mask every two hours as needed and Ipratropium-Albuterol 3 ml by inhaled every eight hours. Observation on 06/28/27 at 12:00 P.M. of Resident #4's room revealed her nebulizer (breathing machine) was located on the floor next to her television. The oxygen tubing and mask were laying on the floor. Interview with the Resident stated nebulizer had been on the floor due to no plug available. Interview 06/28/27 at 12:02 P.M. with Certified Nursing Assistant (CNA) #714 verified the nebulizer should not be on the floor and stated she will get new tubing for the machine. Review of the facility policy titled Oxygen Administration dated 01/04/26, stated infection control measures included to keep delivery devices covered in plastic bags when not in use. 3. Observation on 07/07/26 at 3:05 P.M. with the Interim Administrator revealed Housekeeper Aide #771 was in the laundry room washing clothing. Observations revealed multiple soiled washcloths with feces and other soiled laundry were lying on the floor in front of the washers. Dried feces were noted on the floor in front of the washers. During an interview on 07/07/26 at 3:07 P.M., Housekeeper Aide #771 stated the other laundry personnel had quit recently, and he had dumped the soiled linens on the floor to sort, so the soiled laundry could be put in the washer. Housekeeper Aide #771 confirmed dried feces were noted on the floor in front of the washers. During an interview on 07/07/26 at 3:10 P.M., the Interim Administrator revealed the facility had recently lost their laundry personnel, and the facility was trying to catch up on the laundry. Review of the Infection Prevention and Control Program, dated 04/01/26, revealed the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. Clean linen shall be separated from soiled linen at all times. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task was complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. Environmental services staff shall not handle soiled linen unless it was properly bagged.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Heritage Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 24613 Broadway Avenue Oakwood Village, OH 44146	
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review, the facility failed to maintain a clean and sanitary resident environment that was also in good repair. This affected 10 residents (#11, #13, #14, #15, #21, #23, #26, #27, #28, and #31) and had the potential to affect all residents residing in the facility. The facility census was 30. Findings include: 1. Observation on 06/28/26 at 9:00 A.M. during tour of the facility revealed the entire unit smelled like dirty mop water, and the area around Residents #11, #15, #23, #27's rooms smelled like urine. The entire hallway floor was dirty and sticky. Observation of Resident #13's wheelchair was dirty with dried food all over and something spilled and dried on the resident's seat. The tile in front of nurses station was missing. Interviews during this time with Certified Nurse Aides (CNAs) #711 and #714 verified the identified findings. Observations on 06/29/26 at 4:21 P.M. with Director of Maintenance (DOM) #792 of Resident #31's room revealed a white patched-over crack that ran from the top of the window to the bottom. The rest of the wall was painted blue. Observation of Resident #14's floor revealed five of the floor tiles were tan/beige in front of bathroom door, next to them were nine green tiles under sink next to the bathroom door, and the rest of the room floor tiles were an off-white color. Observed also near the bathroom were 11 chipped, off white colored floor tiles. Interview at this time with DOM #792 verified the identified findings. DOM #792 stated he patched Resident #31's wall a couple of weeks ago and verified it needed to be painted. DOM #792 stated the floor tiles in Resident #14's room should be all one color, and they were in the process of ordering new tiles. 2. Observation on 06/28/26 at 9:36 A.M. of Resident #21's room revealed half of the windowsill was covered with silver duct tape and the room had a strong urine odor. Interview with Resident #21 at the time of observation revealed the resident stated the windowsill has been like that for six months. Interview with Certified Nursing Assistant (CNA) #809 at 9:36 A.M. verified Resident #21's room had a strong odor and the windowsill was covered with duct tape. CNA #809 stated the resident was non-compliant with asking for help to go to the bathroom. Interview on 06/28/26 at 9:45 A.M. with Housekeeper #793 verified Resident #21's room had a strong urine odor and the room is checked and cleaned every day. Interview with the Administrator on 06/29/26 at 2:00 P.M. stated he felt the odors were coming from the floor scrubber machine. The Administrator stated he bought a power scrubber to clean out the floor scrubber machine. 3. Observation on 06/28/26 at 9:28 A.M. of Resident #28's room revealed the top cover of the heating unit was pulled away from the from the unit. There was an empty tube of barrier cream laying on the floor. There were several large areas on the wall that were patched white and not primed. Interview with Certified Nursing Assistant (CNA) #809 on 06/28/26 at 9:36 A.M. verified Resident #28's room had an empty tube of barrier cream, the walls were primed and not painted, and the cover to the heating unit pulled away from the unit. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on 06/28/26 at 11:15 A.M. of Resident #26's room revealed there was a brown substance on the wall above the trash can measuring 12 inches in length by six inches in width. Interview on 06/28/26 at 11:23 A.M. with Housekeeper #801 verified the brown substance was dried on and stated he would clean it off the wall. Review of the policy Safe and Homelike Environment, dated 04/13/26, revealed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure call lights were in reach of residents. This affected two residents (#2 and #28) reviewed for access to call lights. The facility census was 30. Findings include: 1. Review of the medical record for Resident #28 revealed an admission date 05/01/25 with diagnoses including hemiplegia and hemiparesis to right side, cerebral infarction a stroke, muscle weakness, and vascular dementia, anxiety, and rheumatoid arthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had impaired cognition and was dependent on staff for toileting, showering, and transfers. Review of the care plan dated 06/24/26 revealed the resident needed assistance for activities of daily living related to hemiplegia, history of falls, and dementia. Interventions included keeping call light in reach while in bed. The resident was totally dependent and does not participate in any aspect of the for chair to bed transfers and required a mechanical lift for all transfers. Observation on 06/28/26 at 9:28 A.M. of Resident #28 revealed he was trying to get out of bed. There was a mat on the floor next to the bed. Resident #28's call light was hanging from the light above his bed out of reach. Resident #28 stated he wanted to get up and go to breakfast. Interview on 06/28/26 at 9:28 A.M. with Certified Nursing Assistant (CNA) #809 verified the call light was not in reach. 