

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Fox Run Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44815 Based on observations, resident interview and staff interview, the facility failed to serve residents in the dining room in a dignified manner. This affected five residents (#6, #8, #18, #39, and #66) of 23 residents in the dining room. The facility census was 76. Findings include: Observation in the A-hall dining room on 04/01/24 at approximately 11:50 A.M. revealed Resident #58, Resident #66, and Resident #8 were seated together at a table, Resident #39, Resident #37, and Resident #6 were seated together at a table., and Resident #54, Resident #67, and Resident #18 were seated together at a table. Additional observation at that time revealed State tested Nurse Aide (STNA) #319 handed a stack of meal order tickets to Dietary Aide #210 and stated the meal order tickets were in order by table. Observation and interview n 04/01/24 at 12:06 P.M. revealed Resident #58 was seated at a table with Resident #66 and Resident #8. Resident #58 received his meal. 12 minutes later on 04/01/24 at 12:18 P.M., an interview with STNA #272 confirmed Resident #58 had his meal and Resident #66 and Resident #8 still did not have a meal. Observation and interviews on 04/01/24 at 12:11 P.M. revealed Resident #37, Resident #39, and Resident #6 sitting together at a table. Resident #37 received her meal at 12:11 P.M. and six minutes later on 04/01/24 at 12:17 P.M. revealed Resident #39 received her meal while Resident #6 continued without a meal. 22 minutes later on 04/01/24 at 12:39 P.M. revealed STNA #271 served Resident #6 her meal. Interview with STNA #271 on 04/01/24 at 12:39 P.M. confirmed Resident #37 finished her meal and left the table and Resident #39 remained at the table with a finished meal when Resident #6 was served her meal. Observation on 04/01/24 at 12:13 P.M. revealed Resident #54, Resident #67, and Resident #18 sitting at a table. Continued observation revealed Resident #54 received her meal at 12:13 P.M. Eight minutes later on 04/01/24 at 12:21 P.M. with Resident #18 revealed she did not have her meal and was hungry. Interview on 04/01/24 at 12:21 P.M. with STNA #271 confirmed Resident #18 did not have a meal. Eight minutes later on 04/01/24 at 12:29 P.M. revealed Resident #18 was served a meal of grilled cheese and soup. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/10/24 at 8:23 A.M. with STNA #272 confirmed residents should be served at the same time when seated at the same table.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on observation, medical record review, resident interview, and staff interview, the facility failed to timely respond to the resident's call light. This affected one (#70) of 18 residents observed for call lights. The facility census was 77. Findings include: Review of the medical record revealed Resident #70 was initially admitted on [DATE] and readmitted on [DATE]. Diagnoses included muscle weakness, difficulty in walking, pressure ulcer of left heel, right buttock, and left buttock, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment, dated 03/06/24, revealed Resident #70 was cognitively intact. Resident #70 was dependent on staff for toileting, shower/bathing, upper and lower body dressing, and personal hygiene. The resident as frequently incontinent of urinary continence and bowel incontinence. Review of the most recent care plan revealed Resident #70 had an activities of daily living (ADL) self-care performance due to decreased mobility and incontinence. Resident #70 required one staff participation for transfers and to use the toilet. Observation on 04/02/24 at 3:28 P.M. revealed Resident #70's call light was on for an unknown amount of time. Continuous observation revealed Resident #70's call light remain unanswered through 4:29 P.M. This was one hour and one minute later. Interview on 04/02/24 at 3:57 P.M. with Resident #70 verified she was waiting for assistance with turning off overhead light and needed to use the bathroom. Interview on 04/02/24 at 4:28 P.M. with Registered Nurse (RN) #257 verified the state tested nursing aides were unavailable assisting other residents and RN #257 was providing medication administration. RN #257 was notified of Resident #70's call light alerting for at minimum one hour. RN #257 answered Resident #70's call light at 4:29 P.M.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48570 Based on review of resident council minutes and staff and resident interviews, the facility failed to ensure resident concerns were resolved timely. This affected four residents (#12, #15, #21, and #62) who regularly attended the resident council meetings. The facility census was 77. Findings include: Review of the resident council meeting minutes dated 01/25/24, 02/29/24, and 03/28/24, revealed concerns every month regarding nurses and state tested nursing aides (STNAs) turning off call lights, telling residents they will be back and do not come back and with call lights not being answered timely. There was no evidence the facility responded to the resident's concerns regarding call lights. Interview on 04/01/24 at 10:37 A.M. with Resident #65 confirmed having to really wait to have call lights answered. Resident #65 stated she takes herself to the bathroom because no staff were available, even though she knows she shouldn't. Interviews on 04/03/24 at 1:26 P.M. during the Resident Council meeting, Residents #12 and #62 stated staff turns call lights off and say they will return but they don't. The Resident Council President, Resident #15, confirmed call lights not being responded to timely. Residents #12, #15, #21, and #62 confirmed call lights not being answered timely was a concern. Interview on 04/10/24 at 8:22 A.M. with Activities Director #299 confirmed Resident Council members have brought up concerns with call lights not being answered timely on multiple occasions. Interview also confirmed all Resident Council member concerns, brought up in the meetings, were given to the Administrator after each resident council meeting.		

