

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 03/13/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451</p> <p>Based on observation and staff interview, the facility failed to ensure resident beds were maintained in a safe condition. This affected one resident (#53) of nine reviewed for physical environment concerns. The facility census was 81.</p> <p>Findings include:</p> <p>Review of Resident #53's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, stroke, type II diabetes, psychosis, altered mental status, major depressive disorder, anxiety disorder, and muscle weakness.</p> <p>Review of Resident #53's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired and rarely or never understood. Resident #53 was dependent on staff for toilet use, bed mobility and transfer.</p> <p>Observation on 03/10/25 at 11:27 A.M. of Resident #53's room found the headboard of the bed leaning to the left when facing the bed. When the headboard was touched it was found to have been broken free from the bed frame on the left side and was attached only by the right side to the frame of the bed.</p> <p>Interview on 03/10/25 at 11:29 A.M. with Certified Nursing Assistant (CNA) #641 verified Resident #53's bed was broken. She was unsure how long it had been that way since she does not regularly work on Resident #53's hallway.</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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516</p> <p>Based medical record review, observation, staff interview, and policy review, the facility failed to ensure residents were free from any physical restraints. This affected two (#28 and #73) out of two residents reviewed for restraints. The facility census was 81.</p> <p>Findings include:</p> <p>1. Review of Resident #28's medical record revealed diagnose of Alzheimer's, dementia, right hand contractures, reduced mobility, glaucoma, and cognitive communication deficit.</p> <p>Review of physician orders, dated 12/18/24, revealed no physician order for a standard pillow to be placed under a fitted sheet on the left side of resident when in bed.</p> <p>Review of Resident #28's care plan, dated 01/17/25, revealed the right side of the bed was to be against the wall.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 12/27/24, revealed Resident #28 required maximal assistance with bed mobility.</p> <p>Observation on 03/10/25 at 03:54 PM revealed Resident #28 laying in bed on her right side facing the wall. Bilateral mobility bars were in place and pulled up. A standard size pillow was placed length wise under the fitted sheet and pressed tightly up against resident's back and buttocks area. Coinciding interview with Certified Nursing Aide (CNA) #646 at the time of the finding verified the pillow was in place to keep Resident #28 in the bed.</p> <p>Review of the facility policy titled Guidelines for Restraint/Enabler Use, dated 12/17/24, revealed use for safety devices to be evaluated by interdisciplinary team before use with risk and benefits of restraint use. A device can not restrict a resident from what they could previously could do this would be considered a restraint.</p> <p>2. Review of Resident #73's medical record revealed an admitted [DATE]. Diagnoses included traumatic subdural hemorrhage without loss of consciousness, atrial fibrillation, Alzheimer's disease, dementia, restlessness, and agitation.</p> <p>Review of physician orders, dated 01/15/25, revealed no physician order was written for a standard pillow to be placed under a fitted sheet on the left side of resident when the resident was in bed.</p> <p>Review of the care plan revealed Resident #73 had reduced safety awareness due to Alzheimer's and dementia</p> <p>Review of the MDS assessment, dated 01/29/25, revealed the resident required moderate assistance with mobility and maximal assistance with sit and stand.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/10/25 at 2:19 P.M. revealed Resident #73 was laying in her bed. The right side of the bed was against the wall. A standard pillow was placed length wise under the fitted sheet and pressed securely against Resident #73's back and hip. A high backed wheelchair was placed sideways beside Resident #73's bed by at her hip and legs area.</p> <p>Interview on 03/10/25 at 2:28 P.M. with CNA #628 verified the pillow was placed to keep Resident #73 in bed so Resident #73 could not swing her legs over the side of the bed. CNA #628 moved the wheelchair to the other side of the room.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516</p> <p>Based on medical record review and staff interview, the facility failed to ensure the care plan was updated timely to include the development of a pressure ulcer for one (#4) out two residents reviewed for pressure ulcers. The facility census was 81.</p> <p>Findings include:</p> <p>Review of Resident #04's medical recorded revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, osteoarthritis of right hip, major depressive disorder, and scoliosis.</p> <p>Resident #4 enrolled in hospice care 03/04/25.</p> <p>Review of Resident #04's Minimum Data Set (MDS) assessment, dated 12/20/24, identified Resident #4 was at risk for pressure ulcer development but no pressure ulcer noted.