STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365541	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage The	2820 Greenacre Dr Findlay, OH 45840

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, observation, record review, and policy review, the facility failed to notify a resident representative of a new skin condition. This affected one (#15) of five residents reviewed for a change in condition. The facility census was 73.Review of the medical record for Resident #15 revealed an admission date of 01/11/22 with diagnoses of dementia, anxiety, anemia, and Type II diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, completed 06/06/25, revealed Resident #15 had impaired cognition and required substantial/maximal assistance for bed mobility and was dependent for transfers. Review of Resident #15's electronic medical record (EMR) from 06/01/25 through 07/17/25 at 9:30 A.M. revealed no documentation regarding a bruise or new skin concern to Resident #15's face or neck. Additional review revealed no evidence Resident #15's representative was notified of a new skin condition on Resident #15's neck.Interview on 07/17/25 at 9:14 A.M. with Certified Nursing Assistant (CNA) #103 revealed she observed a change in condition to Resident #15 wherein bruising was noted to Resident #15's left neck and right jawline. CNA #103 stated she documented it in the CNA charting and it was also charted by the CNA on the previous shift.Observation on 07/17/25 at approximately 9:30 A.M., with Registered Nurse (RN) #202, of Resident #15 revealed a red area to Resident #15's neck on the left side of the front of her neck, halfway between the shoulder and jaw. Concurrent interview with RN #202 confirmed he did not document his assessment of the area on Resident #15's neck. RN #202 stated he was alerted to the new skin area on Resident #15 by the previous shift's nurse but could not clarify when he first became aware of the area. RN #202 confirmed he did not notify Resident #15's representative about the new skin area. Interview on 07/17/25 at 11:02 A.M. with the Administrator and RN Clinical Support (RNCS) #501 revealed the facility conducted an investigation into the new area on Resident #15's skin after the surveyor identified the lack of documentation in the EMR. RNCS #501 stated Resident #15's bruise was initially identified on 07/12/25 by Licensed Practical Nurse (LPN) #206 and reported to RN #202 to follow up on. RNCS #501 confirmed an assessment of the bruise was not documented and Resident #15's representative was not notified. RNCS #501 confirmed resident representatives should be notified when a new skin condition was identified. Review of the policy, Notification of Change in Condition, dated 05/10/16, revealed the resident's representative should be notified if there was an accident resulting in injury, a significant change in the resident's condition, or if there was a need to alter treatment significantly. Further review revealed documentation of notification should be recorded in the resident's electronic health record.This deficiency represents non-compliance investigated under Complaint Number 2561896.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, record review, observation, and policy review, the facility failed to ensure timely assessments of a new skin condition. This affected one (#15) of five residents reviewed for change in condition. The facility census was 73.Findings include:Review of the medical record for Resident #15 revealed an admission date of 01/11/22 with diagnoses of dementia, anxiety, anemia, and type 2 diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, completed 06/06/25, revealed Resident #15 had impaired cognition and required substantial/maximal assistance for bed mobility and was dependent for transfers.Review of Resident #15's Profile in the electronic medical record (EMR) revealed she required a mechanical lift for transfers since 06/10/22.Review of Resident #15's electronic medical record (EMR) dated 06/01/25 through 07/17/25 at 9:30 A.M. revealed no documentation regarding a bruise or new skin concern to Resident #15's face or neck.Review of the late entry Incident Report, initiated 07/17/25 at 11:08 A.M., revealed Resident #15 had a bruise to her left neck suspected to be caused by a mechanical lift sling.Interview on 07/17/25 at 9:14 A.M. with Certified Nursing Assistant (CNA) #103 revealed she observed a change in condition to Resident #15 wherein bruising was noted to Resident #15's left neck and right jawline. CNA #103 stated she documented it in the CNA charting and it was also charted by the CNA on the previous shift.Observation on 07/17/25 at approximately 9:30 A.M., with RN #202, of Resident #15 revealed a red area to Resident #15's neck on the left side of the front of her neck, halfway between the shoulder and jaw. Concurrent interview with RN #202 confirmed he did not document his assessment of the area on Resident #15's neck. Further, RN #202 denied any knowledge of a mark on Resident #15's jawline. RN #202 stated he was alerted to the new skin area on Resident #15 by the previous shift's nurse but could not clarify when he became aware of the area. RN #202 stated he did not create an Event in the EMR because he assumed the nurse on the previous shift would have initiated the Event. Additionally, RN #202 stated the Event in the EMR system created a prompt for staff to assess the area on each shift to monitor the new condition. RN #202 stated he was not prompted to complete and document an assessment of the area and confirmed he did not document any assessment of Resident #15's new skin condition.Interview on 07/17/25 at 11:02 A.M. with the Administrator and RN Clinical Support (RNCS) #501 revealed the facility conducted an investigation into the new area on Resident #15's skin after the surveyor identified the lack of documentation in the EMR. RNCS #501 stated Resident #15's bruise was initially identified on 07/12/25 by LPN #206 and reported to RN #202 to follow up on. RNCS #501 confirmed an assessment of the bruise was not documented. Concurrent review of a written statement obtained by RNCS #501 from RN #202 on 07/17/25 revealed RN #202 assessed Resident #15's bruise on 07/12/25 and RN #202 did not find the bruise suspicious as Resident #15 was transferred via mechanical lift and RN #202 had seen the lift sling rub against Resident #15's neck. Further review of the statement revealed RN #202 did not document an assessment of the bruise or suspected cause of the bruise.Observation on 07/17/25 at 11:55 A.M. revealed RN #202 measuring and assessing Resident #15's bruise. Concurrent interview with RN #202 confirmed it was left of center on her neck and halfway between her shoulder and jaw. RN #202 measured the area with a ruler, determining a width of two centimeters and a height of 0.7 centimeters. The coloring was brownish with yellowing around the edges. The edges were irregular and undefined. RN #202 stated the area had the appearance of an aging bruise. Further observation of Resident #15 revealed a scab on her left jaw. RN #202 stated it appeared to be an area Resident #15 picked. An attempted interview with Resident #15 at the time of the observation was unsuccessful.Follow-up interview on 07/17/25 at approximately 12:30 P.M. with the Administrator and RNCS #501 confirmed Resident #15's medical record contained no evidence of an assessment of a new bruise between 07/12/25 and 07/17/25 until a late entry Incident Report was initiated on 07/17/25 at 11:08 A.M. RNCS #501 stated the facility policy allowed for back-dating documentation up to two weeks. Review of the facility policy titled, Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines, dated 05/10/16, revealed an identified skin alteration occurring after admission should be followed by completing a Bruise incident in the EMR along with a progress note. Continued monitoring of the wound should be completed.This was an incidental finding identified during the Complaint Survey completed 07/17/25.