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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** 48570 Based on record review, staff interview, and policy review, the facility failed to ensure the physician was notified of the resident's significant weight change. This affected one (Resident #27) of two residents reviewed for nutrition. The facility census was 77. Findings include: Review of the medical record for Resident #27 revealed a readmitted [DATE]. Diagnoses included acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure. Review of the Minimum Data Set (MDS) assessment, dated 02/23/24, revealed the resident was cognitively intact. Review of Resident #27's weights revealed the following weights were obtained: 192.0 pounds on 02/19/24 and 179.4 pounds on 03/20/24. This was a 6.56 percent (%) significant weight loss in less than one month. There was no documentation indicating the physician was notified of Resident #27's significant weight loss from 03/20/24 to 04/03/24. Interview on 04/04/24 at 12:03 P.M. with Dietary Tech #346 confirmed she reviews weight changes weekly and reports significant changes to the physician. Dietary Tech #346 verified the physician was not notified of Resident #27's significant weight loss. Review of the Weight Policy Scales, dated 03/2017 revealed the clinical technician/Registered Dietitian will notify the physician of the resident's weight gain or loss and nursing will notify the family.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review and staff interview, the facility failed to develop a baseline care plan with the minimum necessary information to include activities of daily living (ADL) information for two residents (Resident #57 and #332), skins concerns, psychotropic medications and anticoagulation medication information for one resident (Resident #332). This affected two residents (Resident #57 and #332) of two residents reviewed for baseline care plan. The facility census was 77. Findings include: 1. Record review of Resident #57 revealed she admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, pain in right hip bursitis, and cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery. Review of the physician orders dated 01/12/24 revealed a pressure reducing cushion to chair when out of bed for prevention, monitor for signs and symptoms of bruising / bleeding-anticoagulant therapy every shift for prophylactic , monitor for signs and symptoms of dehydration: unquenchable thirst, dry/sticky mouth, decreased urine output, dark-colored urine, unexplained tiredness, dizziness, confusion, notify physician if yes. Review of the baseline care plan dated 01/13/24 revealed Resident #57 was to discharge home or to another facility, had skin concerns, has increased nutrition needs, and was on anticoagulant therapy. There was no information found in the baseline care plan related to Resident #57's required activities of daily living needs (ADLs). Interview on 04/02/24 at 12:59 P.M. with Licensed Practical Nurse (LPN) #247 indicated pertinent diagnoses, physician orders, ADL information, skin concerns, anticoagulant and psychotropic use information should be included in baseline care plans and confirmed Resident #57's baseline care plan did not include information related to ADLs. Interview on 04/03/24 at 2:42 P.M. with the Director of Nursing confirmed the baseline care plan was not complete and did not contain information for ADLs on Resident #57. 2. Record review of Resident #332 revealed he admitted to the facility on [DATE]. Diagnoses included sepsis, urinary tract infection, extended spectrum beta lactamase (ESBL) resistance, infection and inflammatory reaction due to indwelling urethral catheter, disorientation, congestive heart failure, weakness, atrial flutter, and diabetes mellitus. Review of the physician orders dated 03/27/24 revealed the resident was to be monitored for signs and symptoms of bruising/bleeding due to anticoagulant therapy, was to receive apixaban (anticoagulant) 2.5 milligrams (gm) daily for atrial flutter and atherosclerotic heart disease, amitriptyline (tricyclic antidepressant) 10 milligrams (mg) daily at bedtime for depression, trazodone 50 mg daily for insomnia / depression. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the baseline care plan dated 03/27/24 revealed Resident #332 was to discharge home or to another facility, was on antibiotics, and was using oxygen. There was no information found in the baseline care plan related to Resident #332's required activities of daily living needs (ADLs), skins concerns, psychotropic medications usage and anticoagulation medication usage. Interview on 04/02/24 at 12:59 P.M. with Licensed Practical Nurse (LPN) #247 indicated pertinent diagnoses, physician orders, ADL information, skin concerns, anticoagulant and psychotropic use information should be included in baseline care plans and confirmed Resident #332's baseline care plan did not include information related to ADLs, skin concerns, anticoagulant use or psychotropic use. Interview on 04/03/24 at 2:42 P.M. with the Director of Nursing (DON) confirmed the baseline care plan was not complete and did not contain information for ADLs on Resident #332. The DON confirmed the baseline care plan did not include anticoagulant use, psychotropic use or skin concerns for Resident #332. Interview on 04/09/24 at 12:35 P.M. with the Administrator stated the facility does not have a policy for baseline care plans.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, observation, staff interview, and policy review, the facility failed to ensure Resident #57 had a complete comprehensive care plan. This affected one (Resident #57) of 18 residents reviewed for comprehensive care plans. The facility census was 77. Findings include: Record review of Resident #57 revealed an admitted to the facility of 01/12/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, pain in right hip bursitis, and cerebral infarction due to unspecified occlusion or stenosis of the middle cerebral artery. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact and had functional limitation impairment in range of motion to bilateral upper and lower extremities, required substantial assistance from staff with toileting hygiene, bathing, dressing, personal hygiene and was dependent on staff for bed mobility and transfers. Review of the current care plan was silent for activities of daily living (ADLs). Observation on 04/02/24 at 12:58 P.M. revealed Resident #57 transferred to a wheelchair by use of a Hoyer lift by State tested Nursing Assistants (STNA) #306 and #308. Interview on 04/02/24 at 12:59 P.M. with Licensed Practical Nurse (LPN) #247 indicated activities of daily living (ADL) information should be included in the comprehensive care plan and confirmed Resident #57's care plan did not include information related to ADLs. Interview on 04/03/24 at 2:42 P.M. with the Director of Nursing (DON) confirmed Resident #57's current care plan did not address ADLs. Review of the facility's Comprehensive Care Plan policy, dated 11/02/16, revealed the facility will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The care plan must include the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. A comprehensive care plan must be developed within seven days after the completion of the comprehensive assessment.		