2. Review of the medical record for Resident #2 revealed an admission date 04/16/26 with diagnoses including hemiparesis, chronic respiratory failure, obesity, type II diabetes, heart failure, depression, dementia, asthma, lymphedema, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had impaired cognition and was dependent on staff for toileting, showering, and transfers. Review of the care plan dated 06/17/26 revealed the resident needed assistance for activities of daily living related to cognitive impairment and decreased mobility. Interventions included keeping the call light in reach while in bed and assisting as needed with daily hygiene and showering per facility policy. Observation on 06/28/26 at 9:37 A.M. of Resident #2 revealed she was lying in bed. The call light was hanging behind the bed out of reach. Interview on 06/28/26 at 9:45 P.M. with Licensed Practical Nurse (LPN) #790 verified the call light was out of reach. Further observation on 06/30/26 at 9:38 A.M. of Resident #2 was lying in her bed with call light on the floor, out of reach. Interview on 06/30/26 at 9:45 P.M. with LPN #790 verified the call light was on the floor and out of reach. LPN #790 stated Resident #2 was non-verbal and was able to use the call light. LPN #790 stated she will try to reposition the bed so the call light would not fall off the bed. Review of the facility policy titled Call lights Accessibility and Timely Response, dated 04/01/26 stated within each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accommodate Resident #28's preference for arising. This affected one Resident (#28) of one resident reviewed for preferences. The facility census was 30. Findings include: Review of the medical record for Resident #28 revealed an admission date 05/01/25 with diagnoses including hemiplegia and hemiparesis to right side, cerebral infarction a stroke, muscle weakness, and vascular dementia, anxiety, and rheumatoid arthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had impaired cognition and was dependent on staff for toileting, showering, and transfers. Review of the care plan dated 06/24/26 revealed the resident needed assistance for activities of daily living related to hemiplegia, history of falls, and dementia. Interventions included keeping call light in reach while in bed. Resident #28 was totally dependent on staff and required a mechanical lift for all transfers. Observation on 06/28/26 at 9:28 A.M. of Resident #28 revealed he was trying to get out of bed. There was a mat on the floor next to the bed. Resident #28's call light was hanging from the light above his bed out of reach. Resident #28 stated he wanted to get up and go to breakfast. Interview on 06/28/26 at 9:28 A.M. with Certified Nursing Assistant (CNA) #809 stated staff usually got Resident #28 up for breakfast. CNA #809 stated Resident #28 required a mechanical lift device to transfer out of bed. CNA #809 stated there was not a clean mechanical lift pad available, so she was unable to transfer Resident #28 out of bed and into his wheelchair to eat breakfast. As soon as the pad returned from laundry, staff would get Resident #28 up into his wheelchair.		

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure Resident #37's medical records were provided per the family request. This finding affected one (Resident #37) of one resident reviewed for medical record requests. The facility census was 30. Findings include: Review of Resident #37's medical record revealed the resident was admitted on [DATE] and discharged on 03/08/26 with diagnoses including Alzheimer's disease, narcissistic personality disorder and essential hypertension. Review of an email authored by Prior Administrator #739 to the Director of Nursing (DON), Resident #37's Power-of-Attorney (POA) and another daughter of Resident #37 dated 01/29/26 at 10:17 A.M. revealed all record requests can go to the following email recordrequest@embassyhealthcare.net. Review of the email to Former Administrator #739 from Resident #37's POA at recordrequest@embassyhealthcare.net dated 02/01/26 at 9:20 P.M. revealed the resident's POA requested medical records for current medications, doctor's visits, therapy notes, and a copy of the referral. Review of Resident #37's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Interview on 06/28/26 at 2:19 P.M. with Regional Registered Nurse (RN) #828 confirmed the above email was not valid, and the family was to request records directly through the facility. RN Regional #828 confirmed the request would be processed, and the records would be sent out. When questioned, she stated it was a form the family filled out and provided directly to the facility. She verified the records had not been sent as of 06/28/26. Telephone interview on 06/28/26 at 3:50 P.M. with Prior Administrator #739 revealed he did not remember a record request for Resident #37. Attempts to interview Resident #37's POA throughout the survey were unsuccessful. Review of the Release of Medical Records policy, revised 06/01/26, revealed medical records would be released with a valid request and in accordance with state and federal laws. This deficiency represents non-compliance investigated under Complaint Number 2737707.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and review of the witness statements for a facility self-reported incident (SRI), the facility did not ensure Resident #24 was free from resident-to-resident sexual abuse by Resident #26. This affected one (Resident #24) of two residents reviewed for abuse. The facility census was 30. Findings include:Record review revealed Resident #24 was admitted on [DATE] with diagnoses of Alzheimer's disease with early onset, dementia, severe, with other behavioral disturbance, bipolar disorder, and major depressive disorder. Resident #24 was not able to be interviewed due to severe cognitive impairment. Review of the care plan dated 04/13/26 revealed Resident #24 had a goal to remain safe in her environment with interventions including being allowed to wander in acceptable areas and keeping her environment constant without making random changes to routine or environment.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 was severely cognitively impaired and was dependent on staff for oral hygiene, toileting hygiene, showers, dressing, and personal hygiene.Record review revealed Resident #26 was admitted [DATE] with diagnoses of dementia, mild, with other behavioral disturbance, chronic obstructive pulmonary disease, anxiety disorder, and major depressive disorder, single episode. Review of the resident's admission paperwork provided to the facility from the transferring facility revealed an order dated 05/13/26 to monitor for sexually inappropriate behaviors. Review of the MDS revealed Resident #26 was severely cognitively impaired and required supervision with oral hygiene, toileting hygiene, dressing, personal hygiene, sit to stand, transfers, and moderate assistance for showers. Review of the admission physician's orders dated 06/09/26 revealed Resident #26 had an order for cimetidine 300 milligrams (mg) (medication to manage sexually inappropriate behaviors) one tablet by mouth two times a day for sexual ideations. Review of the care plan dated 06/09/26 was absent of any interventions to address Resident #26's history of sexually inappropriate behaviors. Resident #26's care plan was updated on 07/06/26, after the incident, to include displaying sexually inappropriate behavior (exposure of genitals). Interventions included limiting any at risk situations, changing Resident #26's room, and redirection from entering females or males rooms without permission. During an interview on 07/06/26 at 11:06 A.M., the Director of Nursing (DON) confirmed she knew Resident #26 was on a sexual medication upon admission but reported she did not know what it was. The DON also confirmed the care plan was not updated until 07/06/26 to include sexually inappropriate behaviors and advised the interdisciplinary team is responsible for updating the care plan. During an interview on 07/06/26 at 12:28 P.M., the Director of Nursing (DON) stated she was notified on 07/05/26 at 7:15 A.M. that Resident #26 was observed in Resident #24's room standing near the head of her bed with his pants down. Resident #26 was removed from the room and directed back to his room. A head-to-toe assessment was completed on Resident #24.During an interview on 07/06/26 at 12:25 P.M., Resident #26 stated he did not recall wandering into Resident #24's room. During an interview on 07/07/26 at 10:16 A.M., Certified Nursing Assistant (CNA) #811 stated, while walking past Resident #24's room on 07/05/26 at 7:00 A.M. she observed Resident #26 standing near the head of Resident #24's bed near her face while the bed was tilted at a 30-degree angle. Resident #26's incontinent brief was pulled down to his ankles and Resident #24 was observed moving her hands around his pelvic region. She called CNA #784 to assist with getting Resident #26 back to his room. During an interview on 07/07/26 at 11:45 A.M., CNA #784 revealed on 07/05/26 she heard CNA #811 calling her name while giving report to the oncoming staff. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When she arrived at Resident #24's room, she observed Resident #26's incontinence brief down at his ankles and he was standing over Resident #24's bed. Resident #26 was removed from the room and taken back to his room. Review of the witness statement for SRI tracking number 276571 dated 07/04/26 (should have been dated 07/05/26) at 7:50 A.M. revealed CNA #811 found Resident #26 in Resident #24's room with his incontinent brief down with his penis in Resident #24's face while she touched it. Review of the clarification statement dated 07/06/26 by the DON revealed CNA #811 reported she observed Resident #24 moving her hand away from Resident #26. She also reported Resident #24 was in good spirits and laughed per her normal self. Review of the Abuse, Neglect, and Exploitation Policy dated 01/01/26 revealed the facility would implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieved: Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur, with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility Self-Reported Incident (SRI) #261861, and policy review, the facility failed to ensure a complete and accurate investigation was completed for an allegation of resident-resident physical abuse between Residents #3 and #36. This affected two residents (Residents #3 and #36) of four residents reviewed for abuse and had the potential to affect all residents in the facility. The facility census was 30. Findings include: Review of Resident #3's medical record revealed an admission date of 04/01/24. Diagnoses included vascular dementia, mild protein calorie malnutrition, hypertensive emergency, toxic encephalopathy, history of transient ischemic attack, and cerebral infarction. Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and was dependent on staff for all activities of daily living (ADL). Review of Resident #36's medical record revealed an admission date of 04/10/23 and a discharge date of 10/24/25. Diagnoses included hyperosmolality, hyponatremia, congestive heart failure, cardiac arrhythmias, pulmonary fibrosis, and type II diabetes. Review of Resident #36's discharge MDS 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition and required setup or clean up assistance with eating, oral hygiene, was dependent on staff for toileting hygiene, and showers, required partial to moderate assistance with dressing, and was independent with bed mobility. Review of SRI #261861 created on 06/20/25 and completed on 06/26/25 related to resident-to-resident psychical abuse stated Resident #36 was seen by other resident touching Resident #3 breasts over her shirt. The investigation completed by facility was unsubstantiated. The facility was unable to provide an investigation for SRI #261861. During an interview on 06/30/26 at 12:15 P.M., Regional Registered Nurse (RN) #828 revealed she confirmed they were unable to find and provide the investigation. She stated she was unable to find any additional information including the witness statements and complete investigation done by the facility. Review of the Abuse, Neglect, and Exploitation Policy, dated 01/01/26, revealed the facility would implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieved: Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur, with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. Additionally, the policy stated the facility would complete an investigation.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure required transfer and discharge procedures were completed for Residents #3, #36, and #38. The facility failed to provide bed-hold notices and notify the Long-Term Care (LTC) Ombudsman for residents transferred to the hospital, failed to provide required transfer documentation, and failed to complete a discharge summary/recapitulation upon resident discharge. This affected three (Residents #3, #36, and #38) of three residents reviewed for discharge. The facility census was 30. Findings include: 1. Review of the closed medical record for Resident #38 revealed an admission date of 01/23/24 and a discharged date of 09/24/25. Diagnoses included Alzheimer's disease, hip fracture, vitamin B and D deficiencies, muscle weakness, mood disorder, depression, and dementia with behavioral disturbances. Review of the census revealed Resident #38 was transferred to the hospital on [DATE] through 09/02/25 and again on 09/09/25 until discharge on [DATE]. Review of the progress note dated 08/23/25 at 12:06 P.M. revealed the nurse informed the nurse practitioner (NP) that Resident #38 was unable to obtain x-ray to left hip and leg, x-ray technician stated the resident was unable to follow instruction and stay still to perform the procedure. A new order was given by the NP to send Resident #38 out via 24/7 transportation to emergency room (ER) for further evaluation, resident/family made aware. Review of the progress note dated 09/09/25 at 7:05 P.M. and 7:45 P.M. revealed the NP called back and ordered to send resident to the hospital and she promised to call transport as well. At about 7:30 P.M., 24/7 transportation personnel arrived and transported Resident #38 out to the ER for evaluation and treatment of patchy right-sided infiltrates. Resident #38's responsible party, was notified about resident's chest x-ray result and transferred to the hospital. Review of the evidence of notification to the LTC Ombudsman revealed Resident #38 was not listed for the August 2025 and September 2025 hospitalizations. During interviews on 06/30/26 at 2:31 P.M. and 4:19 P.M., Regional Registered Nurse (RRN) #828 stated she was unable to locate the bed hold notices for Resident #38's hospital transfers on 08/23/25 and 09/09/25 for a change in condition. RRN #828 verified the LTC Ombudsman was not notified of the resident's hospital transfers on those dates as well. RRN #828 stated she would have to look for the transfer notices. During a follow-up interview on 07/07/26 at 4:57 P.M. with RRN #838 via email stated was unable to find the hospital transfer notices for Resident #38's hospital transfers on 08/23/25 and 09/09/25. Review of the facility policy titled Transfer and Discharge (including Against Medical Advice (AMA), revised 01/07/26 revealed emergency transfers/discharges initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as soon as possible, but no later than 24 hours of the transfer. Provide transfer notice as soon as practicable to the resident and the resident's representative. Social Services Director, or designee, shall provide notice of transfer to a representative of the LTC Ombudsman via monthly list. 2. Review of the medical record for Resident #36 revealed an admission date on 04/0/23 and a discharge date of 10/24/25. Diagnoses included congestive heart failure, type II diabetes mellitus, muscle weakness, and dementia with behavioral disturbances. Review of the nursing note dated 10/24/25 at 12:12 P.M. revealed Resident #36's power of attorney (POA) arrived at the facility to transfer the resident to another facility. Skin assessment completed prior to discharge: no new skin issues noted. Resident #36 had an indwelling Foley catheter, and it was draining clear yellow urine. Vital signs were obtained. The resident was stable at (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Heritage Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 24613 Broadway Avenue Oakwood Village, OH 44146	