</p> <p>Review of Resident #04 nurse's notes revealed on 02/23/25 at 10:11 P.M. an open area was found on the sacrum during care. Certified Registered Medication Aide (CRMA) #622 notified Licensed Practice Nurse (LPN) #643 at the time of the finding. Further reviewed of nurses note dated 02/27/25 at 3:27 A.M. revealed the resident's daughter was notified of the wound and a treatment was established.</p> <p>Review of Resident #04's comprehensive care plan revealed the pressure ulcer was not addressed on the plan of care until 03/11/25.</p> <p>Interview on 03/13/25 at 12:10 P.M. with Regional Director of MDS Nurse #659 confirmed Resident #04's care plan for pressure ulcer was not initiated until 03/11/25.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451</p> <p>Based on observation, medical record review, and staff interview, the facility failed to follow physician orders to apply washcloths to the hands of one (#53) of four residents reviewed for skin conditions. The facility census was 81.</p> <p>Findings include:</p> <p>Review of Resident #53's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, stroke, type II diabetes, psychosis, major depressive disorder, anxiety disorder, muscle weakness, abnormal posture, contusion of part of the head (12/09/24), and dementia with behavioral disturbance.</p> <p>Review of Resident #53's Minimum Data Set (MDS) assessment, dated 11/21/24, revealed Resident #53 was severely cognitively impaired. Resident #53 was dependent on staff for eating, toilet use, bathing, dressing and mobility.</p> <p>Review of Resident #53's physician orders revealed an order dated 01/21/25 for wash cloths to hands change daily and as needed.</p> <p>Review of Resident #53's care plan, revised 03/10/25, revealed supports and interventions for risk for skin breakdown. Interventions for risk for skin breakdown included keeping Resident #53's skin as clean and dry and possible, minimize skin exposure to moisture and apply treatments as ordered.</p> <p>Observation on 03/10/25 at 1:46 P.M. found Resident #53 lying in bed. Resident #53's arms were bent at the elbows and her hands were clenched in fists. No washcloths were observed in her hands protecting her palms.</p> <p>Interview on 03/10/25 at 1:52 P.M. with Certified Nurse Assistant (CNA) #646 verified Resident #53 was to have washcloths placed in her hands and they had not been placed as ordered.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516</p> <p>Based on record review, observation, and staff interview, the facility failed to accurately assess a pressure ulcer, failed to complete an assessment of a pressure ulcer when identified, and failed to obtain a treatment for a pressure ulcer. This affected two (#38 and #4) out of three residents reviewed for pressure ulcers. The current census is 81.</p> <p>Findings include:</p> <p>1. Record review for Resident #38 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #38 include dementia, urinary tract infection, respiratory failure, and chronic kidney disease.</p> <p>Review of Resident #38's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had impaired cognition and was incontinent of bowel and bladder.</p> <p>Review of Resident #38's wound management revealed on 02/13/25 the resident was noted to have an open wound measuring 7 centimeters (cm) by 2 cm by 0.1 cm depth. Per the wound assessment the wound had a 'foul' odor with necrotic tissue, irregular edges with a dark purple/rusty discoloration. In the comment section of the assessment the nurse documented the Director of Health Services (DHS) observed with the nurse and identified the ulcer as a Kennedy ulcer. The wound assessment was signed by Licensed Practical Nurse (LPN) #580. No further documentation or confirmation was noted in the record from the DHS.</p> <p>Review of the document titled The Pressure Ulcer Letter of Unavoidability dated 02/19/25, revealed LPN #580 documented Resident #38's pressure ulcer was unavoidable due to being a [NAME] Ulcer. Per the document the resident was referred to hospice and the Certified Nurse Practitioner (CNP) signed the document on 02/20/25.</p> <p>Review of Resident #38's wound management revealed on 02/19/25 the wound was measured at 7 cm by 3 cm with no depth, moderate serous exudate, foul odor, necrotic tissue and the skin around the wound was dark purple.</p> <p>Review of Resident #38's wound management revealed on 02/25/25 the wound measured 6.4 cm by 2.5 cm with no depth, moderate exudate with seropurulent drainage, odor, with slough, and well defined wound edges with pink and normal skin surrounding the wound. The wound was documented as 'stable'.