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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** 34745 Based on resident and staff interview, record review, and review of the facility policies, the facility failed to ensure comprehensive care plans were updated timely. This affected two (#56 and #67) of 18 residents reviewed for comprehensive care plans. The facility census was 77. Findings included : 1. Review of the medical record for Resident #56 revealed an admitted [DATE]. The resident was admitted with diagnoses including urinary tract infection (UTI) and muscle weakness. The resident was discharged on [DATE] to hospital and readmitted on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had moderately impaired cognition. The resident required substantial or maximum assistance from staff for toileting and was always incontinent of bowel and bladder. Review of the physician's orders revealed an order dated 03/31/24 for check and change brief every two hours and as needed. Review of the care plan relative to bowel and bladder incontinence revealed interventions which included to assist with incontinence care as needed and monitor for signs or symptoms of urinary tract infection. The care plan was not updated with the new intervention which included every two hour check and change. Interview on 04/02/24 at 10:30 A.M. with Resident #56 revealed the staff had gotten her up at 7:00 A.M. and had changed her depends. Resident #56 was concerned with staff not getting her changed every two hours like they should be. Resident #56 stated she was anxious due to being in the hospital with a urinary tract infection which caused sepsis. She does not want to get this sick again. Resident #56 believes she got the infection because they would let her set for hours in urine and feces. Interview with the Director of Nursing on 04/09/24 at 9:31 A.M. verified Resident #56's care plan had not been updated with the new orders she received when coming back from the hospital of check and change every two hours. 44815 2. Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses of dementia and hypertension. Review of the quarterly Minimum data set (MDS) assessment dated [DATE] revealed Resident #67 had impaired cognition. Resident #67 had no falls since the previous assessment completed 11/30/23. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 03/16/24 revealed Resident #67 was found on the floor in her bedroom with feces on her hands, clothing, and on the floor at 3:12 P.M. A large bump was noted on her forehead. Resident #67 was assessed, was alert and interactive, and was sent to the hospital via emergency transport for assessment. Resident #67 returned to the facility on [DATE] at 11:16 P.M. with no new orders. Review of the interdisciplinary team (IDT) progress note dated 04/02/24 revealed Resident #67's fall was reviewed and a new intervention was developed for staff to assist Resident #67 with toileting. Review of the current care plan for Resident #67 revealed she was at risk for falls and fall related injuries. An intervention was added 04/02/24 for assistance by one person with toileting. Interview on 04/02/24 at approximately 2:00 P.M. with State tested Nursing Aide (STNA) #319 revealed she was familiar with Resident #67 and said she rarely fell . STNA #319 was aware of Resident #67's recent fall with facial bruising and stated the new intervention was to monitor Resident #67 more frequently. Interview on 04/09/24 at 4:06 P.M. with the Director of Nursing (DON) verified the IDT team developed a fall intervention for Resident #67 after her fall on 03/16/24, but did not add it to the care plan until 04/02/24. The DON stated she was responsible for updating care plans with fall interventions. Review of the facility policy titled Fall Reduction Policy, dated 04/29/16, revealed if a resident experiences a fall, follow-up investigations will be done to ascertain the cause of the incident to reduce the risk of further occurrences. The policy provided no guidance regarding updating the care plan with interventions to address the identified cause of the incident. Review of the facility policy titled Comprehensive Care Plan, dated 11/2016, revealed the facility would develop a comprehensive person-centered care plan for to meet each resident's medical and nursing needs, and the care plan would be periodically reviewed and revised after each assessment. The policy provided no guidance regarding the revision of a care plan after an accident or event.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, resident and resident representative interview, and staff interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) had their personal care needs met. This affected two (#10 and #64) of seven residents reviewed for ADL. The facility census was 77. Findings include: 1. Review of the medical record revealed Resident #10 was admitted on [DATE]. Diagnoses included muscle weakness, major depressive disorder, and psychotic disorder with hallucinations due to known physiological conditions. Review of the Minimum Data Set (MDS) assessment, dated 01/26/24, revealed the resident was severely cognitively impaired and required substantial/maximum assistance from staff with personal hygiene. Review of the most recent care plan revealed Resident #70 had ADL self care performance due to weakness and had impaired cognitive function/dementia or impaired thought processes due to advanced age. Review of the shower task documentation, dated the last 14 days, revealed Resident #10 received a shower or bath on 03/23/24, 03/27/24, 03/30/24, and 04/03/24. Observation on 04/01/24 at 3:25 P.M. revealed Resident #10 to have numerous (approximately 20 or more) grown out white stubble chin hairs. Interview on 04/01/24 at 3:28 P.M. with Resident #10's representative revealed Resident #10's chin hairs were too long and the family always ends up trimming/shaving them. Resident #10's representative stated it would be preferable if the facility would meet the resident's personal hygiene requirements. Observation on 04/04/24 at 3:27 P.M. revealed Resident #10 continued to have numerous outgrown stubble chin hairs. Interview on 04/04/24 at 3:29 P.M. with State tested Nursing Assistant (STNA) #280 verified residents were shaved on their shower days. STNA #280 verified Resident #10's chin hairs were outgrown and in need of trimming. 