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the time of transfer. Personal belongings and paperwork were sent with the resident's POA. Further review of Resident #36's medical revealed no evidence of a discharge summary or recapitulation. During an interview on 07/08/26 at 9:31 A.M. with RRN #828 via email stated she did not see a discharge recapitulation for Resident #36. Review of the facility policy titled Transfer and Discharge (including AMA), revised 01/07/26, revealed anticipated transfers or discharges initiated by the resident noted a member of the interdisciplinary team completes relevant sections of the discharge summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the discharge summary is complete and includes, but not limited to, the following: a recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results, a final summary of the resident's status, reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter); and a post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. 3. Review of Resident #3's medical record revealed an admission date of 04/01/24. Diagnoses included vascular dementia, mild protein calorie malnutrition, hypertensive emergency, toxic encephalopathy, history of transient ischemic attack, and cerebral infarction. Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and was dependent on staff for all activities of daily living (ADL). Review of Resident #3's hospitalizations revealed the resident was hospitalized from [DATE] through 02/12/26 and 06/06/26 through 06/09/26. The resident returned to the facility after each hospitalization. Review of Resident #3's bed hold letter dated 02/12/26 revealed it was not filled out or delivered to the resident's guardian until 02/12/26. (She went to the hospital on [DATE]). There was not a bed hold letter provided for Resident #3's hospitalization on 06/06/26. During an interview on 06/30/36 at 2:35 P.M., RRN #828 confirmed they did not have Bed Hold Notices completed accurately for Resident #3. She stated she was unsure if they had the transfer notices either.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and review of the facility policy and procedure, the facility failed to ensure care conferences were completed as required and/or included the required attendees. This affected two residents (#5 and #38) of three residents reviewed for care conferences. The facility census was 30. Findings include: 1. Review of the closed medical record for Resident #38 revealed an admission date of 01/23/24 and a discharge date of 09/24/25. Diagnoses included Alzheimer's disease, hip fracture, vitamin B and D deficiencies, muscle weakness, mood disorder, depression, and dementia with behavioral disturbances. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #38 had severely impaired cognition, had no behaviors, did not use any mobility devices, require setup and clean up assistance from staff for eating but was dependent on staff for toileting, shower/baths, and personal hygiene. The assessment also indicated the resident was independent with bed mobility, transfers, and ambulation. Review of the care conference forms provided by the facility revealed two care conference forms for 2024 dated 05/01/24 and 08/08/24 and one for 2025 dated 09/12/25 that was not completed. During an interview on 06/30/26 at 8:43 A.M., Regional Registered Nurse (RRN) #828 stated care conferences were not done within 72 hours of admission and then quarterly. RRN #828 verified the above findings. 2. Review of Resident #5's medical record revealed an admission date of 03/04/26. Diagnoses included neurocognitive disorder with Lewy bodies, type II diabetes, hyperlipidemia, psychosis, anxiety, acute kidney failure, and hypertension. Review of Resident #5's care plan last updated 03/04/26 revealed the resident had the potential for alteration in skin integrity, required protective and preventative skin care. The care plan was not updated to reflect the new blister to the residents right shoulder, present from 06/15/26 to 06/22/26. Review of Resident #5's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. He was dependent on staff for all activities of daily living (ADL) and was incontinent of bowel and bladder. Review of Resident #5's Care Conference progress notes dated 05/25/26 at 11:23 A.M. revealed the facility held a quarterly care conference with only the resident's registered nurse (RN) and the social service designee (SSD) present and did not include all required staff. During an interview on 06/30/26 at 10:00 A.M., SSD #779 stated she was unaware that the resident's wife's phone number was disconnected, she confirmed they were having a hard time getting a hold of the resident's wife. She stated dietary and activities staff do not attend the care conference meetings. She stated if there were concerns, she passed them on verbally and asked them to follow (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up; she stated she does not do any follow up to make sure the concerns were addressed. During an interview on 06/30/26 at 10:20 A.M., Assistant Director of Nursing (ADON) #766 confirmed the care plan was not updated to reflect the new blister to Resident #5's shoulder from 06/15/26 through 06/22/26 and stated it should of been. This deficiency represents non-compliance investigated under Master Complaint Number 2989928 and Complaint Number 2737707.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide adequate nail care for Resident #21. This affected one Resident (#21) of four residents reviewed for activities of daily living. The facility census was 30. Findings include: Review of the medical record for Resident #21 revealed an admission date 08/19/22 diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, hypertension, cerebral infarction, adult failure to thrive, and type 1 diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had impaired cognition and required set up with personal hygiene. Review of the care plan dated 04/01/26 revealed the resident was at risk for decline in activities of daily living related to weakness and left hemiplegia and abnormal gait. Intervention included wearing a left-hand splint. The care plan referenced staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly. Review of Resident #21's activity log for June 2026 revealed nail care was provided on 06/10/26. Observation and interview on 06/28/26 at 11:30 A.M. of Resident #21 revealed his fingernails were long extending over his fingertips. The nails had brown dirt under embedded under the nail. Interview with Resident #21 at the time of observation revealed the resident stated his nails were long and needed to be cut. Interview with Certified Nursing Assistant (CNA) #809 at 11:30 A.M. verified Resident #21's nails were long and appeared dirty under the nails. CNA #809 stated she would notify the activity staff to provide nail care. Interview on 06/30/26 at 9:25 A.M. with Activity Staff #774 verified nail care was provided on 06/10/26 and again on 06/28/26 when it was identified by staff. Review of the facility policy titled Resident Care dated 10/01/25 stated residents will be given nursing care and supervision based upon individual needs and abilities. Types of personal hygiene for residents will include cleaning and cutting of fingernails and toenails.		

