STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365896	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Run Manor	11745 Township Road 145 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, review of the admission authorizations document, staff interview, and policy review, the facility failed to notify a resident's representative of a change in condition. This affected one (Resident #78) out of three residents reviewed for representative notification. The facility census was 63.Findings include:Review of Resident #78's medical record revealed an admission date of 10/06/25 and a discharge date of 02/11/26. Diagnoses included schizophrenia, neuromuscular dysfunction of the bladder, aneurysm of the ascending aorta, anxiety, hypertension, depression, and hypercalcemia. Review of Resident #78's modification of admission/Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of seven. Furthermore, Resident #78 was frequently incontinent of urine and bowel and was dependent for toileting hygiene. Review of Resident #78's care plan dated 10/06/25 revealed Resident #78 had an indwelling urinary catheter with interventions that included to monitor intake and output per the facility policy, monitor, record, and report to the Medical Director signs or symptoms of Urinary Tract Infections (UTI) such as pain, burning, blood tinged urine, cloudiness, and change in behavior, and to provide catheter care per the physician orders and as needed. Review of Resident #78's admission authorization document dated 10/07/25 revealed Resident #78 had a resident representative that signed the admission authorization alongside Resident #78.Review of the provider progress note for Resident #78 dated 12/02/25 revealed Resident #78 was experiencing severe penile pain and swelling with a pain rating of nine out of ten. The pain was described as excruciating and was localized to the glans penis, which appeared swollen. There was a significant amount of serosanguineous discharge around the urethral meatus, but no blood was noted in the indwelling catheter bag. Resident #78 had been given tramadol and other pain medications, but there had been no improvement in his pain. The plan was to refer Resident #78 to the hospital for urological evaluation due to significant pain and potential risk of urethral injury. Resident #78 consented to the hospital transfer for further assessment and management by a urologist.Interview on 06/03/26 at 3:13 P.M. with Certified Nurse Practitioner (CNP) #405 verified Resident #78 was supposed to have been sent to the hospital on [DATE] and was not sent. CNP #405 verified she did not have any triage note or any knowledge of him being sent to the hospital.Interview on 06/08/26 at 8:52 A.M. with the Director of Nursing (DON) verified Resident #78 was not sent to the hospital per the physician's order on 12/02/25 and was unable to state why he was not sent to the hospital. The DON called the hospital and there was no documentation that Resident #78 was sent to the hospital on [DATE]. Furthermore, the DON verified the resident's representative was not made aware of the change in condition or the order to send Resident #78 to the hospital.Review of the facility policy titled Notification of Changes Policy with a revision date of November 2016 revealed the manor would inform the resident, the attending physician, and the resident's representative or interested family member of changes which affect the resident.This deficiency represents non-compliance investigated under Complaint Numbers 3005035 and 2795186.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, discharge notice, interview, and policy review the facility failed to issue a 30-day discharge. This affected one (Resident #77) of three residents reviewed for discharge. The facility census was 63.Findings include:Review of medical record for Resident #77 revealed an admission date of 07/11/25 and discharge date of 02/27/26 with diagnoses including but not limited to dementia, blindness right eye category three, and other specified sepsis.Review of minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact with no behaviors during the look back period. Resident #77 was independent for bed mobility, transfers, and ambulation.Review of physician orders revealed 15-minute checks until further notice (02/21/26-02/27/26), check placement of secure care (wander guard) device every shift (07/30/26-08/06/26) and (01/03/26-02/27/26), and check function of secure care device daily (07/30/26-08/06/26) and (01/06/26-02/27/26).Review of care plan dated 07/11/25 revealed resident is an elopement risk/wanderer as evidenced by history of attempts to leave the facility unattended. The resident with multiple attempts to leave the facility and cutting off secure care device. Interventions included 15-minute checks, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, remove all sharp objects from room and educate family not to provide scissors, and wander alert device.Review of alert note dated 02/21/26 at 11:37 A.M. revealed the nurse was alerted to the resident being down the road at the neighboring assisted living facility at approximately 8:45 A.M. Staff immediately went to