</p> <p>Review of Resident #38's wound management revealed on 03/04/25 the wound measured 6 cm by 2.5 cm with no depth, exudate present with slough, and skin blanchable around wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/12/25 at 3:30 P.M. with LPN #580 revealed she does all wound assessments, measuring, and dressing changes for wounds, however she was certified in wound care LPN #580 verified she had identified Resident #38's coccyx wound as a Kennedy ulcer and had notified the physician of this. The physician then consulted hospice on 02/20/25. LPN #580 stated to her knowledge the CNP, the current DHS, and the physician had not visibly assessed Resident #38's wound. LPN #580 verified she had documented the wound was an unavoidable pressure ulcer and assessed it to be a [NAME] wound. LPN #580 stated the previous DHS had observed Resident #38's ulcer but had not commented or documented on the stage of the ulcer in the records.</p> <p>Interview on 03/12/25 at 3:15 P.M. with CNP #459 stated she was told by staff Resident #38 had a Kennedy ulcer and she had signed orders for the care. CNP #459 stated she had not visibly assessed the wound herself but was told by LPN #580 what the wound was. CNP #459 stated she had not measured or provided care for the wound and relied on the nursing staff to update her on the status of the wounds.</p> <p>Interview and observation of wound care for Resident #38 on 03/13/25 at 7:55 A.M. with current DHS #515 and LPN #580 revealed Resident #38 had a wound on his coccyx. The wound appeared to be an unstageable wound. DHS #515 stated per her opinion the wound was a typical unstageable pressure ulcer. DHS #515 verified the wound appeared to be well defined and the skin around the wound appeared pink and blanchable. The edges had small traces of red blood noted and the wound had no odor. DHS #515 stated the bed of the wound was obstructed by what appeared to be slough and verified there were no defined shapes related to a Kennedy ulcer. DHS #515 verified it was an unstageable ulcer and did not appear to be a Kennedy ulcer.</p> <p>2. Review of Resident #04's medical recorded revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, osteoarthritis of right hip, major depressive, and scoliosis. Resident #4 enrolled in hospice care 03/04/25.</p> <p>Review of the quarterly MDS assessment, dated 12/20/24, revealed the resident was cognitively intact, required moderate assistance with bed mobility, transfers, and toileting. Resident #04 was at risk for pressure ulcer development and did not have a pressure ulcer at the time of the assessment.</p> <p>Review of Resident #04's nurse's note, dated 02/23/25 at 10:11 P.M., revealed an open area was found on the sacrum during care. The note stated Certified Registered Medication Aide (CRMA) #622 notified the nurse. The nurse's note stated the area on the sacrum was observed to be bloody. The resident complained of pain to the area and severe back pain. There were no orders for treatment to the area. There was no assessment of the area.</p> <p>Review of a nurses' note, dated 02/26/25 at 4:25 A.M., stated the dressing to the sacral area was clean, dry, and intact. The resident had no signs and symptoms of pain. Review of the nurse's note dated 02/27/25 at 3:27 P.M., written by Licensed Practical Nurse (LPN) #560, stated Resident #04 was noted to have an open are to the coccyx and a treatment had been established. There were no orders for treatment to the area.</p> <p>Review of Resident #04 weekly wound management evaluation dated 02/27/25 revealed a ulcer to the coccyx. The facility identified the ulcer to be a Kennedy ulcer due to sudden onset and resident decline. The evaluation revealed the wound measurement to be 3.5 cm by 3.5 cm, with no depth noted.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #04's physician order dated 02/27/2025 revealed a treatment to the coccyx wound to cleanse wound with wound cleanser or normal saline, apply skin prep to peri-wound, apply Medihoney, and cover with foam dressing as needed.</p> <p>Review of physician order dated 2/28/25 revealed a treatment for Medihoney 80% to be applied topically daily with no location for application identified.</p> <p>Review of physician order dated 03/03/25 revealed to cleanse the coccyx wound with wound cleanser, pat dry with gauze, apply Medihoney gel to wound bed, and to cover wound with boarder gauze. The order stated to change dressing every three days and hold one day.</p> <p>Review of Resident #04's February 2025 Treatment Administration Record (TAR) revealed no wound care was ordered from 02/23/25 to 02/28/25.</p> <p>Review of the wound management evaluation dated 03/11/25 revealed the ulcer to the coccyx had moderate serous to purulent drainage. The wound bed was noted to have 50% slough with 50% granulation. The peri area was red and blanchable. The evaluation revealed the wound measurement to be 3 cm by 1.5 cm with no depth noted.</p> <p>Interview on 03/12/25 at 3:17 P.M. CRMA #622 stated the wound was found on 02/23/25 during personal care and she notified Registered Nurse #563 at time of finding. CRMA #622 described the wound as bloody with no black areas noted. It was about the size of a quarter, round in shape, and was superficial.</p> <p>Interview on 03/13/25 at 10:05 A.M. Regional Director of Nursing (DON) #658 confirmed the medical record for Resident #4 did not contained documentation to support the facility evaluated Resident #4 coccyx wound when first observed on 02/23/25 nor was a treatment initiated at that time.