STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365860	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence House	1000 Independence Rd Fostoria, OH 44830

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of wound clinic notes, staff interview and review of the facility policy, the facility failed to ensure non-pressure ulcer wound treatments were completed according to physician orders and further failed to monitor ongoing effectiveness of wound treatments by not conducting ongoing assessments of the wounds. This affected one (#8) of four residents reviewed for wound care. The facility census was 29.Findings include:Review of the medical record for Resident #8 revealed he was admitted on [DATE]. Diagnoses included diabetes mellitus Type II with foot ulcers, need for personal assistance, congestive heart failure (CHF), hypertension, peripheral vascular disease (PVD) and non-pressure chronic ulcer of the right heel and midfoot.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact and required the application of ointments or medications.Review of the care plan revised April 2026 revealed Resident #8 was care planned for venous statis ulcer of bilateral (both) lower extremity related to PVD. Interventions included documentation of location of wound, amount of drainage, peri-wound (around) area, pain, edema (swelling), evaluate the wound for size, depth, sinuses, undermining, exudate (drainage), granulation (healthy tissue), infection, necrosis (dead tissue), and gangrene. Document in wound healing on an ongoing basis and notify the physician as indicated, treatments per order, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and drainage and any notable changes or observations.Review of the February 2026 physician orders revealed Resident #8 had a treatment ordered placed to wash the right heel with soap and water, apply triple antibiotic ointment, and cover with mepilex (type of adhesive dressing) every morning on Monday, Wednesday and Friday and an order for bilateral lower leg wounds to cleanse with soap and water, pat dry, apply triple antibiotic ointment to wound and cover with mepilex border every Monday, Thursday, and Saturday for wound care three times per week and as needed. Further review of the April 2026 physician orders revealed a treatment order for the right fourth tip of toe to paint the tip of the toe with betadine and cover with a band-aid daily until healed.Review of the Treatment Administration Record (TAR) for February 2026 revealed no evidence the right heel treatment was completed on 02/02/26 and 02/04/26. Further review revealed no evidence the bilateral lower leg treatment was completed on 02/02/26. Lastly, review of the April 2026 TAR revealed no evidence treatment was completed on 04/10/26 and 04/24/26. Further review of the medical record revealed Resident #8 had received wound care at a community wound clinic, with visits on 12/02/25, 12/23/25, 01/07/26, 01/21/26, 02/11/26, and 03/11/26 for management of wounds to the bilateral lower extremities and right heel. The wound clinic notes included wound measurements and treatment updates and any changes to wound care treatments.Additional review of Resident #8's medical record revealed no evidence of wound monitoring from the last documented community wound clinic visit on 03/11/26 through 04/28/26. An interview on 04/27/26 at 4:02 P.M. with Regional Clinical Nurse (RCN) #400 and the Director of Nursing (DON) verified there was no evidence the facility completed any skin and wound grids for Resident #8 other than what was completed during visits to the community wound clinic.Interview on 04/28/26 at 12:55 P.M. RCN #400 verified the missing initials, indicating treatments were not (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365860	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026

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Independence House	1000 Independence Rd Fostoria, OH 44830

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed, on the TAR for Resident #8 for the five missing treatments. Review of the facility policy titled, Assessment Schedule, undated, revealed pressure and non-pressure grids were required to be completed for all wounds upon discovery and then weekly.Review of the facility policy titled, Wound Treatment Management, dated December 2021, revealed to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments would be monitored through ongoing assessment of the wound and take into consideration progression towards healing, change in wound, and changes in resident's goals and preferences, such as end of life.This deficiency represents non-compliance investigated under Master Complaint Number 2787800, Complaint Number 2784759, and Complaint Number 2742748.

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	365860	A. Building B. Wing	04/28/2026