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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 record review and interview, the facility failed to ensure notification of a change in condition to the resident's responsible party affecting Resident #5. The facility also failed to timely address a change in condition affecting Resident #38. This affected two residents (#5 and #38) of two residents reviewed for change in condition. The facility census was 30. Findings include: 1. Review of the closed medical record for Resident #38 revealed an admission date of 01/23/24 and a discharge date of 09/24/25. Diagnoses included Alzheimer's disease, hip fracture, vitamin B and D deficiencies, muscle weakness, mood disorder, depression, and dementia with behavioral disturbances. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #38 had severely impaired cognition, had no behaviors, did not use any mobility devices, require setup and clean up assistance from staff for eating but was dependent on staff for toileting, shower/baths, and personal hygiene. The assessment also indicated the resident was independent with bed mobility, transfers, and ambulation. Review of the progress notes dated 08/22/25 at 6:05 P.M. revealed Resident #38 was observed with left leg discomfort during supper time. However, was up in the wheelchair most of the shift sleeping and now screams out in pain whenever his left leg is moved. On assessment, his skin was warm and dry to touch, no shortness of breath (SOB), no swelling or bruising noted at the site this moment. The resident was unable to explain how he got the injury. The nurse practitioner (NP) was called and notified about the above and ordered an x-ray of the left hip and thigh, and neurological checks and vital signs every shift. Resident #38 consumed 100% of his meals and nursing will continue to monitor closely. Review of the physician order dated 08/22/25 at 6:07 P.M. revealed x-ray of left leg on 08/23/25. Review of the nursing note dated 08/22/25 at 6:32 P.M. revealed Resident #38's guardian was notified about resident's left leg discomfort and the NP's orders for a left hip and thigh x-ray. Review of the nursing note dated 08/23/25 at 12:06 P.M. revealed the nurse informed the NP that Resident #38 was unable to obtain x-ray to left hip and leg; the x-ray technician stated the resident was unable to follow instruction and stay still to perform the procedure. A new order was received to send the Resident #38 out via 24/7 transportation to the hospital emergency room (ER) for further evaluation. The resident and family were notified. Review of the nursing note dated 08/23/25 at 2:45 P.M. revealed resident #38 left the facility with 24/7 transportation at 12:30 P.M. to the hospital. Review of the nursing note dated 08/23/25 at 6:14 P.M. revealed the nurse spoke with the hospital, and Resident #38 was admitted for left hip fracture. Resident's guardian was notified of admission to hospital. During an interview on 06/30/26 at 8:43 A.M., Regional Registered Nurse (RRN) #828 verified the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for x-ray was not a STAT (immediate) order, stating, I would have thought it would have been a STAT order and done sooner. 2. Review of Resident #5's medical record revealed an admission date of 03/04/26. Diagnoses included neurocognitive disorder with Lewy bodies, type II diabetes, hyperlipidemia, psychosis, anxiety, acute kidney failure, and hypertension. Review of Resident #5's care plan last updated 03/04/26 revealed the resident had the potential for alteration in skin integrity, required protective and preventative skin care. The care plan was not updated to reflect the new blister to the resident's right shoulder. Review of Resident #5's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. They were dependent on staff for all activities of daily living (ADL) and was incontinent of bowel and bladder. Review of Resident #5's progress notes revealed on 06/17/26 at 8:15 A.M. the Certified Nursing Assistant (CNA) assigned to him reported an open blister to the resident's right shoulder measuring 2 centimeters (cm) X 1.5 cm X 2 cm, it was cleansed with normal saline, and a dry sterile dressing was applied. The wound team was notified for assessment and follow up orders. The Director of Nursing (DON) was notified. There was no documented evidence that the resident's responsible party was notified. During an interview on 06/30/26 11:15 A.M., Assistant Director of Nursing (ADON) #766 and Regional RN #828 revealed they confirmed the family was not notified of the new blister to the resident's shoulder and they should have been. This deficiency represents non-compliance investigated under Complaint Numbers 2737707 and 2609902.		

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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 open and closed record review, policy review, and interview, the facility failed to ensure appropriate supervision levels were provided to residents while smoking and residents did not have access to smoking materials in their room. This affected one resident (Resident #36) of five residents reviewed for accidents and one resident (Resident #37) of three residents reviewed for discharge. The facility also failed to ensure residents didn't exit the facility without staff knowledge/supervision. This affected one resident (Resident #7) of five residents reviewed for accidents. The facility census was 30. Findings include: 1. Review of Resident #37's closed medical record revealed the resident was admitted on [DATE] and discharged on 03/08/26 with diagnoses including Alzheimer's disease with early onset, narcissistic personality disorder, and essential hypertension (high blood pressure). Review of Resident #37's Smoking assessment dated [DATE] revealed the resident was a smoker, did not use oxygen, did not attempt to smoke in non-designated areas and was assessed as an independent smoker. However, the facility is a locked facility and according to policy all residents are to be supervised while smoking. Review of Resident #37's progress note dated 08/26/25 at 6:39 P.M. revealed the resident was observed giving another resident half of a smoked cigarette. The resident was advised by activity aides not to do so, but the resident responded that no one had the right to tell him what to do. The resident was educated on the smoking policy. Review of Resident #37's progress note dated 01/09/26 at 2:00 A.M. revealed the resident was found to be on the patio through the dining room sliding doors, smoking. Assistant Director of Nursing (ADON) #766 was made aware. The progress note did not reveal evidence that the family or physician were notified. Review of Resident #37's progress note dated 01/09/26 at 6:24 A.M. revealed the resident went out the dining room patio doors at 6:20 A.M. to smoke. The nurse attempted to reeducate the resident. The progress note did not reveal evidence that the family or physician were notified. Review of Resident #37's progress note dated 01/21/26 at 5:03 P.M. revealed the resident had verbal and physical behaviors during the shift. The resident came out of his room at 3:45 P.M., 15 minutes after the smoke break and the smoke room was locked. The resident went into the bathroom near the kitchen to smoke a cigarette. The resident sat in the bathroom for twenty minutes and then went into his room. The resident was educated on smoking safety. The note did not reveal evidence that the family or physician were notified. Review of Resident #37's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 06/28/26 at 3:50 P.M. Prior Administrator #739 revealed Resident #37 was non-compliant with smoking and that was the main reason the resident was provided a 30-day discharge notice. Prior Administrator #739 confirmed the latest incident with smoking was when the resident was found in the staff bathroom by the kitchen smoking. The Administrator stated the facility determined the resident was obtaining smoking materials when they went on leave of absence and did not provide the smoking materials to staff upon his return. During an interview on 06/29/26 at 7:59 A.M., Activity Director (AD) #747 confirmed Resident #47 had a laptop or computer, and smoking was his number one main activity. AD #747 confirmed the facility kept a lock box for resident cigarettes, and she was unaware of how the resident obtained the cigarettes to smoke without supervision. During an interview on 06/30/26 at 8:51 A.M., Regional Registered Nurse (RN) #828 confirmed the facility did not secure the resident's cigarettes and did not ensure appropriate supervision for the resident's identified supervised smoking. 