</p> <p>Review of facility policy titled Guidelines for General Wound and skin Care, dated 12/17/24, revealed the facility will document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, per wound tissue, and treatment of the wound weekly.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529</p> <p>Based on observation, resident and staff interviews, record review, and review of facility policy, the facility failed to document a fall in the medical record, complete post fall assessments, and investigate a fall in a timely manner. This affected one (#54) of three residents reviewed for falls. The facility census was 81.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #54 revealed she was admitted on [DATE] for physical therapy following joint surgery to her left shoulder. Admitting diagnoses included presence of left artificial shoulder joint, type two diabetes mellitus, chronic kidney disease, hyperlipidemia, hypothyroidism and gout. On 03/03/25 a diagnosis of unspecified fracture of shaft of left tibia was added.</p> <p>Review of the admission Minimum Data Set 3.0 (MDS) assessment, dated 02/11/25, revealed she was cognitively intact, required substantial assistance with dressing, toileting and showering, and utilized a cane, walker, or wheelchair.</p> <p>Review of the facility fall assessment for Resident #54 revealed she was a moderate fall risk.</p> <p>Review of a physical therapy treatment encounter note dated 02/17/25 for Resident #54 revealed this resident got caught in the hemi walker and was lowered to the ground by staff. Resident #54's nurse was notified and came to the therapy room to obtain vital signs. Resident #54's vital signs were noted to be stable and Resident #54 insisted on continuing therapy session.</p> <p>Review of the medical record for Resident #54 revealed no documentation to support Resident #54 sustained a fall on 02/17/25 in the therapy gym. Further review of the medical record for Resident #54 revealed no documentation to support the facility completed post fall assessments or implemented interventions after the fall on 02/17/25.</p> <p>Review of emergency room discharge instructions dated 03/03/25 revealed Resident #54 sustained a tibial plateau fracture.</p> <p>Review of physician note dated 03/05/25 revealed Resident #25 had severe osteopenia and this fracture would likely not have occurred in the absence of osteopenia suggesting this was a pathologic fracture.</p> <p>Observation on 03/10/25 at 1:50 P.M. of Resident #54 in her room revealed she had a sling applied to her left arm and a full hinged leg brace applied to her left leg. Concurrent interview with Resident #54 revealed she sustained a fall during physical therapy which caused the injury to her left leg.</p> <p>Review of the facility incident report log for falls, with a date range of 01/01/25 to 03/09/25, revealed there was no record of Resident #54's fall on 02/17/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility event report dated 03/04/25 revealed Resident #54 sustained a fall on 02/17/25, but the report was not completed until 03/04/25.</p> <p>Review of a facility investigation summary dated 03/04/25 revealed Resident #54 sustained a fall on 02/17/25, but the investigation summary was not completed until 03/04/25.</p> <p>Review of a facility witness statement dated 03/04/25 revealed Resident #54 sustained a fall on 02/17/25, but the witness statement was not obtained until 03/04/25.</p> <p>Interview on 3/12/25 at 10:51 A.M. with Resident #54 revealed after the fall in physical therapy on 02/17/25 she experienced some swelling over the next few days, but did not experience pain with movement or during therapy until 03/03/25.</p> <p>Interview on 03/12/25 at 11:50 A.M. with Clinical Support Registered Nurse #657 confirmed Resident #54 sustained a fall on 02/17/25 in the therapy gym and a fall investigation should have been initiated on 02/17/25. Additionally, she confirmed there was no documentation to support post-fall assessments were completed for Resident #54.</p> <p>Review of facility policy titled Fall Management Program Guidelines, dated 12/17/24, indicated the facility would mitigate fall risk factors and implement preventative measures. This policy defines a fall as unintentionally coming to rest on the ground, floor, or other lower level. This policy indicates if a resident falls, the attending nurse would complete a Fall Event that included an investigation to determine cause, reassessment of fall risk, interventions to decrease risk of repeat episode, and the interdisciplinary team would evaluate thoroughness and appropriateness of the investigation and interventions.</p> <p>This deficiency represents non-compliance identified during the investigation for Complaint Number OH00162379.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516</p> <p>Based on observation, record review, resident interview, staff interview and policy review, the facility failed to ensure a physician order was present to administer oxygen. This affected one (#13) of three residents viewed for oxygen. The facility census was 81.