44815 2. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses of ataxia and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had intact cognition and was dependent on staff for personal hygiene. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current care plan for Resident #64 revealed she had an activities of daily life self care performance deficit related to weakness and would demonstrate use of adaptive devices to increase her ability with personal hygiene. Review of the care provided by staff to Resident #64 revealed she received extensive assistance or was totally dependent on staff for personal hygiene at least twice daily between 03/13/24 and 04/09/24. Observation on 04/01/24 at 10:42 A.M. with Resident #64 revealed she had several long chin hairs. Interview at that time with Resident #64 revealed she was aware she had long chin hairs and would like them shaved. Resident #64 stated staff did not offer to shave her on a regular basis. Interview and observation on 04/02/24 at 2:06 P.M. revealed Resident #64 lying in bed. Resident #64 continued to have long chin hairs. Resident #64 stated she did not ask staff to shave her because she felt staff would not be willing to provide the care. Resident #64 stated she was supposed to shower the next day (04/03/24). Observation on 04/03/24 at 9:34 A.M. revealed Resident #64 sitting in a chair in her room. Long chin hairs remained present on her chin. Interview and observation on 04/04/24 at 7:56 A.M. revealed Resident #64 sitting in dining room with long hairs present on her chin. Resident #64 stated she was offered a shower the previous day but refused it because it was offered too late in the day. Interview and observation on 04/04/24 at 9:05 A.M. with State tested Nurse Aide (STNA) #319 confirmed she assisted Resident #64 out of bed that morning and worked with her on Monday and Tuesday this week. STNA #319 stated shaving normally occurs during showers and knew Resident #64 was scheduled for a second shift shower. STNA #319 confirmed Resident #64's chin hair appeared like it had not been shaved in over a week.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
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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** 44815 Based on staff interview, record review, and review of the facility policies, the facility failed to ensure the interdisciplinary team reviewed falls timely, and interventions were developed and implemented timely. This affected one (#67) of two residents reviewed for falls. The facility census was 76. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses of dementia and hypertension. Review of the Nursing Fall Review assessment dated [DATE] revealed Resident #67 was at moderate risk for falls. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had impaired cognition. Resident #67 had no falls since the previous assessment completed 11/30/23. Review of the current care plan for Resident #67 revealed she was at risk for falls and fall related injuries. An intervention was added 04/02/24 for assistance of one staff with toileting. Review of the progress notes dated 03/16/24 revealed Resident #67 was found on the floor in her bedroom with feces on her hands, clothing, and on the floor at 3:12 P.M. A large bump was noted on her forehead. Resident #67 was assessed, was alert and interactive, and was sent to the hospital via emergency transport for assessment. Resident #67 returned to the facility on [DATE] at 11:16 P.M. with no new orders. Review of the hospital records dated 03/16/24 revealed Resident #67 had no fractures or intracranial (inside the skull) abnormality. Review of a physician progress note dated 03/18/24 revealed Resident #67 was sent to the emergency room after a fall on 03/16/24. Resident #67 suffered a contusion and hematoma to the left forehead. Bruising was noted down her face. Resident #67 was verbal and at baseline, not oriented but her responses to questions were appropriate. The right eye was clear and the left eye was completely closed by the upper and lower eyelid hematoma. There was a hematoma and swelling of the forehead above the eye. Resident #67 had bruising extending down the upper part of her left cheek. Review of the interdisciplinary team (IDT) progress note dated 04/02/24 revealed Resident #67's fall was reviewed and a new intervention was developed for staff to assist Resident #67 with toileting. Observation and interview on 04/01/24 at 10:38 A.M. with Resident #67 revealed she had purple/green bruising down the left side of her face. Resident #67 stated was aware of the bruising, but could not recall the cause. (continued on next page)		

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Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/24 at approximately 2:00 P.M. with STNA #319 revealed she was familiar with Resident #67 and said she rarely fell . STNA #319 was aware of Resident #67's recent fall with facial bruising and stated the new intervention was to monitor Resident #67 more frequently. Interview on 04/09/24 at 4:06 P.M. with the Director of Nursing (DON) verified the IDT team developed a fall intervention for Resident #67 after her fall on 03/16/24, but did not implement it by adding it to the care plan until 04/02/24. Additionally, the DON could provide no evidence the facility investigated the fall prior to 04/02/24 when the IDT progress note was entered in Resident #67's record. Review of the facility policy titled Accidents and Incidents Policy, revised 04/2016, revealed the facility must conduct an investigation of the accident or incident ASAP (as soon as possible). Review of the facility policy titled Fall Reduction Policy, dated 04/29/16, revealed if a resident experiences a fall, follow-up investigations will be done to ascertain the cause of the incident to reduce the risk of further occurrences. The policy provided no guidance regarding updating the care plan with interventions to address the identified cause of the incident.