| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a resident representative was notified of change in condition. This affected one (#79) of three residents reviewed for changes in condition. The facility census was 74. Findings include:Review of the closed medical record for Resident #79 revealed an admission date of 06/27/25 and a discharge date of 02/08/26. Diagnoses included cerebral infarction, Alzheimer's disease, anxiety, and depressive disorder.Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living. Review of a physician order dated 01/22/26 at 10:30 A.M. revealed an order for a STAT left arm x-ray, two views of whole arm, humerus, forearm, and hand for edema.Review of a physician order dated 01/22/26 and 10:30 A.M. revealed to apply ice to the left arm and hand, on 20 minutes and off 20 minutes every two hours as needed for edema for seven days. Review of a nurse's note dated 01/22/26 at 10:45 A.M. revealed the nurse practitioner was notified of left arm edema with new orders for an x-ray of the left humerus, forearm, and hand. All parties were notified of the new orders.Review of a nurse's note dated 01/22/26 at 6:00 P.M. revealed an x-ray of the resident's left arm was completed. The resident had a quiet uneventful day with no signs and symptoms of distress or pain. Ice was applied to left arm and hand as needed.Review of the radiology report dated 01/22/26 with a reported time of 9:54 P.M. revealed the resident had a non-displaced fracture of the distal end of the left radius.Review of a nurses' note dated 01/23/26 at 3:07 P.M. revealed the nurse practitioner reviewed the x-ray results this morning with no new orders.Review of a nurse's note dated 01/27/26 at 12:00 P.M. revealed the nurse practitioner was onsite to evaluate the resident and review abnormal left hand/wrist x-rays results with new orders. Refer to physician orders for details/updates. Further review of the nurse's note revealed all parties were notified.Review of a hospice provider progress note dated 01/27/26 at 4:19 P.M. revealed the resident was showing no signs of discomfort. The resident had an x-ray of the left hand due to swelling and staff reported the x-ray was negative. The resident's hand was slightly swollen but no bruising or edema. Further review of the hospice note revealed a staff person then came in with a splint and placed on resident's left hand and wrist and stated the resident had a radial fracture. The hospice nurse then spoke with the facility nurse and nurse practitioner who noted the resident had a nondisplaced radial fracture likely related to osteoporosis as the resident had not fallen. The facility nurse to update the resident's representative.Review of a physician order dated 01/27/26 at 7:00 P.M. revealed an order for a left extremity wrist/hand splint every shift for left radial fracture. Review of a nurse's note dated 01/29/26 at 10:27 A.M. revealed the hospice nurse notified the resident's family regarding the x-ray results and treatments.Interview on 02/11/26 at 3:11 P.M., Unit Manager Licensed Practical Nurse (UMLPN) #262 revealed the resident had a swollen hand and the nurse practitioner was notified. UMLPN<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #262 verified the resident's x-ray noted a fracture on 01/22/26 and there was no documentation the resident's family was notified of the fracture of the left arm until 01/27/26. Review of the facility policy Change in a Resident's Condition or Status, revised 02/2021, revealed the facility would promptly notify the resident, physician, and resident representative of changes in the resident's medical/mental condition and/or status. The nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number 2726162 and Complaint Number 2732081. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, resident interview, and policy review, the facility failed to ensure there were effective procedures in place to protect the residents' personal belongings. This affected five (#80, #2, #11, #37, and #55) of seven residents reviewed for personal property and missing items. This had the potential to affect all residents except four residents (#6, #52, #64, #75) not receiving facility laundry services. The facility census was 74. Findings include:1. Review of the closed medical record for Resident #80 revealed an admission date of 10/06/26 and a discharge date of 12/31/26. Diagnoses included Alzheimer's disease, type two diabetes mellitus, depressive disorder, anxiety, atrial fibrillation, and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #80's inventory of personal effects form dated 10/06/25 and signed by the resident's representative and facility nurse revealed the resident had hats, pajamas, shoes, slacks, slippers, undershirts, and photographs of family. No quantities were listed. Further review of the inventory sheet revealed no documentation the resident