</p> <p>The findings include:</p> <p>Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included heart failure, chronic obstructive pulmonary disease with acute exacerbation, acute and chronic respiratory failure with hypercapnia, left bundle-branch block, atrial fibrillation, type two diabetes mellitus, hypoxemia and nonspecific abnormal finding of lung field.</p> <p>Review of the care plan, dated 02/18/25, revealed Resident #13 was oxygen dependent and to use oxygen as ordered.</p> <p>Review of the physician orders revealed no orders for oxygen.</p> <p>Observation on 03/10/25 at 02:13 P.M. revealed Resident #13 sitting in her wheelchair with oxygen concentrator on and running at three liters via nasal cannula. Coinciding interview with Resident #13 revealed she has been on oxygen since 2021.</p> <p>Observation on 03/12/25 at 10:38 A.M revealed Resident #13 was on 3 liters of oxygen. Coinciding interview with Register Nurse (RN) #575 verified there was no order for Resident #13 to use oxygen.</p> <p>Interviewed on 03/11/25 at 4:06 P.M. with Licensed Practice Nurse #589 revealed Resident #13 was on two to three liters of oxygen throughout the day and was dependent on oxygen.</p> <p>Review of the facility policy titled Administration of Oxygen, dated 12/13/24, revealed the staff were to verify physician's order for the procedure.</p>		

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 03/13/2025
NAME OF PROVIDER OR SUPPLIER Heritage The		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 Greenacre Dr Findlay, OH 45840	
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<p>F 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>51529</p> <p>Based on employee file review, staff interview, and review of facility policy, the facility failed to ensure certified nursing assistants (CNAs) had evaluations completed every 12 months. This had the potential to affect all residents residing in the facility. The facility census was 81.</p> <p>Findings include:</p> <p>Review of employee file for CNA #598 revealed she was hired on 11/12/13. No annual performance evaluation was found.</p> <p>Review of employee file for CNA #609 revealed she was hired on 03/05/24. No annual performance evaluation was found.</p> <p>Interview on 03/13/25 at approximately 9:30 A.M. with The Administrator revealed employee evaluations were in the employee files. If the evaluations were not in the file they were not done.</p> <p>Interview on 03/13/25 at 9:51 A.M. with Employee Experience Manager #581 confirmed CNA #598 and CNA #609 did not have performance evaluations in their files within the past 12 months.</p> <p>Review of the facility policy titled Trilogy Performance Procedures & Evaluation, dated March 2014, indicated CNA performance evaluations would be completed after six months of service, after 12 months of service, and annually thereafter.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035</p> <p>Based on record review, review of the facility policy, and staff interview, the facility failed to ensure the physician responded to pharmacy recommendations timely and included a reason for the denial of gradual dose reductions. This affected one (#48) out of five residents reviewed for unnecessary medications. The facility census was 81.</p> <p>Findings include:</p> <p>Record review for Resident #48 revealed the resident was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, dementia, depression, post-traumatic stress disorder, and obsessive compulsive disorder.</p> <p>Review of Resident #48's Minimum Data Set (MDS) assessment, dated 02/21/25, revealed the resident had intact cognition and was having hallucinating behaviors during the assessment period.</p> <p>Review of Resident #48's care plans dated 12/05/23, and revised on 02/14/25, revealed a focus for adverse consequences for psychotropic drug use. Interventions include attempt gradual dose reduction in two separate quarters and then yearly unless contraindicated.</p> <p>Review of the monthly pharmacy medication regimen reviews for Resident #48 revealed on 07/31/24 the pharmacist recommended a gradual dose reduction of Buspar 15 milligrams (mg) twice a day for anxiety.</p> <p>Further review of the recommendation documentation revealed the recommendation was marked denied on 12/29/24. No explanation or reason for denial was noted in the records. Further review of the medical records presented to the surveyor during the survey revealed a signed note dated 11/13/24 from a Nurse Practitioner (CNP) for neurology documenting patient needs to follow up with psychiatry, resident with significant anxiety withdrawal and reduction contraindicated.</p> <p>Review of the monthly pharmacy medication regimen reviews for Resident #48 revealed on 12/29/24 revealed the pharmacist recommended a gradual dose reduction for venlafaxine 76 mg three times a day for depression. Further review of the recommendation documentation revealed the recommendation was marked denied, no signature or date of denial was noted in records. Review of signed form provided by staff to the surveyor during the survey for the 12/29/24 recommendation revealed a CNP's signature dated 01/14/25. No rationale or explanation for the denial was noted in the records.