

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/18/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Center for Rehab and Speciality Care		STREET ADDRESS, CITY, STATE, ZIP CODE  24 North Hamilton Street Minster, OH 45865	

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 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>45751</p> <p>Based on employee file review and staff interview, the facility failed to ensure the Activity Director was qualified. This had the potential to affected 28 residents (#1, #2, #3, #4, #5, #7, #12, #14, #16, #18, #20, #25, #26, #28, #29, #31, #33, #34, #35, #36, #37, #39, #41, #46, #47, #48, #52 and #53) who regularly attend activities. The facility census was 53.</p> <p>Findings include:</p> <p>Review of the employee file for Activities Director (AD) #340 revealed a hire date of 07/25/21 to the activity department as a part time activities assistant. Review of application revealed no previous activities experience. No documentation located regarding when AD #340 went full-time or was promoted to Activities Director.</p> <p>Interview on 02/18/25 at 12:59 P.M. with AD #340 revealed she believed she was promoted approximately a year ago to Activities Director and went full-time approximately three months after hire. AD #340 stated she was taking the certification program through a sister facility. AD #340 verified she did not have a certificate for Activities Director. The facility confirmed there were 28 residents (#1, #2, #3, #4, #5, #7, #12, #14, #16, #18, #20, #25, #26, #28, #29, #31, #33, #34, #35, #36, #37, #39, #41, #46, #47, #48, #52 and #53) who regularly attend activities.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00162380.</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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