

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Addison Heights Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 Butz Rd Maumee, OH 43537	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742</p> <p>Based on medical record review, staff interview, physician interview and review of facility policy, the facility failed to notify the physician timely of abnormal laboratory (lab) results. This affected one (#19) of three residents reviewed for notification of change. The facility census was 68.</p> <p>Findings include:</p> <p>Review of Resident #19's medical record revealed an admitted [DATE]. Diagnoses included dementia, anxiety, psychotic disorder, hypertension (HTN), unspecified symbolic dysfunctions, hyperosmolality and hypernatremia, chronic kidney disease (CKD) stage 3B, and schizoaffective disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/20/25, revealed a Brief Interview of Mental Status (BIMS) score was unable to be determined due to Resident #19's cognition.</p> <p>Further review of the medical record revealed Resident #19 had routine labs drawn on 01/15/25, including a complete metabolic panel (CMP) and a complete blood count with differential (CBC w/diff). The labs were resultted and reported to the facility on [DATE]. Additional review of the lab report revealed Resident #19 had an elevated sodium level of 156 milliequivalents per liter (mEq/L), with the normal reference range being 136-145 mEq/L. An illegible, handwritten marking was observed on the facility copy of the lab results.</p> <p>Further review of Resident #19's medical record revealed no evidence the physician was notified of the abnormal lab values on 01/15/25.</p> <p>Interview on 03/04/25 at 11:25 A.M. with Medical Director (MD) #185 revealed he was unsure of when he was notified of Resident #19's lab results, stating it had been over one month ago.</p> <p>Interview on 03/04/25 at 2:32 P.M. with the Director of Nursing (DON) revealed Resident #19's labs were collected and resultted on 01/15/25. The DON verified the facility had no evidence MD #185 was notified of the abnormal lab results on 01/15/25. The DON stated the illegible marking on the lab report was MD #185's signature and a date of 01/16/25, when she stated he reviewed the results during rounds at the facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Change in a Resident's Condition or Status, revised November 2015, revealed the nurse supervisor/charge nurse would notify the resident's attending physician or on-call physician when there was a need to alter the resident's medical treatment significantly. This deficiency represents non-compliance investigated under Complaint Number OH00161172.		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>41528</p> <p>Based on observation, resident interview, resident representative interview, staff interview and review of facility policy, the facility failed to ensure the facility was free from pervasive odors. This had the potential to affect all residents in the facility except for 16 (#12, #13, #15, #16, #18, #19, #24, #26, #31, #37, #38, #41, #46, #57, #58, #75) residents identified by the facility as residing on the secured memory care unit. The facility census was 68.</p> <p>Findings include:</p> <p>Observation on 02/19/25 at 9:38 A.M., upon entering the facility, revealed the facility reception area was malodorous.</p> <p>Observation on 02/19/25 at 10:30 A.M. revealed the resident halls, excluding the memory care unit, had a pungent odor. A strong foul odor was noted near the nurses station, with no residents present.</p> <p>Interview on 02/19/25 at 10:35 A.M. with Certified Nursing Assistant (CNA) #148 verified the pungent odor and stated the odor primarily came from the hall where there were residents who declined assistance with care. CNA #148 stated the hall always smelled foul. CNA #148 confirmed the odor was noticeable from the nurses station, which was approximately 20 feet from the resident hall identified.</p> <p>Observation on 02/19/25 at 12:40 P.M. revealed Resident #36 had three family visitors. The visitors were observed covering their noses with their shirts and making groaning sounds.</p> <p>Interview on 02/19/25 at 12:42 P.M. with Resident #36's three family visitors revealed they visited weekly and there was always a foul odor from the front door to the resident's room.</p> <p>Interview on 02/19/25 at 2:55 P.M. with Licensed Practical Nurse (LPN) #127 verified there was a foul odor in the facility, excluding the secured memory care unit.