</p> <p>Review of the facility policy titled, 'Medication Regimen Review' dated 11/2018 revealed the facility will ensure all recommendations are provided to the physicians and designees. The providers will act upon the recommendations and provide a rationale if denied.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/13/25 at 9:45 A.M. the Regional Clinical Support Registered Nurse (RN) #657 and the Director of Nursing (DON) verified the pharmacy recommendation for a gradual dose reduction for the venlafaxine medication dated 12/29/24 was denied by the previous CNP on 01/14/25 with no explanation or rationale for the denial. RN #657 verified the rationale provided for the denial of Buspar medication was dated 11/13/24 and was outside the timeframe for the 07/31/24 recommendation for a gradual dose reduction attempt.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529</p> <p>Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure medication was administered as ordered by a physician. This affected one (#386) of five residents reviewed for unnecessary medications. The facility census was 81.</p> <p>Findings include:</p> <p>Medical record review for Resident #386 revealed an admitted [DATE] for physical and occupational therapy following hospitalization for influenza A. Diagnoses included chronic respiratory failure with hypoxia, urinary tract infection (UTI), congestive heart failure, atrial fibrillation, unspecified dementia, anxiety, depression, history of cerebral infarction with left hemiparesis, and seizure disorder.</p> <p>Review of the hospital discharge medication orders included one tablet of ciprofloxacin 500 milligram (mg) given by mouth twice a day for four days and one tablet hydrocodone-acetaminophen 5 mg - 325 mg given by mouth every six hours as needed.</p> <p>Review of the medication administration record dated February 2025 and March 2025 for Resident #386 revealed ciprofloxacin and hydrocodone-acetaminophen were not administered during either month.</p> <p>Review of the Pharmacist Drug Regimen Review dated 03/05/25 for Resident #386 revealed the hospital records included orders for ciprofloxacin and hydrocodone-acetaminophen, but these medications were not entered in her medical record.</p> <p>Interview on 03/11/25 at 3:00 P.M. with Clinical Support Registered Nurse #657 confirmed Resident #386 was discharged from the hospital with orders for ciprofloxacin and hydrocodone-acetaminophen. These orders were not entered in the medical record for Resident #386, nor were these medications administered as ordered.</p> <p>Review of facility policy titled Guidelines for Medication Orders, dated 12/17/24, revealed the facility would maintain a current list of orders in the electronic medical record.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<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>51516</p> <p>Based on observations, staff interview, and policy review, the facility failed to ensure medications were not prepared and stored in medication cart prior administration. This affected four (#05, #19, #42, #65) out of the fourteen residents that resided on Legacy Hall. Additionally, the facility failed to ensure an opened insulin pen was dated upon first use and was not expired. This affected one (#09) out of three resident insulin pens observed in the Legacy Hall medication cart. The facility census was 81.</p> <p>The findings include:</p> <p>Observation on 03/12/25 at 8:15 A.M. of the Legacy Hall medication cart revealed four separate clear, plastic medication cups with unidentified medications sitting in the second drawer. The observation revealed two letters were written on each plastic medication cup. The observation of the medication cart also noted Resident #09's Lantus Solostar 100 units per milliliter (ml) Insulin pen injector, opened, without an open date and with expiration date of 02/13/25.</p> <p>Interview with Registered Nurse (RN) #620 at 8:20 A.M. confirmed the Legacy Hall medication cart contained four medication cups with unidentified medications. RN# 620 stated she prepared the medications for Residents #05, #19, #42, #65 and when she went to administer the medications the residents they were sleeping therefore she placed the medication cups back into the Legacy Hall cart to administer at a later time. RN #620 confirmed the two letters written on the medication cups were the initials for Residents #05, #19, #42, #65. RN #620 confirmed the Lantus Solostar insulin pen injector was opened, not dated, and expired on 02/23/25.</p> <p>Review of facility policy titled Specific Medication Administration Procedures, revised 11/2018, stated the policy was to administer medications in a safe and effective manner. The policy stated prior to removing medication package/container from the cart/drawer to prepare the resident for medication administration and to check for vital signs, other tests to be done during/prior to medication administration.