2. Review of Resident #36's closed medical record revealed an admission date of 04/10/23 and a discharge date of 10/24/25. Diagnoses included hyperosmolality, hyponatremia, congestive heart failure, cardiac arrhythmias, pulmonary fibrosis, and type II diabetes. Review of Resident #36's determination of smoking statuses dated 04/12/23 through discharge revealed all were marked as supervised smoker (except the one completed on 05/07/25 which was marked in error as independent). Review of Resident #36's smoking assessment dated [DATE] revealed the resident needed assistance with lighting his cigarette and was required to wear a smoking apron. Review of Resident #36's care plan initiated on 05/03/23 revealed there was potential for safety hazard or injury related to smoking. The care plan indicated the resident was able to smoke with supervision by staff or family. Goals and interventions included the staff would continue to follow the facility smoking policy, notify management if resident is observed being unsafe with smoking, observe clothing for burn holes, keep smoking materials at the nurse's station and while smoking the resident will have direct supervision by staff or family. Review of facility incident report dated 08/16/25 related to Resident #36 revealed he was brought out to smoke by facility staff who assisted with lighting his cigarette at approximately 8:15 P.M. The nurse was notified by the certified nursing assistant (CNA) that there was smoke coming from under the door of Resident #36's room. Resident #36 was in the his room on the bed and there was a burning brief on the floor next to the bed. Resident #36 was moved to safety, and 911 was called. The fire department arrived and disposed of the burning brief and cleared the smoke and ensured the building was safe. The incident report indicated Resident #36 put a lit cigarette in his brief and brought it back into the facility. Review of the Fire Marshal Report revealed there was a lit cigarette that Resident #36 placed in his brief caused the fire. Review of Resident #36's discharge MDS 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition and required setup or clean up assistance with eating, oral hygiene, was dependent on staff for toileting hygiene, and showers, required partial to moderate assistance with dressing and wheelchair mobility, and was independent (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with bed mobility. During an interview on 06/29/26 at 8:15 A.M., Resident #36's family revealed the resident was wearing a brief when it caught on fire and was removed. The family stated the fire department was called due to the brief being on fire and a large amount of smoke was noted in the resident's room. The family stated they came to the facility and instructed staff that the resident was no longer allowed to smoke with facility staff, and if the resident wanted to smoke, they were to be notified, and they would come up to the facility and take him out due to the staff lack of supervision. During an interview on 06/29/26 at 1:26 P.M., RN #823 revealed Resident #36 was brought back from the smoking room by another resident with a lit cigarette in his brief which then became hot. The resident removed the brief and threw it on the floor of his room. She stated at approximately 8:15 P.M. on 08/16/25 she was notified by a CNA that there was smoke pouring out from underneath Resident #36's door. Upon entering the room, she found the resident's brief on the floor on fire, the CNA then picked up the brief and ran with it out in the hallway. She stated, at this point, the brief was flaming, and she tried to call 911 from her cell phone but was unable to due to connection issues. She stated she removed Resident #36 from the room to ensure safety. She did not perform a skin assessment until approximately two hours after the incident because she had to wait for the fire department to clean out all the smoke and clear the scene. RN #823 stated it was common for other residents who walked to push residents in wheelchairs back from smoking. Review of the Resident Smoking policy, dated 01/16/26, revealed purpose of the policy was to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. The facility does not permit unsupervised smoking. Designated smoking times will be supervised by a staff member. Review of the facility Smoking Times form revealed smoke breaks were scheduled for 9:30 A.M.; 11:30 A.M.; 1:30 P.M.; 3:30 P.M.; 7:30 P.M.; and 9:30 P.M. 3. Review of the medical record for Resident #7 revealed an admission date 08/27/25 with diagnoses including dementia, chronic obstructive pulmonary disease, type II diabetes, malnutrition, myocardial infarction, repeated falls, hypertension, unsteadiness on feet. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had intact cognition and required supervision with transfers and could ambulate 150 feet with supervision. Review of the elopement risk assessment dated [DATE] revealed the resident was not at risk for elopement. Review of the Care Plan dated 06/24/26 revealed plan for impaired cognitive process for daily decision making. At risk for further decline in cognitive status and dementia. Interventions included providing cues, prompting to complete tasks and to reorient and redirect as needed. Review of the progress note dated 07/05/26 at 8:20 P.M. written by Registered Nurse (RN) #780 stated approximately 7:00 P.M. Certified Nursing Assistance (CNA) reported that there was a resident (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside. The resident was observed standing on the next-door company's sidewalk. Resident was standing with these two couples when this writer approached them. The resident was standing with her rolling walker and no injury noted. Resident said that she was attempting to leave the facility to go home and take care of business. RN #780 believed that residents left the building from the front door because this door was found open during this incident. In addition, the facility door opens immediately after pushing onto it for a couple of minutes. The door alarm is not loud enough for the staff members to notice it. Resident was reassured and assisted back to the facility without any difficulties. The Resident was then placed on five minutes check for safety reasons. Review of the witness statement written by Licensed Practical Nurse (LPN) 733 stated she received a phone call stating there was a lady walking in the middle of the street outside. Interview on 07/06/26 at 11:50 A.M. with Corporate Registered Nurse (CRN) #828 stated when the resident was brought back into the facility a head to toe assessment was completed with no negative finding. Doors were checked for safety. The resident monitored the rest on the night. The security company came out to ensure the doors were functioning. CRN #828 believed staff could not hear the door alarm over the temporary air conditioner. Interview on 07/06/26 at 1:30 P.M. with Resident #7 stated she did not remember leaving the facility to go outside. Interview on 07/06/26 at 4:41P.M. with RN #780 stated she went out of the building to find Resident #7. Resident #7 was observed with standing with her walker on the sidewalk with two civilians and two staff members in front of building. RN #780 stated the alarm was so faint and felt the unit was not secure due to the doors are able to be pushed open. Interview on 07/06/26 at 2:46 P.M. with CNA # 