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34745 Based on medical record review, observation, resident interview and staff interview, the facility failed to ensure the residents were provided incontinence care timely. This affected two (#56 and #72) of three residents reviewed for incontinence care. The facility census was 77. Findings include: 1. Review of the medical record for Resident #56 revealed admitted [DATE]. The resident was admitted with diagnoses including urinary tract infection (UTI) and muscle weakness. The resident was discharged on [DATE] to hospital and readmitted on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had moderately impaired cognition. The resident required substantial or maximum assistance from staff for toileting and was always incontinent of bowel and bladder. Review of the physician's orders revealed an order dated 03/31/24 to check and change brief every two hours and as needed. Review of the care plan relative to bowel and bladder incontinence revealed interventions which included to assist with incontinence care as needed and monitor for signs or symptoms of urinary tract infection. The care plan was not updated with the new intervention which included every two hour check and change. Interview on 04/02/24 at 10:30 A.M. with Resident #56 revealed the staff had gotten her up at 7:00 A.M. and had changed her depends. Resident #56 was concerned with staff not getting her changed every two hours like they should be. Resident #56 stated she was anxious due to being in the hospital with an urinary tract infection which caused sepsis. She does not want to get this sick again. Resident #56 believes she got the infection because they would let her set for hours in urine and feces. Observation on 04/02/24 at 12:40 P.M. revealed Resident #56 was taken from the dining room to her room for incontinence care. State tested Nurse Aide (STNA) #272 and STNA #271 returned the resident to bed via Hoyer lift. Resident #56 was saturated through to her pants in front and back. The resident's brief was saturated with urine and feces. Interview with STNA #272 on 04/02/24 at 12:40 P.M. verified Resident #56 was last checked and changed at 7:00 A.M. upon getting her up this morning. STNA #272 verified she usually tried to get her changed before lunch but her assignment had quite a few check and changes, and they were not able to get all residents changed every two hours. Interview with STNA# 325 on 04/04/24 at 5:20 A.M. revealed her assignment included Resident #56. STNA #325 stated on third shift, there were times when you work alone on the hall, there was no way to get check and changes completed every two hours due to having 18 residents to check and change. Third shift also had 13 residents to get up each night with 11 of them being a Hoyer or sit-to-stand which required two persons. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record of Resident #72 had an admitted [DATE] with diagnoses of schizoaffective disorder, periprosthetic fracture of right knee, and difficulty in walking. Review of the physician orders revealed an order for non-weight bearing to right lower extremities and wear all times. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was cognitively intact. He required maximum assistance from staff with toileting and activities of daily living (ADL). Review of the plan of care revealed the resident required assistance with ADLs related to fracture of right knee prosthesis and leg brace. Interventions included the resident was dependent on one or two staff assistance. The plan of care for bladder incontinence included interventions to check him frequently as tolerated for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Continuous observation and interview with Resident #72 on 04/01/24 from 10:10 A.M. to 10:40 A.M. revealed staff did not enter Resident #72's room during these 30 minutes. Resident #72 stated he had his call light on prior to 10:10 A.M. and staff came into the room and turned off his call light. The resident informed the staff that he wet his pants and the staff responded to him that they needed to help someone else first. Resident #72's room smelled of urine and his shorts were noticeably wet. Interview and observation on 04/01/24 at 10:40 A.M. revealed STNA #271 and STNA #272 entered Resident #72's room to provide incontinence care. STNAs #271 and #272 verified they had answered the call light prior and saw his pants were wet with urine, and explained they would have to come back later to clean him up. They had to get up another resident who was paraplegic. STNAs #271 and #272 stated they do not have enough staff for the resident's acuity levels at the facility.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41528 Based on observations, resident and staff interviews, and review of the facility assessment, the facility failed to ensure there was sufficient staff to timely meet the resident's needs. This affected 13 residents (#1, #12, #15, #21, #31, #38, #56, #62, #65, #70, #72, #73, and #82) and had the potential to affect all 77 residents residing in the facility. Findings include: 1. Review of the resident council meeting minutes dated 01/25/24, 02/29/24, and 03/28/24, revealed concerns every month regarding nurses and state tested nursing aides (STNAs) turning off call lights, telling residents they will be back and do not come back, and with call lights not being answered timely. Interviews on 04/01/24 from 8:00 A.M. to 5:15 P.M. with Residents #1, #31, #38, #65, #73, and #82 revealed the residents had concerns related to long call light times with some reports stating call lights were up to two hours long. Resident #65 stated she really had to wait to have her call light answered. Resident #65 stated she takes herself to the bathroom because no staff were available, even though she knows she shouldn't. Interviews on 04/03/24 at 1:26 P.M. with Residents #12 and #62 stated staff turn off their call lights and say they will return but don't actually return. Resident #15 confirmed call lights were not being responded to timely. Residents #12, #15, #21, and #62 confirmed call lights not being answered timely was a concern. 