</p> <p>Interview on 02/19/25 at 3:01 P.M. with LPN #125 verified there was a foul odor in the facility that emanated from two resident rooms. LPN #125 stated the odor was recognizable from the hall to the nurses station, with the nurses station being approximately 20 feet from the residents' rooms.</p> <p>Interview on 02/20/25 at 12:05 P.M. with Resident #21 revealed the facility's halls always had a foul odor.</p> <p>Review of the facility policy titled, Homelike Environment, dated February 2021, revealed the facility staff and management maximized, to the extent possible, the characteristics of the facility that reflected a personalized homelike setting including pleasant, neutral scents and minimizes institutional odors.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161393.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742</p> <p>Based on medical record review, staff interview, physician interview, Nephrology Nurse Practitioner (NNP) interview and review of facility policy, the facility failed to ensure the physician provided adequate and timely follow up for resident care needs. This affected one resident (#19) of three residents reviewed for physician services. The facility census was 68.</p> <p>Findings include:</p> <p>Review of Resident #19's medical record revealed and admitted [DATE]. Diagnoses included dementia, anxiety, psychotic disorder, hypertension (HTN), unspecified symbolic dysfunctions, hyperosmolality and hypernatremia, chronic kidney disease (CKD) stage 3B, and schizoaffective disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/20/25, revealed a Brief Interview of Mental Status (BIMS) score was unable to be determined due to Resident #19's cognition.</p> <p>Review of a laboratory (lab) report revealed Resident #19 had a routine complete metabolic panel (CMP) and a complete blood count with differential (CBC w/diff) drawn, resulted, and reported to the facility on [DATE]. The lab results revealed Resident #19 had an abnormal sodium level of 156 milliequivalents per liter (mEq/L), with the normal reference range being 136-145 mEq/L. Further review of the lab report revealed illegible handwriting on the document.</p> <p>Review of a nursing progress note dated 01/20/25 revealed Medical Director (MD) #185 reviewed Resident #19's labs from 01/15/25 and the resident's sodium level was 156. MD #185 wanted the facility to follow up with Resident #19's nephrologist. The nephrology office was closed, the Director of Nursing (DON) and family were notified.</p> <p>Interview on 03/04/25 at 11:16 A.M. with the DON revealed the illegible writing noted on Resident #19's 01/15/25 lab report was MD #185's signature and a date of 01/16/25.</p> <p>Additional review of the medical record revealed no evidence of a physician progress note for 01/16/25.</p> <p>Interview on 03/04/25 at 11:25 A.M. with MD #185 revealed he was unsure of when he reviewed Resident #19's lab results, stating it had been over a month ago. MD #185 stated he was unable to provide any information related to the resident's labs, or subsequent treatment for elevated sodium levels. MD #185 stated he could not confirm if he completed a visit with Resident #19 or reviewed her lab results during rounds at the facility on 01/16/25.</p> <p>Interview on 03/04/25 at 11:46 A.M. with NNP #180 confirmed she was unaware of Resident #19's elevated sodium level until 01/21/25. NNP #180 stated Resident #19's lab values fluctuated so, while she had no immediate concerns, she requested the resident receive additional hydration. NNP #180 stated Resident #19's sodium level at the time of her hospital admission was similar to the labs completed on 01/15/25, with her sodium level being 155 mEq/L and all other lab values at the resident's baseline.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/04/25 at 2:32 P.M. with the DON confirmed Resident #19's labs were drawn and resulted on 01/15/25, showing an elevated sodium level. The DON stated the resident's lab report was placed in MD #185's folder for him to review during in facility rounds on 01/16/25. The DON confirmed MD #185 completed rounds at the facility on 01/16/25 and provided no new orders for Resident #19. The DON further verified the signature and date on the lab report was MD #185's signature with a date of 01/16/25. The DON had no explanation as to why MD #185 reviewed the lab report on 01/16/25 but gave no orders until 01/20/25.</p> <p>Review of the facility policy titled, Physician Services, revised April 2013, revealed the physician would perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161172.</p>		