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	02/25/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and facility policy review, the facility failed to notify the physician of a resident's change in condition. This affected one (#10) of three residents reviewed for change in condition. The facility census was 81.Findings include:Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses included Alzheimer's disease and memory deficit following cerebral infarction.Review of a Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #10 had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of nine (9). The resident was assessed to require supervision with toileting, bathing, and dressing, was frequently incontinent of bladder and bowel, and had no skin issues.Review of progress notes dated [DATE] at 1:20 P.M. revealed Registered Nurse (RN) #131 documented Resident #10 was not acting like herself, not eating, getting up, or using the restroom. RN #131 contacted Resident #10's daughter and offered to send her to the emergency room, and the daughter decline at that time. There was no evidence the facility notified the facility of the resident's change in condition. Further review revealed on [DATE] at 2:26 P.M., Resident #10 was transferred to emergency room without physician notification.Interview on [DATE] at 5:50 P.M. with Regional Nurse #128 verified the physician was not notified of change of condition for Resident #10.Review of facility policy titled, Notification of Change in Condition, dated [DATE], revealed a significant change in a resident's physical, mental, or psychosocial status results in reasons to notify the physician immediately.This deficiency represents non-compliance investigated under Complaint Number 2731910.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean and home-like environment. This affected two (#13 and #18) of eight residents review for environment. The facility census was 81.Findings include:Observation on 02/23/26 at 9:07 A.M. revealed Resident #13's floor had a large amount of food crumb particles, small pieces of shredded paper, and mud-like substance throughout the entire carpet in the room. Interview on 02/23/26 at 9:09 A.M. with License Practice Nurse (LPN) #130 verified all findings in Resident #13's room.Observation on 02/23/26 at 9:50 A.M. revealed Resident #18's floor had a cover of shredded paper, shredded metallic paper, and food crumb particles from bed area to the door area. Interview on 02/23/26 at 9:52 A.M. with License Practice Nurse (LPN) #130 verified all findings in Resident #18's room. Interview on 02/23/26 at 11:18 A.M. Regional Nurse #128 revealed rooms should be cleaned daily including over the weekend. Review of the undated facility policy titled, Standard Operate Procedure (SOP)-Room Cleaning-Health Center, revealed daily cleaning include organize, trash pickup and dusting, spraying approved disinfectants, wipe surfaces clean, and vacuum room, and mop bathroom.This deficiency represents non-compliance investigated under Complaint Number 2731910.

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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 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, medical record review, staff interview, and review of a facility policy, the facility failed to ensure timely drainage of urinary catheter bags. This affected one (#12) of four residents reviewed for urinary catheters.Findings include:Review of the medical record for Resident #12 revealed he was admitted on [DATE] with diagnoses including hereditary spastic paraplegia, chronic obstructive pulmonary disease, heart disease, cough, wheezing, shortness of breath, malignant neoplasm of bladder, and suprapubic urostomy.Review of a functional assessment dated [DATE] revealed Resident #12 required set-up to partial assistance with activities of daily living, utilized a motorized wheelchair, and was independent with mobility. Review an admission note dated 02/08/26 for Resident #12 revealed he was alert and oriented.Observation on 02/25/26 at 9:00 A.M. of Resident #12's urinary catheter bag revealed it was round, taut, and full of yellow liquid.Interview on 02/25/26 at 9:10 A.M. with Certified Nurse Aide (CNA) #138 confirmed Resident #12's urinary catheter bag was round, taut, and filled with urine. Subsequent observation of CNA #138 emptying the urinary catheter bag revealed 3,000 milliliters (mL) of urine was emptied from the bag.Review of the manufacturer's label for Resident #12's urinary catheter bag revealed the capacity of the bag was 2,000 mL.Review of facility policy dated 12/16/24 and titled, Emptying Urinary Bags, revealed the facility would empty urinary catheter bags each shift or more often if needed to prevent the bag from becoming full.This deficiency represents non-compliance investigated under Complaint Number 2752534.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation medical record review, resident and staff interview, and review of facility policies, the facility failed to ensure respiratory supplies were stored and dated in a safe manner and failed to ensure a resident's need for supplemental oxygen was provided in a timely and sufficient manner. This affected two (#13 and #57) of five residents reviewed for oxygen. The facility census was 81.Findings include:1. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease and chronic respiratory failure. Review of a Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #13 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to require oxygen therapy. Review of the current care plan revealed Resident #13 had potential for complications in functional and cognitive status related to respiratory disease related to obstructive pulmonary disease and oxygen use. Observation on 02/23/26 at 9:07 A.M. revealed Resident #13's oxygen concentrator was running at two liters of oxygen with undated tubing attached to nasal cannula laying on the floor in front of the concentrator. There was also undated tubing with an oxygen mask laying on the floor beside the concentrator. Interview on 02/23/26 at 9:09 A.M. with License Practice Nurse (LPN) #130 verified undated tubing, nasal cannula, and oxygen mask way laying on the floor. 2. Review of the medical record for Resident #57 revealed she was admitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia, stage five chronic kidney disease, chronic heart failure, and obstructive sleep apnea. Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 was cognitively intact and did not display any behaviors at the time of the assessment. She utilized a wheelchair, was dependent for all transfers and mobility, and required partial to maximal assistance with activities of daily living. This assessment indicated she had cardiorespiratory diagnoses and utilized oxygen therapy. Review of physician orders for Resident #57 revealed an order dated 11/25/24 for continuous oxygen to be administered by nasal cannula at 2 liters per minute. Observation on 02/25/26 at 9:15 A.M. of Resident #57 sitting in the dining room revealed she was wearing an oxygen nasal cannula and had a portable oxygen tank on the back of her wheelchair set to two liters per minute. Further observation revealed the nasal cannula was not dated and two gauges on the portable oxygen tank indicated the tank was empty. Interview on 02/25/26 at 9:15 A.M. with Resident #57 revealed she had been feeling increased shortness of breath since she awakened that morning and was still experiencing increased shortness of breath at the time of the interview. Interview on 02/25/26 at 9:30 A.M. with Certified Nurse Aide (CNA) #140 confirmed Resident #57's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nasal cannula was not dated and the gauges on the portable oxygen tank on the back of Resident #57's wheelchair indicated the tank was empty. Review of facility policy titled, Respiratory Equipment, dated 05/11/16, revealed to change the oxygen cannula and tubing monthly and as necessary, and keep the oxygen cannula and tubing in a plastic bag when not used. Review of facility policy dated 12/13/24 and titled, Administration of Oxygen, revealed the facility would date oxygen tubing and administer oxygen according to physician orders. This deficiency represents non-compliance investigated under Complaint Number 2752534 and Complaint Number 2731910.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a facility policy, the facility failed to ensure documentation in the electronic health record was complete and accurate. This affected two (#10 and #11) of eight residents reviewed for documentation. The facility census was 81.Findings include:1. Review of the medical record for Resident #11 revealed he was admitted on [DATE] with diagnoses including type two diabetes mellitus, metabolic encephalopathy, cardiomegaly, morbid obesity, and stage two chronic kidney disease. The resident died at the facility on [DATE]. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact and did not display any behaviors at the time of the assessment. He utilized a walker with supervision and a manual wheelchair independently. He required supervision assistance with activities of daily living and touch assistance with shower transfers. The assessment indicated Resident #11 experienced shortness of breath with exertion, was diagnosed with medically complex conditions including the above noted diagnoses, and was not enrolled in hospice services. Review of physician orders for Resident #11 dated [DATE] revealed he was a full code (initiation of cardiopulmonary resuscitation in the event of cardiac or respiratory failure). Review of nursing progress notes from [DATE] revealed a note written by Licensed Practical Nurse #129 on [DATE] at 3:00 P.M. indicating a funeral home arrived at the facility to retrieve Resident #11's remains. Further review of progress notes and other areas of Resident #11's medical record revealed the absence of documentation of events that led up to the funeral home arrival at the facility. Interview on [DATE] at 9:10 A.M. with Regional Registered Nurse #128 confirmed the events leading up to the death of Resident #11 on [DATE] were not documented in the medical record. 2. Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and died on [DATE]. The resident's diagnoses included Alzheimer's disease and memory deficit following cerebral infarction. Review of the MDS assessment dated [DATE] revealed Resident #10 had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of nine. The resident was assessed to require supervision with toileting, bathing, and dressing, and was frequently incontinent of bladder and bowel, and assessed with no skin issues. Review of nursing progress notes revealed Resident #10 was sent to the emergency room on [DATE] due to a change of condition. On [DATE] at 5:45 P.M., the hospital contacted the facility with an update regarding the resident having a wound on the coccyx. There was no previous notes for Resident #10 regarding any skin breakdown. Interview on [DATE] at 5:50 P.M. with Regional Nurse #130 revealed an internal investigation was completed on Resident #10. Regional Nurse #130 findings revealed on [DATE] at 6:00 A.M. during shift change, Resident #10 was found to have a bruised like area on the coccyx area. A foam pad was placed on area. Regional Nurse #130 stated there was no documentation of skin breakdown or placement of a foam pad placement entered in the resident's electronic health record. Regional Nurse #130 revealed the facility's policy was to open a wound event, assess the wound and document, notify the physician, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the family, initiate treatment, enter order, and complete treatment. Review of facility policy dated [DATE] and titled, Guideline for Late Entry and Corrections to the Medical Record, revealed the facility would record information and events as soon as they occurred. Further review of this policy revealed the facility would maintain accurately documented clinical records. This deficiency represents non-compliance investigated under Complaint Number 2731910.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of a facility policy, the facility failed to ensure proper signage was in place for a resident on enhanced barrier precautions and failed to ensure urinary catheter bags were maintained in a manner to prevent infection. This affected two (#58 and #59) of four residents reviewed for infection control practices.Findings include:1. Record review for Resident #58 revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, bipolar, and cholecystectomy.Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of seven (07). The resident was assessed to have a surgical wound.Review of the care plan dated 02/05/26 revealed Resident #58 had a surgical incision with indication the resident required enhanced barrier precautions during high-contact care related to presence of surgical wounds.Observation on 02/25/26 at 9:41 A.M. revealed Resident #58 had bins containing personal protective equipment (PPE) for infection control precautions in Resident #58's room but there was no signage outside the door.Interview on 02/25/26 at time of finding with Resident #58 revealed the resident was unsure why the bins were in her room. Interview on 02/25/26 at 9:43 A.M. with Licensed Practical Nurse (LPN) #141 revealed the nurse was unaware Resident #58 was in isolation. LPN #141 reviewed the resident's orders and stated Resident #58 was not in any isolation. After reviewing the orders with the Surveyor, LPN #141 verified Resident #58 was in enhanced barrier precautions and confirmed there was no signage was in place to identify the isolation.Interview on 02/25/26 at 10:20 A.M. with Regional Nurse #128 verified enhanced barrier precaution orders were in place for Resident #58, however, no signage was in place.2. Review of the medical record for Resident #59 revealed she was admitted on [DATE] with diagnoses including type two diabetes mellitus, metabolic encephalopathy, urogenital implants, and hydronephrosis.Review of the quarterly MDS assessment dated [DATE] revealed Resident #59 was cognitively impaired and did not display any behaviors at the time of the assessment. She utilized a wheelchair independently, was dependent for transfers, and required substantial assistance with activities of daily living. The assessment indicated Resident #59 utilized a urinary catheter for management of neurogenic bladder.Observation on 02/23/26 at 3:00 P.M. of Resident #59 in her wheelchair in the dining room while participating in activities revealed her urinary catheter bag was on the floor lodged under the small front right wheel of her wheelchair.Interview on 02/23/26 at 3:02 P.M. with LPN #142 confirmed Resident #59's urinary catheter bag was on the floor lodged under the small front right wheel of her wheelchair. Subsequent observation revealed LPN #142 removed the urinary catheter bag from under the wheel and placed the urinary catheter bag under Resident #59's wheelchair, with half of the urinary catheter bag touching the floor. LPN #142 verbally confirmed Resident #59's wheelchair was low, the urinary catheter bag was on the floor, and there was currently no feasible option to hang the urinary catheter bag on the chair to provide placement both below the bladder and off the floor.Observation on 02/23/26 at 3:20 P.M. of Resident #59 in her wheelchair at the nurses' desk in the back of the facility revealed her urinary catheter bag was lying on the floor under her wheelchair.Review of the manufacturer's label for Resident #59's urinary catheter bag revealed the bag should not be on the floor.Review of facility policy dated 12/16/26 and titled, Emptying Urinary Bags, revealed the facility would keep urinary catheter bags off the floor to prevent damage and contamination.This deficiency represents an incidental finding discovered during the complaint survey.