2. Observation on 04/02/24 at 3:28 P.M. revealed Resident #70's call light was on for an unknown amount of time. Continuous observation revealed Resident #70's call light remain unanswered through 4:29 P.M. (one hour and one minute). Interview on 04/02/24 at 3:57 P.M. with Resident #70 verified she was waiting for assistance with turning off overhead light and needed to use the bathroom. Interview on 04/02/24 at 4:28 P.M. with Registered Nurse (RN) #257 verified one state tested nursing aide (STNA) was giving a shower, two other STNAs were assisting another resident, and RN #257 was providing medication administration. RN #257 was notified of Resident #70's call light was alerting for at minimum one hour. RN #257 answered Resident #70's call light at 4:29 P.M. 3. Interview on 04/02/24 at 10:30 A.M. with Resident #56 revealed the staff had gotten her up at 7:00 A.M, and had changed her depends. Resident #56 was concerned with staff not getting her changed every two hours like they should be. Resident #56 stated she was anxious due to being in the hospital with an urinary tract infection which caused sepsis. She does not want to get this sick again. Resident #56 believes she got the infection because they would let her set for hours in urine and feces. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/02/24 at 12:40 P.M. revealed Resident #56 was taken from the dining room to her room for incontinence care. State tested Nurse Aide (STNA) #272 and STNA #271 returned the resident to bed via Hoyer lift. Resident #56 was saturated through to her pants in front and back. The resident's brief was saturated with urine and feces. Interview with STNA #272 on 04/02/24 at 12:40 P.M. verified Resident #56 was last checked and changed was at 7:00 A.M. upon getting her up this morning. STNA #272 verified she usually tries to get her changed before lunch but her assignment had quite a few check and changes, and they were not able to get all residents changed every two hours. Interview with STNA #325 on 04/04/24 at 5:20 A.M. revealed her assignment included Resident #56. STNA #325 stated on third shift, there were times when you work alone on the hall, there was no way to get check and changes completed every two hours due to having 18 residents to check and change. Third shift also had 13 residents to get up each night with 11 of them being a Hoyer or sit-to-stand which required two persons. 4. Continuous observation and interview with Resident #72 on 04/01/24 from 10:10 A.M. to 10:40 A.M. revealed staff did not enter Resident #72's room during these 30 minutes. Resident #72 stated he had his call light on prior to 10:10 A.M. and staff came into the room and turned off his call light. The resident informed the staff that he wet his pants and the staff responded to him that they needed to help someone else first. Resident #72's room smelled of urine and his shorts were noticeably wet. Interview and observation on 04/01/24 at 10:40 A.M. revealed State tested Nursing Aide (STNA) #271 and STNA #272 entered Resident #72's room to provide incontinence care. STNAs #271 and #272 verified they had answered the call light prior and saw his pants were wet with urine, and explained they would have to come back later to clean him up. They had to get up another resident who was paraplegic. STNAs #271 and #272 stated they do not have enough staff for the resident's acuity levels at the facility. Interview on 04/04/24 with STNA #312 revealed they have one STNA (#300) who they keep putting on the schedule. STNA #300 does not show up to work at least once a week. This leaves the staff short and they cannot complete all the get up and check and changes every two hours. STNA #312 works on C-Hall where they had eight residents to get up and four of them were Hoyer lifts which required two people. Interview with Licensed Practical Nurse (LPN) #248 on 04/04/24 at 9:40 A.M. revealed the STNAs have to prioritize which resident care they complete first due to call offs and acuity of residents on the hall. Interview with Registered Nurse (RN) #258 on 04/02/24 at 8:05 A.M. revealed the STNAs have a very hard time getting all the residents checked and changed completed every two hours. The facility has a lot of resident who require Hoyer lifts, incontinence care, feeding and behaviors which causes the staff to be unable to complete all the check and changes timely. The weekends were the worst with staffing. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LPN #241 on 04/04/24 at 5:45 A.M. revealed she worked on the C-Hall. C-Hall has two STNAs which were pretty good at getting their check and changes done. The problem was they usually only have one STNA which then they have a problem getting their assigned tasks done every two hours. Review of the Facility Assessment, dated 03/26/24, revealed the facility had an average daily census of 80 with 13 short term care residents and 67 long term care residents. The facility identified seven residents who required injections, two residents who required intravenous medication, five residents were under the care of hospice, one resident required hemodialysis, and one resident required oxygen therapy.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44815 Based on observation and interview, the facility failed to ensure nurse staffing data was posted on a daily basis and failed to maintain historical staffing data. This had the potential to affect all 76 residents residing in the facility. Findings include: Observation on 04/01/24 at 10:00 A.M. on D Hall revealed the posted daily staffing data was dated 03/24/24. Interview on 04/02/24 at 9:00 A.M. with Medical Records #250 on A Hall confirmed she was placing a notice of daily staffing data in the display case. Medical Records #250 confirmed the most recently posted staffing data was from November 2023. Interview on 04/10/24 at 10:25 A.M. with Medical Records #250 stated she only had daily staffing data beginning 04/03/24 and could not produce any records prior to that. Medical Records #250 stated she did not know who was responsible for posting it before she was assigned on 04/03/24. The facility was unable to provide any historical daily staffing data reports.