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility's fall investigations, staff interview and review of the facility policy, the facility failed to ensure a complete and thorough fall investigation for one (#8) resident and further failed to ensure post fall monitoring was completed for two (#8 and #13) residents. This affected two (#8 and #13) of three residents reviewed for falls. The facility census was 29. Finding include:1. Review of the medical record for Resident #8 revealed an admission date of 01/01/25. Diagnoses included peripheral vascular disease (PVD), diabetes mellitus with foot ulcers, congestive heart failure (CHF), hypertension (high blood pressure), and non-pressure chronic ulcer of the right heel and midfoot. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact and had no falls during the assessment period.Review of the care plan, revised April 2026, revealed Resident #8 was care planned for falls due to deconditioning. Interventions included anticipate and meet needs, call light in reach, educate the resident/family/caregivers about safety reminders, ensure appropriate footwear was in place, follow fall protocol, review information on past falls and attempt to determine cause of fall and record possible root cause, and the most recent intervention was ROHO (type of air filled pockets of cushion to prevent wounds) to be removed from the recliner when resident was in the recliner.Review of the nursing progress note dated 03/28/26 at 6:31 P.M. revealed Resident #8 was found sitting on the floor in front of his recliner. The resident denied injury. Resident #8 stated he slid out of the chair. Vital signs taken.Review of the facility incident report dated 03/28/26, related to Resident #8's fall, revealed the incident report was not completed. The areas on the incident report that were left incomplete included the areas titled predisposing environmental factors, predisposing situational factors, and predisposing physiological factors. Further review of the incident report for Resident #8's fall revealed the only documentation on the form was vital signs, a statement of findings at the time of the fall, and notifications.Review of the Post Fall Monitoring Form for Resident #8 revealed the top section of the form was dedicated for initiation of neurological checks following a fall. The section was crossed off and there was no documentation of immediate neurological monitoring following the resident's fall. Further review revealed the 72-hour post monitoring was to be done for six shifts, every eight hours. The assessment was not completed on the midnight shifts on 03/29/26 and 04/01/26. Further review of Resident #8's medical record revealed an updated fall risk assessment was not completed until 04/05/26, eight days following the resident's fall on 03/28/26. Interview on 04/27/26 at 4:37 P.M. with the Director of Nursing (DON) and Regional Clinical Nurse (RCN) #400 revealed the facility had a fall packet where staff documented their findings at the time of the fall and further investigation was conducted from the staff statements of the events at the time of the fall.A follow-up interview on 04/27/26 at 5:03 P.M. with the DON verified Resident #8's fall on 03/28/26 was unwitnessed and neurological checks should have been implemented and they were not.A follow-up interview on 04/27/26 at 5:09 P.M. with RCN #400 verified the incident report dated 03/28/26 for Resident #8's fall was not completely filled out for a thorough investigation to be completed following the fall for the resident.Interview on 04/28/26 at 10:15 A.M. with RCN #400 verified the post fall assessments were not completed on the midnight shifts on 03/29/26 and 04/01/26 and further confirmed the fall risk assessment should have been completed immediately after Resident #8's fall on 03/28/26 and was not completed until 04/05/26, eight days after the resident's fall. 2. Review of the medical record for Resident #13 revealed an admission date of 06/30/21. Diagnoses included difficulty in walking, deep vein thrombosis (blood clot) of right lower leg, dementia, general weakness, diabetes mellitus, and wheelchair dependence.Review of the quarterly MDS assessment dated [DATE] revealed Resident #13 was cognitively intact and had one fall during the last assessment period that resulted in no injury.Review of the care plan, revised April (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, revealed Resident #13 was care planned for falls due to deconditioning. Interventions included Dycem (special mat that prevents slipping) to chair, appropriate footwear-shoes or gripper socks, call light in reach, ensure items within reach, and custom wheelchair.Review of the nursing progress note dated 04/13/26 at 7:32 P.M. revealed Resident #13 was found sitting upright, leaning against the bed, facing the door with right arm resting on the recliner cushion. The left leg was bent up with his foot flat on the floor, shoes were on. The wheelchair was tipped over and resting on the left side.Review of the Post Fall Monitoring Form for Resident #13 revealed the top section of the form was dedicated for initiation of neurological checks following a fall. The section was crossed off and there was no documentation for immediate neurological monitoring following the fall. Interview on 04/27/26 at 5:15 P.M. with the Administrator revealed the facility expectation was for neurological checks to be initiated for any unwitnessed fall. A follow-up interview on 04/28/26 at 12:50 P.M. with the Administrator verified Resident #13's fall was unwitnessed and neurological checks were not completed and should have been implemented. Review of the facility policy titled, Standard for Falls, undated, revealed the purpose was to ensure resident safety from fall-related injury. Unwitnessed falls, if patient was alert and oriented to person, place, and thing (x3), then ask the patient if they hit their head or face during the fall, if patient admitted to hitting their head or face, document the patient's statement and follow head injury protocol. If the patient denied hitting their head or face, document the patient's statement, perform physical assessment and follow general procedure. General procedure was to place patient on 24 hour report and monitor the resident for the next 72 hours.Review of the facility policy titled, Fall Prevention and Management Policy, revised August 2024, revealed each resident would be assessed for fall risk on admission, quarterly, after any fall and as needed. In the event of a fall, the resident would be assessed by the licensed nurse, physician or Nurse Practitioner (NP) and interventions aimed to prevent further falls would be implemented. Details of the fall would be gathered and documentation completed as indicated. Falls would be reviewed by the Interdisciplinary Team. This review would include, but not limited to, new interventions that were identified/implemented, results of the new fall risk assessment, discussion with the resident and/or witness as to potential contributing factors, review of the environment where the fall occurred and discussion as to any new interventions that my help prevent any further falls.This deficiency represents non-compliance investigated under Complaint Number 2784759.