pick the resident up from the assisted living facility. When the resident returned to the facility, they stated that they were going to the bank. Nurse asked the resident where his wander guard bracelet was. The resident stated he cut it off and it was in his chair. Nurse inspected the chair noting the wander guard bracelet in between the chair cushion and the arm of the chair and noted to be cut.Review of Mental Health Services note dated 02/23/26 at 1:31 P.M. revealed the writer met with the client per facility request due to recent elopement incident. During the session, client was alert and oriented, able to recall recent and remote events, denied auditory or visual hallucinations, denied suicidal or homicidal ideations. The client was able to process with the writer his elopement incident and stated, I just wanted to get out of the building and explained that he planned to leave the facility to see his grandchildren. Although future behavior cannot be predicted, the client appeared fully aware of his actions and their implications and expressed no remorse at the time of the assessment. Continued monitoring and reinforcement of safety planning are recommended.Review of alert note dated 02/25/26 at 6:54 A.M. revealed the resident was alert and oriented times three and well aware of what he is doing and expressed that he wanted to go to the bank when it was daytime. The nurse mentioned that he needed to have someone accompany him and approval from the office.Review of Case management note dated 02/25/26 at 4:55 P.M. revealed spoke with daughter about transferring the resident to a secure unit for the resident's safety. Daughter gave consent for transfer.Review of notification note dated 02/26/26 at 11:54 A.M. revealed daughter notified of transfer to secure unit will take place on 02/27/26. Daughter stated okay and if refrigerator cannot be kept in new room she will pick it up.Review of Discharge summary dated [DATE] at 11:22 A.M. revealed the resident discharged to sister facility. All medications and orders were sent with the resident. The resident does not need discharge appointments or pharmacy. Daughter notified of transfer and will pick up fridge. The resident took all other belongings with him.Review of Interdisciplinary Team Progress Note (IDT) dated 03/04/26 at 9:27 A.M. revealed IDT team met with the resident's family to discuss the resident's continued plans to elope and determined that this facility was no longer appropriate for the resident. Referral made to sister facility with secure memory care unit. The resident discharged to secure memory care unit on 02/27/26.Review of discharge notice dated 02/27/26 revealed the resident was discharged to sister (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on 02/27/26 which included that if less than a 30-day notice was being provided it was because: the welfare and needs of the resident cannot be met in the facility.Interview on 06/04/26 at 11:15 A.M. with Resident Services Coordinator (RSC) #369 revealed Resident #77 would go through cycles which seemed to happen at the first of the month when he wanted to go out and get his money. RSC #369 stated the resident would case the facility and find out the routines of the staff and had plans to cut off secure care bracelet and leave the facility. RSC #369 verified they did not issue a 30-day notice due to speaking with family and that they were agreeable to transferring the resident to sister facility with a secure unit. RSC #369 verified the referral was sent on 02/25/26 and the resident was transferred on 02/27/26.Review of policy titled Admission, Transfer, Discharge and Room Change Policy not dated revealed the facility will notify resident and/or responsible part in writing, by certified mail, return receipt requested, in advance of any proposed transfer or discharge from the manor. Written notification will also be provided to the resident (whether facility or resident initiated) which will include the following information: the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharge, a statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, and the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. The notice shall be provided at least thirty (30) days in advance of the proposed transfer or discharge, unless any of the following applies: an emergency arises in which the resident's urgent medical needs require a more immediate transfer or discharge. If the resident is discharged for any forgoing reasons, the facility will provide the resident/representative the notice as many days in advance of the proposed transfer or discharge is practicable. This deficiency represents noncompliance investigated under Complaint Number 2962360.