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41528 Based on observations, staff interview, and review of facility policy, the facility failed to ensure adequate hand hygiene was performed during food service and failed to monitor food temperatures before serving meals. This had the potential to affect all residents in the facility except Resident #40 identified to receive no food from the kitchen. Findings include: 1. Observation on 04/01/24 at 11:52 A.M. revealed lunch meal service being served in the C hall kitchenette. Dietary Aide #212 was observed wearing disposable gloves while handling sandwich buns. While wearing disposable gloves, Dietary Aide #212 was observed leaving the kitchenette and using the gloved hand to use the door keypad and enter the storage/dish room. Dietary Aide #212 reentered the kitchenette and changed gloves without hand washing. After applying new disposable gloves, Dietary Aide #212 was observed touching drawer handles, microwave handles and keypad while wearing the gloves then picked up sandwich buns to continue serving lunch Interview on 04/01/24 at 12:52 P.M. with Dietary Aide #212 verified the lack of handwashing and applying new gloves prior to touching the resident's food. 2. Observation on 04/03/24 at 11:43 A.M. revealed Dietary Aide #206 wearing disposable gloves and making a peanut butter and jelly sandwich. Dietary Aide #206 was observed touching the bread with the disposable gloves, putting the bread on the counter, touching non food items including drawer handles, peanut butter and jelly containers, then touching the bread again with no handwashing or glove change. Interview on 04/03/24 at 11:44 A.M. with Dietary Manager #212 verified Dietary Aide #206 did not wash her hands and change gloves between touching resident food and nonfood items. It was noted there was no handwashing sink available in the kitchenette and the closest handwashing sink was behind the locked storage/dish room door. Dietary Manager #212 stated no one had identified it was a problem and there was no solution identified. 3. Observation on 04/01/24 12:28 P.M. of the lunch meal service revealed Dietary Aide #212 placed a bowl of tomato soup in the microwave, set the cook time and after removed the soup, and provide it to Resident #28 without obtaining a temperature of it. Observation on 04/01/24 at 12:45 P.M. of the lunch meal service revealed Dietary Aide #212 place a bowl of chicken noodle soup in the microwave, set the cook time and after remove the soup and provide it to an unknown resident. Dietary Aide #212 did not obtain the temperature of the soup prior to serving it to the resident. Interview on 04/01/24 at 12:52 P.M. with Dietary Aide #212 verified she did not obtain the temperatures of the soup prior to serving it to the residents. Dietary Aide #212 stated she always warms soup for one minute thirty seconds. Dietary Aide #212 stated she was unaware she had to obtain the temperature of the soup prior to serving i to the resident. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/01/24 at 12:56 P.M. with Dietary Aide #209 stated to know if soup was hot enough, she places a plastic lid on the bowl of soup and when the soup reaches a certain temperature, the lid will melt in. Dietary #209 did not know what the certain temperature was and questioned if the soup needed to be a certain temperature. 48570 4. Observation on 04/01/24 at 12:30 P.M. of Cook-Dietary Aides #208 and #209 revealed barbeque pulled pork and tater tots pulled from the steam table in the kitchenette on Dogwood Hall. Hot food was pulled prior to verifying the temperatures of the food. Chicken noodle soup pulled from a plastic container, ladled into a glass bowl and microwaved. Both Cook-Dietary Aides #208 and #209 started to serve food to the residents and were stopped. Interview and observation on 04/01/24 at 12:32 P.M. with Cook-Dietary Aides #208 and #209 confirmed they did not check the temperatures of any of the food prior to starting service. Cook-Dietary Aides #208 and #209 confirmed temperatures should be done prior to serving food from the kitchenette. Both confirmed they were not aware of what the actual temperatures should be. Cook-Dietary Aide #208 confirmed she has never obtained the temperatures of any food she serves from the kitchenette. Temperatures of the food were checked and revealed the chicken noodle soup was 120 degrees Fahrenheit (F), the barbeque pulled pork was 131 degrees F, and tater tots were 127 degrees F. Cook-Dietary Aides #208 and #209 confirmed with their direct supervisor what the temperatures should be and heated the barbeque pulled pork, tater tots and chicken noodle soap to an acceptable temperatures of 140 F. Review of the facility policy titled Food Temperature, revised February 2018, revealed at the point of service in the kitchen, all hot foods are served at 135 degrees F or higher. In addition, temperatures are taken and record for each meal for all hot and cold foods.