</p> <p>Review of facility policy titled Medication Storage in the Facility, revised 10/2019, stated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The policy stated outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secures closures are immediately removed from the inventory and disposed of according to procedures for medication disposal and reordered from the pharmacy , if a current order exists. The policy stated all expired medications would be removed from the active supply and destroyed in the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51529</p> <p>Based on observation, staff interview, and review of facility policies, the facility failed to ensure food was labeled and properly refrigerated, the kitchen was maintained in a sanitary manner, and food was not handled with contaminated gloves. This had the potential to affect all residents who consume food from the kitchen. The facility census was 81.</p> <p>Findings include:</p> <p>1. Observation of the walk-in cooler on 03/10/25 at 8:54 A.M. revealed four quart sized containers of strawberries not dated. Three of the four quarts had a gray fuzzy substance on the strawberries.</p> <p>Interview with [NAME] #596 on 03/10/25 at 8:58 A.M. confirmed the observed strawberries were moldy and not dated.</p> <p>Observation of the deep fryer on 03/10/25 at 8:59 A.M. revealed three overcooked and oil-saturated French fries along the edge of the deep fryer and overcooked crumbs floating in the oil.</p> <p>Interview with Director of Food Services (DFS) #583 on 03/10/25 at 9:02 A.M. confirmed the observations of the deep fryer. Additionally, she stated the fryer was typically cleaned every Thursday, but it had been heavily used the previous day and should have been cleaned.</p> <p>Observation of the walk-in freezer on 03/10/25 at 9:05 A.M. revealed one bag of chicken strips and one bag of onion rings were opened without being dated and the bags were not tied closed.</p> <p>Interview with DFS #583 on 03/10/25 at 9:07 A.M. confirmed the observed chicken strips and onion rings in the walk-in freezer were opened, untied, and undated.</p> <p>Observation of the shelving unit next to the meat reach-in refrigerator on 03/10/25 at 9:08 A.M. revealed one 2/3 full gallon sized container of syrup placed on the shelf. The syrup labeling indicated it should have been refrigerated after opening.</p> <p>Interview with DFS #583 on 03/10/25 at 9:09 A.M. confirmed the observed syrup was on the shelf and the label indicated it should have been refrigerated after opening.</p> <p>Review of facility policy titled Storage Procedures, dated January 2025, indicated food shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance. Additionally, frozen foods would dated and wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn.</p> <p>2. Observation on 03/10/25 at 12:09 P.M. of meal service in the House Dining Room revealed [NAME] #596 plating food for residents. She touched the top shelf of the steam table and meal tickets with her gloved hand then touched a handful of chips and unwrapped sandwiches with the same contaminated gloved hand. She placed the contaminated food on a plate that was served to residents.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 03/10/25 at 12:12 P.M. with [NAME] #596 confirmed she touched food that was served to residents with her contaminated gloved hand.</p> <p>Observation on 03/11/25 at 12:15 P.M. of meal service in the Manor Dining Room revealed Dining Services Assistant (DSA) #536 plating food for residents. He touched the top shelf of the steam table and meal tickets with his gloved hand then touched sandwich buns with the same contaminated gloved hand. He placed the contaminated food on a plate that was served to residents.</p> <p>Interview on 03/11/25 at 12:21 P.M. with DSA #536 confirmed he touched food that was served to residents with his contaminated gloved hand.</p> <p>Review of facility policy titled Guideline for Handwashing/Hand Hygiene, dated 12/17/24, indicated hand hygiene would be used frequently and appropriately.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451</p> <p>Based on observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure call lights were in reach of residents. This affected four residents (#15, #14, #57 and #4) of nine residents reviewed for call lights. The facility census was 81.</p> <p>Findings include:</p> <p>1. Observation on 03/10/25 at 4:28 P.M. of Resident #15 in her room revealed she was sitting in a chair crying and her call light cord was tied to the bed handle out of her reach.</p> <p>Interview on 03/10/25 at 4:28 P.M. with Resident #15 confirmed she was crying due to pain and she could not reach her call light cord to alert staff she needed assistance.</p> <p>Interview on 03/10/25 at 4:28 P.M. with Licensed Practical Nurse (LPN) #518 confirmed Resident #15 could not reach the call light cord to alert staff that she needed assistance.</p> <p>2. Review of Resident #14's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, morbid obesity, anxiety disorder, aphasia and dysphagia following a stroke.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #14 was cognitively intact. Resident #14 was dependent on staff for toilet use, parts of dressing, and transfer. Resident #14 required maximal assistance with bathing.