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care conference notices were sent out timely and care conferences were attended by appropriate Interdisciplinary Team (IDT) members. This affected three (Resident #31, #47, and #77) of four residents reviewed for care conferences. The facility census was 63.Findings include:1. Review of the medical record for Resident #31 revealed an admission date of 02/20/25 and discharge date of 05/31/26 with diagnoses including Alzheimer's disease, epilepsy, depression, and cognitive communication deficit.Review of minimum data set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. Resident #31 required setup or clean-up assistance for activities of daily living, transfers, and bed mobility. Resident #31 was independent with mobility in wheelchair.Review of nursing interdisciplinary meeting opened on 04/28/26 revealed the resident/responsible party were notified on 04/29/26. Care conference was held on 05/13/26 with the following in attendance: resident, nursing, and social services.Review of nursing interdisciplinary meeting opened on 05/12/26 revealed the resident was notified on 05/12/26 and the representative was notified on 04/28/26. Care conference held on 05/14/26 with the following in attendance: resident, family, and Resident Service Coordinator.2. Review of the medical record for Resident #47 revealed an admission date of 01/07/26 with diagnoses including dementia, anxiety, and senile degeneration of brain.Review of the MDS dated [DATE] revealed Resident #47 was rarely/never understood.Review of the nursing interdisciplinary meeting opened on 02/04/26 revealed the resident/representative was notified on 02/23/26. Care conference held on 02/23/26 with the following in attendance: family and the Assistant Director of Nursing.3. Review of medical record for Resident #77 revealed an admission date of 07/11/25 and discharge date of 02/27/26. Diagnoses included dementia, blindness right eye category three, and other specified sepsis.Review of minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact with no behaviors during the look back period. Review of the nursing interdisciplinary meeting opened 08/11/25 revealed the resident/responsible party notified on 09/06/25. Care conference was held on 09/06/25 with the following in attendance: resident, family, and social services.Review of nursing interdisciplinary meeting opened 11/06/25 revealed the resident/responsible party notified on 11/06/25. Care conference held on 11/28/25 with the following in attendance: resident, family, and social services.Review of nursing interdisciplinary meeting opened on 02/04/26 revealed the resident/responsible party notified on 02/24/26. Care conference held on 02/27/26 (day of discharge) with the following in attendance: resident, family, and nursing.Interview on 06/04/26 at 11:28 A.M. with Clinical Educator (CE) #450 verified the care conferences for the residents listed above were not attended by the IDT team. CE #450 verified timely notification was not given for the care conferences for Resident #77 and #47.This deficiency represents noncompliance investigated under Complaint Number 2962360.

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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, staff interview, and policy review, the facility failed to send a resident to the hospital as ordered for a change in condition. This affected one (Resident #78) of three residents reviewed for changes in condition. The facility census was 63.Findings include:Review of Resident #78's medical record revealed an admission date of 10/06/25 and a discharge date of 02/11/26. Diagnoses included schizophrenia, neuromuscular dysfunction of the bladder, aneurysm of the ascending aorta, anxiety, hypertension, depression, and hypercalcemia. Resident #78 had a urinary indwelling catheter.Review of Resident #78's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of seven. Furthermore, Resident #78 was frequently incontinent of urine and bowel and was dependent upon staff for toileting hygiene. Review of the provider progress note for Resident #78 dated 12/02/25 revealed Resident #78 was experiencing severe penile pain and swelling with a pain rating of nine out of 10. The pain was described as excruciating and was localized to the glans penis, which appeared swollen. There was a significant amount of serosanguineous discharge around the urethral meatus, but no blood was noted in the indwelling catheter bag. Resident #78 had been given tramadol and other pain medications, but there had been no improvement in his pain. The plan was to refer Resident #78 to the hospital for urological evaluation due to significant pain and potential risk of urethral injury. Resident #78 consented to the hospital transfer for further assessment and management by a urologist.Review of Resident #78's progress notes revealed no progress notes indicating Resident #78 was sent to the hospital as ordered.Interview on 06/03/26 at 3:13 P.M. with Certified Nurse Practitioner (CNP) #405 verified Resident #78 was supposed to have been sent to the hospital on [DATE] and was not sent. CNP #405 verified she did not have any triage note or any knowledge of him being sent to the hospital.Interview on 06/08/26 at 8:52 A.M. with the Director of Nursing (DON) verified Resident #78 was not sent to the hospital per the physician's order on 12/02/25 and was unable to state why he was not sent to the hospital. The DON called the hospital and there was no documentation that Resident #78 was sent to the hospital on [DATE].This deficiency represents non-compliance investigated under Complaint Number 2795186.