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, observation, staff interviews, and policy review, the facility failed to ensure staff used appropriate personal protective equipment (PPE) while in Resident #332's room who was positive for extended spectrum beta lactamase (ESBL) resistance. Additionally, the facility failed to ensure a resident's catheter bag was not on the floor. The affected two residents (Resident #34 and #332) observed during the annual survey. The facility census was 77. Findings include: 1. Review of the medical record for Resident #332 revealed an admitted [DATE]. Diagnoses included sepsis, urinary tract infection, extended spectrum beta lactamase (ESBL) resistance, infection and inflammatory reaction due to indwelling urethral catheter. Review of Resident #332's physician orders dated 03/27/24 revealed an order for Ertapenem (antibiotic) 1, 000 milligrams intravenously daily related to sepsis, organism unspecified. Review of the Brief Interview for Mental Status (BIMS) dated 03/29/24 revealed Resident #332 has moderately impaired cognition. Review of Resident #332's care plan dated 03/27/24 revealed the resident has an active infection of ESBL and will be on contact precautions until resolved. Observation on 04/01/24 at 11:03 A.M. revealed a Contact Isolation sign on the door of Resident #332's room. Observation also revealed Physical Therapy Assistant (PTA) #347 and Certified Occupational Therapy Assistant (COTA) #348 were in Resident #332's room without a gown or gloves on. Interview on 04/01/24 at 11:04 A.M. with PTA #347 and COTA #348 confirmed they know they should have had the proper personal protective equipment (PPE) on which was gown and gloves. Both voiced they just seen the resident's friend in the room and went on in without putting any PPE on. Interview on 04/01/24 at 11:06 A.M. with Licensed Practical Nurse (LPN) #236 confirmed Resident #332 was in contact isolation and all staff who enter the room needs to wear a gown and gloves when entering the room and must wash their hands prior to exiting the room. LPN #236 confirmed there was not a physician's order for contact isolation, but there should be and she will take care of that now. Observation on 04/01/24 at 4:24 P.M. revealed State tested Nursing Assistant (STNA) #282 was in Resident #332's room with Resident #332 without PPE of gown or gloves. STNA #282 was touching the bedside table and talking to the resident and resident's friend. STNA #282 exited the room without washing his hands or using hand sanitizer. Interview on 04/01/24 at 4:24 P.M. with STNA #282 confirmed PPE was not worn while in the room with Resident #332 and that he did not wash his hands or use hand sanitizer prior to exiting the room. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Fox Run Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Standard Precautions Policy, dated 08/2022, revealed it is the policy of this facility to use Transmission Based Precautions in addition to Standard Precautions for a resident with documented or suspected infection or colonization with highly transmissible epidemiologically important pathogens for which additional precautions are necessary. Personal protective equipment: Gloves are indicated for all staff and visitors entering the room. Gloves should be changed after having contact with infective material. Hand hygiene is performed before and after removing gloves; after touching potentially contaminated environmental surfaces or items and before caring for another resident. Impervious gowns are worn when entering the room; during procedures and activities likely to generate splashes and sprays of blood, body fluids, secretions or exudates; removed when leaving the room and placed in a plastic bag, tied and labeled with a biohazard label and taken to the laundry room. Hand hygiene is observed after proper disposal of the gown. 44815 2. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of quadriplegia, neuromuscular dysfunction of bladder, and colostomy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had intact cognition and had an indwelling catheter. Review of the physician order dated 04/09/23 revealed Resident #34 had an indwelling catheter. Observation on 04/01/24 at 11:05 A.M. revealed Resident #34's catheter bag was lying on the floor next to her bed. An empty basin was nearby on the floor. Interview on 04/01/24 at 11:05 A.M. with Resident #34 stated her catheter bag was usually kept in the basin on the floor. Resident #34 stated staff were preparing to get her out of bed and must have placed the catheter bag on the floor to prepare Resident #34 to transfer using a mechanical lift. Interview and observation on 04/01/24 at 11:05 A.M. with Licensed Practical Nurse (LPN) #248 confirmed Resident #34's catheter bag was lying on the floor. LPN #248 put on gloves and moved the catheter bag into the basin. Review of the facility policy titled Bowel/Bladder Incontinence Policy/Indwelling Catheter, dated 11/13/17, revealed residents who are incontinent of bowel/bladder receives appropriate treatment and services to prevent urinary tract infections.		

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NAME OF PROVIDER OR SUPPLIER Fox Run Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 11745 Township Road 145 Findlay, OH 45840	
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 44815 Based on observation and staff interview, the facility failed to ensure call lights were installed in every stall in a common restroom. This had the potential to affect 13 ambulatory residents (#5, #9, #15, #17, #21, #37, #47, #48, #59, #66, #67, #75 and #232) who could self-transfer. The facility census was 76. Findings include: Observation on 04/09/24 at approximately 7:30 A.M. revealed two accessible restrooms in the common area of the facility. One was designated for males and one for females. No other signage was posted around the restrooms. The access doors were unable to be locked. Further observation revealed the women's restroom had three stalls. A pull-cord was installed in the largest stall. No pull cord was accessible from the two smaller stalls. No pull cord was in the common bathroom area. Interview on 04/09/24 at 1:48 P.M. with Resident #21 revealed he used the common bathroom during Bingo. Interview on 04/09/24 at 2:00 P.M. with Resident #66 revealed she used the public restroom during group activities and would use whichever stall was available. Interview and observation on 04/09/24 at 2:35 P.M. with Administrator in Training #205 verified the male restroom had no pull light in two of three stalls. Interview and observation on 04/09/24 at 2:53 P.M. with the Administrator and Administrator in Training #205 confirmed no signage was posted outside the public restrooms indicating it was not for resident use. Continued observation and interview inside the women's restroom with the Administrator confirmed the only pull cord installed in the bathroom was in the largest of the three stalls.		