711 stated it was the end she took the trash out to the dumpster and saw two pedestrians directing traffic across the street. She threw the trash away and saw Resident #7 was on the sidewalk and the two pedestrians were walking back across the street. CNA #711 ran back to alert staff. Interview on 07/07/26 at 11:17 A.M. with Licensed Practical Nurse (LPN) #733 she was working in the sister facility next door when a civilian called the facility and stated there was a lady standing in the middle of the street. LPN #723 instructed LPN #835 to go out and assess the situation. Interview on 07/07/26 at 12:30 P.M. CNA #710 started approximately at 6:55 P.M. Resident# 7 was walking from the nurses' station to her room. CNA #710 provided care to another resident and heard the alarm sound. CNA #710 and went out the door and observed four staff in the parking lot between the two buildings walking back to the facility. Review of the facility policy titled Elopements and Wandering Resident dated 06/01/24 revealed this facility ensures that residents who exhibit wandering behavior and or at risk for elopement receive adequate supervision to prevent accidents This deficiency represents non-compliance investigated under Complaint Numbers 2737707 and 2609095.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interview, the facility failed to ensure Residents #18 and #27 received timely incontinence care. This finding affected two (Residents #18 and #27) of three residents reviewed for incontinence care. The facility census was 30. Findings include: 1. Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses including alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder, and difficulty in walking. Review of Resident #27's activities of daily living (ADL) care plans revealed an intervention dated 01/14/25 to praise ADL self-performance and an intervention dated 05/04/26 for one-person assistance with transfers and ambulation. Review of Resident #27's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment, was occasionally incontinent of urine and occasionally incontinent of bowel. Observation on 06/28/26 at 9:25 A.M. revealed Resident #27 was sleeping on the bed near the window. The room had an odor of urine. Upon inspection, Resident #27 linens appeared soiled, and the resident stated he was cold. Gnats were observed flying around the resident and landing on the resident's left hip area partially exposed by a sheet which covered the resident. A second observation on 06/28/26 at 9:27 A.M. with Certified Nursing Assistant (CNA) #714 of Resident #27 revealed the resident was wearing a brief, t-shirt and jogging pants. The resident's morning care including incontinence care revealed the resident's brief and jogging pants were saturated with urine, and the resident's t-shirt was wet with urine up the right side of the resident's t-shirt to just under the armpit. Attempted interview on 06/28/26 at 9:28 A.M. with Resident #27; the resident was not interviewable due to severe cognitive impairment. Interview on 06/28/26 at 9:30 A.M. with CNA #714 confirmed the above observation. 2. Review of Resident #18's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia, essential hypertension, and hyperlipidemia. Review of Resident #18's care plans revealed a care plan dated 02/03/24 to provide incontinence care every two hours and as needed. Review of Resident #18's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment, was frequently incontinent of bladder and bowel and was dependent on staff for toileting. Observation on 06/29/26 at 6:17 A.M. revealed Resident #18 asked the nightshift staff including CNA #807, CNA #784 and Licensed Practical Nurse (LPN) #757 to use the bathroom to urinate. During an interview on 06/29/26 at 6:30 A.M., CNAs #807 and #784 revealed Resident #18 was incontinent and was a check and change, and the resident asking to use the bathroom was a behavior. During an interview on 06/30/26 at 9:55 A.M., the Director of Nursing (DON) stated Resident #18 was both checked and changed and taken to the bathroom for toileting. The DON confirmed if Resident #18 requested to go to the bathroom, the staff should have taken the resident to the bathroom. Review of the Resident Care policy, dated 10/01/25, revealed residents would be given nursing care and supervision based upon individual needs and abilities.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure psychiatric services were provided timely and per orders This finding affected one (Residents #5) of two residents reviewed for psychiatric services. The facility census was 30. Findings include: Review of Resident #5's medical record revealed an admission date of 03/04/26. Diagnosis included neurocognitive disorder with Lewy bodies, psychosis, and anxiety, Review of Resident #5's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. They were dependent for all Activities of Daily Living (ADLs). The Resident was incontinent of bowel and bladder. Review of Resident #5's medical record revealed and order for psych services on 04/10/26 and again on 05/03/26. Psych did not see until 06/28/26. Interview on 06/30/26 at 10:58 A.M. with the DON revealed the delay in Psych services was related to getting the consent from the wife. She verified there was an order from 04/10/26 to consult psych services for eval and treatment again in May 2025 based on a pharmacy recommendation completed on 05/03/26. The Nurse Practitioner consulted Psych services to eval and treat. Interview on 06/30/26 at 11:30 A.M. with SSD #825 revealed they did not receive verbal consent from the wife until the care conference held on 05/25/26. She was unsure why it took so long for Psych services to see Resident #5 after the care conference. She stated the Psych NP only comes to the facility every two weeks and was on vacation and no one was covering for them while they were on vacation. Interview on 06/30/26 at 2:06 P.M. with Psych NP #829 revealed she was aware the resident was not seen for approximately one month after receiving the consent to treat. She stated there are times when new referrals are pushed based off of her case load and she only comes to the facility every two weeks. This deficiency represents non-compliance investigated under Complaint Numbers 2737707 and 2609095		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure pharmacy recommendation were acted on timely. This affected one Resident (#28) of five residents reviewed for unnecessary mediations. The facility census was 30. Findings include: Review of the medical record for Resident #28 revealed an admission date 05/01/25 with diagnoses including hemiplegia and hemiparesis to right side, cerebral infarction (stroke), muscle weakness, vascular dementia, anxiety, and rheumatoid arthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had impaired cognition and received an antidepressant, and anticoagulant. Review of the care plan dated 06/24/26 revealed the resident had the potential for adverse side effect of psychotropic drugs. Interventions included documenting side effects of medication and to notify the physician of any mental status changes. Review of the current physician orders for Resident #28 revealed the resident was ordered Sertraline 50 milligram (mg), an antidepressant, daily and Trazodone 50 mg, antidepressant, nightly at bedtime. Review of the pharmacy recommendation dated 11/05/25 for Sertraline 50 milligrams (mg) and Trazodone 50 mg revealed for the provider to consider a gradual dose reduction trial. The dose reduction was noted to be contraindicated as additional attempts would likely impair the resident's function. The form was signed by the Physician Assistant (PA) on 01/27/26. Interview with the Regional Registered Nurse (RN) #828 on 07/07/26 at 4:09 P.M. verified the recommendation was not addressed in a timely manner. Review of the facility policy titled Use of Psychotropic Medications dated 10/01/25 stated resident who use psychotropic drugs shall receive gradual dose reduction unless contraindicated, in an effort to discontinue these drugs.		

