STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365566	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center for Rehab and Speciality Care	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of a Facility Reported Incident, review of police report, review of hospital records, and review of policy, the facility failed to ensure a cognitively impaired resident was free from physical abuse by a facility staff member. This resulted in physical harm when Resident #01 was forcefully pushed down on to a bed by Certified Nursing Assistant (CNA) #200 causing physical injuries of bruising, skin impairments and pain. During the incident, Licensed Practical Nurse (LPN) #202 observed and failed to intervene to protect Resident #01 from abuse. This affected one (#01) of three residents reviewed for abuse. The facility census was 55. Findings include:Review of the medical record of Resident #01 revealed an admission date of 11/26/24. Diagnoses include unspecified psychosis, depressive disorder, Alzheimer's disease, and dementia.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #01 was cognitively impaired and required set-up or clean-up assistance for transfers and personal care. Resident #01 was self-ambulatory.Review of the care plan revealed a focus, initiated 12/09/24, of delirium, or an acute confusion episode related to acute disease process, dementia, and Alzheimer's disease with interventions to include engage resident in simple, structured activities, make eye contact when speaking with him, and if becomes agitated, stop and return. Another focus, initiated 12/09/24, of impaired cognition related to dementia with interventions to keep routine consistent as possible and cue and re-orient as able. A third focus of potential for behavior problems, initiated 12/09/24, with interventions to medicate as ordered, approach and speak in a calm voice, and psych/counseling services as needed. A focus, initiated 04/17/25, revealed Resident #01 resides on the secure unit related to elopement risk and aggressive behavior. Review of the Facility Reported Incident (262612) dated 07/10/25 revealed an alleged incident occurred on 07/10/25 at approximately 2:00 A.M. involving Resident #01 and Certified Nursing Assistant (CNA) #200. The alleged incident was reported to the local police by a neighbor. The police arrived at the facility and conducted an interview with Licensed Practical Nurse (LPN) #202 and CNA #200. Resident #01 was taken to the emergency room for an evaluation. The report revealed the neighbor, who lived approximately 500 feet from the facility, witnessed Resident #01 stumbling and a staff member, with arms extended towards the resident. The report indicated the neighbor was interviewed by the Administrator and the Regional Director of Clinical Operations #900 and stated he had witnessed Resident #01 stumble and one staff member (identified by the facility as CNA #200) extend out their arms. This was taken directly from the FRI. The facility did not substantiate the allegation.Review of the police report #25-005782 revealed the incident occurred on 07/10/25 between 1:30 A.M. and 2:10 A.M. The report revealed a phone call was received at approximately 2:14 A.M., from a male. The male (neighbor) reported witnessing two nurses acting violently towards a resident at the facility. The officer first made contact with the male, a neighbor, who reported seeing nurses throw the patient onto the bed in an aggressive manner. The officer arrived at the facility and informed LPN #202 of the purpose of his visit. LPN #202 reported CNA #200 had been in the room with Resident #01. LPN #202 stated she had entered the room to observe Resident #01 standing behind the bathroom door. CNA #200 forcefully placed both hands onto Resident #01's shoulders and threw him onto the bed. CNA #200 then lifted Resident #01's legs and forcefully positioned them on the bed. The report indicated LPN #202 expressed concern of CNA #200's handling of Resident #01 appeared rough. The officer interviewed CNA #200 who denied any use of force. The officer observed bruises on the right and left pectoral muscles, the left triceps, and a large bruise on the right buttock. The report further indicated Resident #01 exhibited pain when the left rib cage area was touched, without any visible injuries or markings. Resident #01 was sent to the local emergency room for potential internal injuries. At this point in time, no charges have been filed.Review of the hospital record dated 07/10/25 at 5:20 A.M. revealed Resident #01 was evaluated for alleged assault in the emergency room at the local hospital. The report revealed a physical examination documented an induration between the webspace of digits one and two of the right foot, erythema extending upwards from the toe on the dorsal aspect, and the area was warm to the touch. Resident #01 had four small areas of excoriation located on the right anterior shin without active bleeding. The areas almost look like insect bites. Resident #01 had a half centimeter circumferential eschar on the left proximal tibia, anteriorly. Resident #01 had area of ecchymosis in the left lower quadrant, just lateral to the umbilicus, (without description of color) and two areas of ecchymosis one the anterior chest. One of the areas was above the nipple and medial, the other was four to six inches above and medial to the right nipple