

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER Heritage The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to ensure resident medications were prepared per professional standard. This affected on four Residents (#77, #78, #79, and #80) of four observed. The facility census was 82. Findings Include: Observation on 11/13/25 at 8:53 A.M. to 9:03 A.M. revealed Licensed Practical Nurse (LPN) #134 had three medication cups of unidentified pills on top of medication cart. LPN #134 picked up loose loose pills that were laying on top of medication cart using her bare hand, placed them in a clear sleeve and proceeded to crushed the pills. LPN #134 then was observed to placed the unidentified crushed pills in a fourth medication cup. LPN #134 placed three medication cups of unidentified pills into the medication cart. LPN #134 then placed pudding into the crushed medication cup and walked to Resident #79 in the common area, close to the nurse ' s station and administered the medication. LPN #134 removed one of the pre set medication cups with unidentified pills from medication cart, grabbed a pudding cup, walked to dining room and placed medications with pudding in front of Resident #78 to take medication. Interview on 11/13/25 at 8:57 A.M. with LPN #134 verified she prepared Resident ' s #77, #78, #79, and #80's medications at the same time. LPN #134 verified she had administered Resident #79 medication then administered Resident #78. LPN #134 stated she will be administering Resident #77 and #80's medications at a later time. LPN #134 verbalized preparing multiple residents medications at once is incorrect but it saves time. Review of facility policy, Preparation and General Guidelines, revised January 2018, revealed medication should be administered one resident at a time.</p>

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to ensure medications were not left unattended. This affected one Resident (#87). The facility census was 82. Observation on 11/13/25 at 11:19 A.M. with Licensed Practical Nurse (LPN) #142 revealed Resident #87's medications (Albuterol Sulfate HFA (bronchodilator) aerosol inhaler, Astepro (antihistamine) nasal spray, Basaglar Kwikpen u-100 Insulin pen (long acting Insulin), Aspart Insulin pen u-100 (quick acting Insulin), and Symbicort HFA (corticosteroid) aerosol inhaler) were laying on top of medication cart unattended for four minutes. During the time the medications were on the medication cart unattended one family member, four residents and two staff members walked by medication cart. Interview on 11/13/25 at 11:23 A.M with LPN #143 verified medication were laying on top of medication cart unattended. LPN #143 stated, I am just trying to get done. Review of facility policy, Preparation and General Guidelines, revised January 2018 revealed no medications are kept on top of cart.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and interview, the facility failed ensure proper handling of medication was used when preparing medication. This affected one Resident (#79) during medication pass. The facility census was 82. Observation on 11/13/25 at 8:53 A.M. with Licensed Practical Nurse (LPN) #134 the nurse was observed to picked up an unidentified number of pills for Resident #79 off of top medication cart with her bare hand, place the medications in a clear sleeve, and crush the medications to be administered for Resident #79. LPN #134 then placed pudding into the crushed medication cup and walked to Resident #79 in the common area, close to the nurse ' s station and administered the medication. Interview on 11/13/25 at 8:57 A.M. with LPN #134 it was verified she did not place Resident #79's pills in a medication cup but placed them on top of the medication cart on purpose. LPN #134 stated she was not aware she could not place pills on top of the medication cart and touch them with her bare hand.</p>		