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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, policy review, and interview, the facility failed to ensure staff did not administer two doses of aspirin (anticoagulant) daily to Resident #4. This finding affected one (Resident #4) of five residents reviewed for unnecessary medications. The facility census was 30. Findings include: Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including vascular dementia with other behavioral disturbance, bipolar disorder, and chronic obstructive pulmonary disease. Review of Resident #4's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #4's physician orders revealed an order dated 09/12/25 (discontinued 06/02/26) for aspirin capsule 81 mg (milligrams) give one tablet by mouth one time a day for heart maintenance. Review of Resident #4's physician orders revealed an order dated 05/05/26 (discontinued 06/02/26) for aspirin 81 mg chewable tablet give one tablet by mouth one time a day for a healthy heart. Review of Resident #4's medication administration records (MARs) from 05/01/26 to 06/02/26 revealed documentation both aspirin orders were administered from 05/05/26 to 06/02/26. During an interview on 07/07/26 at 3:27 P.M., Director of Nursing (DON) #803 confirmed Resident #4's aspirin was documented as administered for two tablets daily from 05/05/26 to 06/02/26. Review of the Medication Administration policy, dated 08/22/25, revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. This deficiency represent noncompliance investigated under Complaint Number 2609902.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure Resident #27's Depakote (antiseizure and mood stabilizer) was discontinued as ordered. This finding affected one (Resident #27) of five residents reviewed for unnecessary medications. The facility census was 30. Findings include: Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses including alcohol abuse, difficulty in walking and chronic obstructive pulmonary disease. Review of Resident #27's physician orders revealed an order dated 04/23/25 (discontinued 09/12/25) for Depakote oral tablet 250 milligrams (mg) give one tablet by mouth two times a day for bipolar disorder. Review of Resident #27's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #27's physician orders revealed an order dated 08/26/25 (discontinued 09/12/25) for Depakote oral tablet give 375 mg by mouth two times a day for dementia with behaviors. Review of Resident #27's Nursing Recommendations dated 09/02/25 revealed the resident had a new order from 08/26/25 for Depakote 375 mg twice daily. Nursing never discontinued the existing Depakote 250 mg twice daily order. Please review and discontinue both active orders then reenter new orders for the correct dosage. The follow-through section of the form was marked as completed on 09/12/25. Review of Resident #27's lab work dated 09/08/25 at 7:11 A.M. revealed the valproic acid level (to check for Depakote toxicity) was 71 (level should be between 50 and 100). Review of Resident #27's physician orders revealed an order dated 09/12/25 (discontinued 10/23/25) for Depakote oral tablet 125 mg give one tablet by mouth two times a day for behaviors (give with Depakote 250 mg twice daily; and an order dated 09/12/25 (discontinued 10/23/25) for Depakote oral tablet 250 mg give one tablet by mouth two times a day for behaviors (give with 125 mg for a total dose of 375 mg). Interview on 06/30/26 at 11:42 A.M. with the Director of Nursing (DON) confirmed Resident #27's medical record and medication administration records (MARs) had documented evidence that both the Depakote 250 mg and Depakote 375 mg were administered from 08/26/25 to 09/12/25. The DON confirmed the resident's valproic acid level was within normal limits. Review of the Medication Administration policy, revised 08/22/25, revealed medications were administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. This deficiency represents non-compliance investigated under Complaint Number 2609902.		

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure physician appointments were attended. This affected one Resident (#27) of one resident reviewed for appointments. The facility census was 30. Findings include: Review of the medical record for Resident #27 revealed an admission date of 01/01/25 with diagnoses including alcohol dependence with alcohol-induced persisting dementia, anxiety, human immunodeficiency virus (HIV), bipolar disorder, and cocaine abuse. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had impaired cognition and was independent with transferring and ambulation. Review of the care plan dated 06/17/26 revealed the resident was non-compliant with care and treatment as ordered by physician. Interventions included to educate the resident on not following physician orders and observe and document on behavior changes. Review of the scheduled appointment list provided by the facility revealed Resident #27 had following appointments scheduled to attend the human Immunodeficiency virus (HIV) clinic. On 02/09/26, the facility was unsure if Resident #27 attended the appointment as there was no documentation. On 03/16/26, Resident #27's appointment was rescheduled due to transportation issues and no [staff] escort. On 08/18/26, the facility was unsure if Resident #27 attended as there was no documentation. On 06/01/26, transportation arrived in a vehicle too small to transport Resident #27 to his appointment. On 06/15/26, Resident #27's appointment was rescheduled due transportation not available. On 06/30/26, Resident #27 attended the appointment as scheduled. Review of the HIV clinic documentation revealed the following additional appointments: On 11/10/25, Resident #27 was seen in the clinic. On 02/02/26, Resident #27 was a no show for the scheduled appointment. On 02/17/26, Resident #27 was a no show for the scheduled appointment. On 04/20/26, Resident #27 was a no show for the scheduled appointment. On 05/4/26, Resident #27's appointment was cancelled due to lack of transportation. On 05/11/26, Resident #27's appointment was cancelled with no reason referenced. Interview on 07/06/26 at 3:00 P.M. with the Director of Nursing (DON) verified Resident #27 did not attend all his appointments. The DON stated some appointments were missed due to transportation. The DON was new to the position and could not find any additional information on when or if the resident attended appointments at the HIV clinic. Review of the facility policy titled Resident Medical Appointments and Transportation dated 01/01/26 revealed it is the policy of this facility to support and facilitate a resident's right to proper transportation to necessary medical appointment. This deficiency represents non-compliance investigated under Complaint Numbers 2737707 and 1320284 (OH00165050).		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interview, the facility failed to ensure Resident #15's meals were provided as ordered and per the approved facility menu. This finding affected one (Resident #15) of two residents reviewed for food. The facility census was 30. Findings include: Review of Resident #15's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease, diabetes, and heart failure. Review of Resident #15's undated meal ticket revealed the resident was on a regular diet, pureed texture, thin liquids, and a divided dish. Review of Resident #15's care plans revealed an intervention dated 11/19/18 for diet as ordered by the physician. Review of Resident #15's physician orders revealed an order dated 09/13/22 for a regular diet, pureed texture, regular/thin consistency with a divided dish for all meals; and an order dated 05/22/24 for a divided dish with all meals. Review of Resident #15's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited memory problems. Observation on 06/29/26 at 1:18 P.M. with Certified Nursing Assistant (CNA) #821 revealed Resident #15's lunch meal tray had a piece of blank paper with the resident's name written on the ticket and mech was written on the ticket. The meal consisted of rice, Italian style green beans and mechanical chicken with gravy. Six ounces of grape drink was observed on the tray. During an interview on 06/29/26 at 1:20 P.M., CNA #821 confirmed Resident #15 did not receive the meal as ordered and the meal should have been pureed. CNA #821 also confirmed the resident did not receive the cake as ordered. Review of the Spring/Summer 2026 Menu revealed the lunch meal on 06/29/26 consisted of honey garlic chicken thigh, steamed white rice, broccoli, frosted cake, beverage and coffee or hot tea. Review of the Therapeutic Diet Orders policy, dated 06/01/25, revealed the facility provided all residents with food in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences.		