</p> <p>Observation on 03/10/25 at 11:18 A.M. of Resident #14 found her up in her wheelchair and her call light was observed on the bed. Coinciding interview with Resident #14 revealed she was not able to get to the call light independently and the staff attempted to get the call light close to her.</p> <p>Interview on 03/10/25 at 11:30 A.M. with Certified Nursing Assistant (CNA) #641 verified Resident #14's call light was not in reach of Resident #14. CNA #641 was observed moving the call light within reach of Resident #14.</p> <p>3. Review of the medical record for Resident #57's medical record revealed an admitted [DATE]. Diagnoses included dementia, cognitive communication deficit, symbolic dysfunctions, muscle weakness, and depressive episodes.</p> <p>Observation on 03/10/24 at 10:59 A.M. of Resident #57 found her lying in bed. Resident #57's call light was observed on the night stand and not in reach of Resident #57 while she was in bed.</p> <p>Interview on 03/10/25 at 11:30 A.M. with CNA #641 verified Resident #57's call light was not in reach. CNA #641 moved the call light and placed it next to Resident #57 in her bed. CNA #641 verified Resident #57 was able to use her call light.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses included dehydration, Alzheimer's disease, osteoarthritis, major depressive disorder, anxiety disorder, scoliosis, chronic pain, and altered mental status.</p> <p>Review of the MDS assessment, dated 12/20/24, revealed Resident #4 was cognitively intact. Resident #4 required moderate assistance with toilet use, bathing, parts of dressing, bed mobility and transfer.</p> <p>Observation on 03/10/25 at 11:23 A.M. of Resident #4 found Resident #4 lying in bed with a neck pillow in place around her neck. Resident #4's call light were observed out of reach on the bedside table approximately a foot from the side of the bed.</p> <p>Interview on 03/10/25 at 11:30 A.M. with CNA #641 verified Resident #4 utilized her call light and the call light was not in reach of Resident #4.</p> <p>Review of the facility policy titled Guidelines for Answering Call Lights, revised 12/17/24, revealed the facility was to ensure the call light was plugged in securely to the outlet and in reach of the resident.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>35035</p> <p>Based on observation, staff interview, and resident interview, the facility failed to provide a clean and comfortable environment. This affected one (#48) resident and has the potential to affect all resident residing in the facility. The current census is 81.</p> <p>Findings include:</p> <p>Observation on 03/10/25 at 8:00 A.M. upon entry to the facility revealed a remodeling in progress. At the front entrance the desk and surrounding area cloths were covering items and there were visible markings along the posts, which appeared to be prepped for painting. No staff were observed in the area working on the front desk area. Observations along the hallway in the main dining room area revealed one room had ladders, drop cloths, and other construction tools laying in the room across from the main dining area. Dust was observed on the handrail in the main hallway across from the main dining room. Observations on 03/10/25 from 11:00 A.M. to 12:10 P.M. revealed noise levels to be elevated during the lunch meal service as contractors were observed painting, nailing, and sanding walls in the room across from the main dining room area.</p> <p>Interview on 03/11/25 at 8:47 A.M. Resident #48 stated he used to eat in the dining room but recently had started to request to eat in his room due to the construction. Resident #48 stated he has requested his as needed allergy medications more frequently due to all the dust and paint fumes from the construction. Resident #48 stated he has reported this to the staff but has been told it has to be done for the renovation. Resident #48 stated it is not a homelike environment and he feels the remodel has been going on far longer than reasonable.</p> <p>Interview on 03/12/25 at 8:50 A.M. with Registered Nurse (RN) #575 verified Resident #48 used to eat in the dining room but recently had been requesting to eat in his room due to the construction. RN #575 verified the resident had been requesting more of his as needed hydroxyzine recently due to allergies from dust and debris from the remodeling in the facility.</p> <p>Interview on 03/13/25 at 11:30 A.M. the Director of Operations (DOP) revealed the construction in the resident areas has been in progress since July 2024. Per DOP there have been complaints from staff and residents regarding the noise and mess of the construction. The DOP verified there was dust and noise during meal times in the main dining room causing residents to complain. Barriers walls were once in use during the construction of the room next to the dining room but where discontinued recently prior to the construction being completed. The DOP verified there was noise and dust in the resident's areas and residents were choosing to eat in their rooms due to the construction.</p> <p>This deficiency represents non-compliance identified during the investigation for Complaint Number OH00162379.</p>		