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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 record review, observations, interview, and policy review, the facility failed to ensure fall investigations included a root cause and intervention. This affected one (Resident #47) of four residents reviewed for falls. The facility census was 63.Findings include:Review of the medical record for Resident #47 revealed an admission date of 01/07/26 with diagnoses including dementia, anxiety, and senile degeneration of brain.Review of the minimum data set (MDS) dated [DATE] revealed Resident #47 was rarely/never understood.Review of the physician orders revealed change gripper socks every night shift, dycem to recliner and cushion, and floor mats.Review of care plan dated 05/01/26 revealed the resident is at risk for falls due to instability related to history of hip fracture, history of falls and weakness, tremors, and hospice services related to end of life care. Interventions included flat call light pad to be attached to recliner and one to the bed, anti-rollbacks on wheelchair, wheelchair to be locked at bedside at all times when in bed, nonskid footwear when transferring or mobilizing in wheelchair, gripper socks to be worn at all times, dycem to recliner chair and on top of cushion in recliner chair, dycem to wheelchair cushion, and fall mats to both sides of bed on the floor.Review of fall investigation dated 04/19/26 at 2:00 A.M. revealed the resident was observed on the floor sitting with two hands leaning on the fall matt on the left side of the bed facing the television area. No signs of injury noted. The resident denied pain or discomfort at that time. Intervention frequent checks and reminding the resident to use call light for assistance. Interdisciplinary note (IDT) dated 04/22/26 revealed the root cause and the resident was noncompliant with current interventions. Intervention changes: all interventions currently in place are to prevent injury. Review of fall investigation dated 04/19/26 at 6:05 P.M. revealed the resident was observed lying on the floor between the wheelchair and the bed lying on left side with head towards the foot of the bed and feet towards the head of the bed. The landing mat was between the body and the floor. No gripper socks or shoes were noted on the resident's feet. Immediate action was the resident assisted to bed. IDT note meeting dated 04/22/26 revealed the root cause as the resident was noncompliant with all interventions and the resident was found lying on the floor mats next to the bed. Observation on 06/01/26 at 9:52 A.M. revealed fall mats on bilateral sides of the bed with the bed in high position with the resident sitting on the side of the bed with legs dangling and head rested on the mattress with the head of the bed elevated.Interview on 06/08/2026 at 9:01 A.M. with the Director of Nursing (DON) verified the falls for the resident did not have root cause analysis and fall interventions were not in place for the fall on 04/19/26 at 6:05 P.M. The DON stated the root cause was that the resident was non-compliant, and they do not know what the root cause should be as the resident was just confused and she had her mind set that she could go wherever and do whatever. The DON verified the resident cannot be redirected or educated which was part of the immediate intervention for the fall on 04/19/26 at 2:00 A.M. The DON verified no immediate intervention was put into place for the fall on 04/19/26 at 6:05 P.M.Review of policy titled Fall Reduction Policy revised 04/2016 revealed if a resident experiences a fall, nurses will investigate and document the incident in the nurse's notes. Follow-up documentation will be done each shift for a minimum of three days or longer if needed. Follow-up investigations will be done to ascertain the cause of the incident to reduce the risk for further occurrences.This deficiency represents noncompliance investigated under Complaint Number 2977286.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record review, interview, and policy review, the facility failed to ensure residents were seen by the physician timely. This affected one (#49) of three residents reviewed for physician visits. The facility census was 63.Findings include: Review of medical record for Resident #49 revealed an admission date of 01/18/20 with diagnoses including quadriplegia C5-C7 incomplete, anxiety, major depressive disorder, and noncompliance with other medical treatment and regimen for other reason.Review of encounter note dated 12/04/25 revealed the resident was seen by the physician for a regulatory visit.Review of encounter note dated 04/09/26 revealed the visit type as non-billable and no transition of care occurred. Note signed by the physician.Review of encounter note dated 05/14/26 revealed the resident was seen by the physician for an acute/follow-up visit.Interview on 06/04/26 at 2:07 P.M. with the Director of Nursing (DON) revealed Medical Records provided the list to the physician of residents he needed to see. The DON stated Resident #49 would refuse to see the physician sometimes. The DON stated the physician should document refusals as well as visits. The DON verified Resident #49 was seen in December 2025 and then non-billable in April 2026 and visited in May 2026 which was longer than the 60 days required by regulation.Review of policy titled Physician Services revised 11/2018 revealed the resident must be seen every 30 days for the first 90 days after admission, then every 60 days thereafter, unless the resident's condition requires more frequent visits. A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. At the option of the physician, after the initial visit, required visits may alternate between visits by the physician and visits by a physician assistant, nurse practitioner or advanced practice nurse in accordance with regulation and the Non-Physician Practitioners Policy.This deficiency represents noncompliance investigated under Complaint Number 2977286.