had a recliner chair. Review of a concern form dated 11/12/25 revealed the resident's representative had reported missing clothing items including two pairs of slippers, pajamas, and a shirt. Further review of the concern form revealed the resident's representative came into the facility and went through the no name clothing and found the pajamas, tee shirt, and a few other items. One pair of the resident's slippers were also found. The facility offered to replace the other pair of slippers and the resident's representative declined. The resident's representative was notified to have the facility label clothing before placing the items in the resident's room.Interview on 02/11/26 at 9:03 A.M., Certified Nursing Assistant (CNA) #272 was asked if she was aware of any residents with missing clothing. CNA #272 replied all the residents. CNA #272 revealed laundry does not come back the way you send it down. CNA #272 revealed missing clothing items were reported to the charge nurse. Interview on 02/11/26 at 3:41 P.M. the Administrator revealed Resident #80's representative had picked up the resident's belongings except for the resident's recliner chair. The Administrator verified the recliner chair was not listed on the resident's inventory sheet. 2. Review of the medical record for Resident #2 revealed an admission date of 02/02/26. Diagnoses included Huntington's disease, depressive disorder, and seizures.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed the resident had moderately impaired cognition. The resident required partial to moderate assistance with dressing and transfers. Review of the nurses notes from 02/02/26 through 02/10/26 revealed no documentation of missing items.Review of the concern log from 02/02/26 through 02/10/26 revealed no documentation of missing items for the resident. Review of Resident #2's undated and unsigned inventory of personal effects form revealed the resident had two shirts, one coat, one pair of shoes, two pants, one pair of socks, one cell phone and charger. Interview on 02/10/26 at 3:32 P.M., Resident #2 revealed she had some missing underwear and had reported the missing items to staff and there had been no follow up from staff. Interview on 02/10/26 at 3:48 P.M., Social Worker (SW) #260 revealed if resident clothing was not labeled the staff would bring the clothing to the receptionist at the front desk to get labeled. SW #260 revealed there were two racks of donated clothing and two racks of unlabeled clothing in her office and the racks went out to the lobby on Fridays for the residents to look through. SW #260 revealed the clothing labeling process still needed fine tuning and label manufacturer kept discontinuing the labels. SW #260 revealed in emergencies staff could label clothing with a permanent marker. SW #260 revealed concern forms were filled out for missing items. Interview on<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 02/12/26 at 8:48 A.M., Laundry Account Manager (LAM) #500 revealed she had spoken with the Administrator, Director of Nursing, and the nursing staff about completing the inventory sheets and making sure clothing items were labeled. LAM #500 revealed about 90 percent of the inventory sheets had not been completed and the clothing was not getting labeled. LAM #500 revealed recently the resident inventory sheets had been updated. LAM #500 revealed the nursing assistants were sending clothing down in bags with no names. LAM #500 revealed if a resident was missing a clothing item then staff should be filling out a missing item form. LAM #500 revealed they had not received any missing item forms recently. LAM #500 revealed the process for inventorying, labeling, and tracking missing items was not working. Observation on 02/12/25 at 8:55 A.M. in the facility laundry room revealed there were two large bags of clothing items with no names plus 47 clothing items hanging on a rack with no name labels. LAM #500 verified the clothing items were not labeled. Interview on 02/12/26 at 8:56 A.M., Laundry Staff (LS) #498 revealed the process of keeping track of resident clothing was broken. LS #498 revealed the laundry staff needed to know descriptions of the clothing and clothing sizes which were not being tracked on the inventory sheets. LS #498 also revealed staff should not label clothing items with room numbers because the residents change rooms. LS #498 revealed the front desk staff would label the residents clothing items. LS #498 also revealed when staff used a black marker on dark colored clothing the label could not be seen. LS #498 revealed the staff need to use a metallic color marker on dark clothing. LS #498 revealed she had not received any missing item forms in approximately six months. Interview on 02/12/26 at 9:36 A.M., Receptionist #228 revealed she was not sure who was responsible for labeling resident clothing. Receptionist #228 revealed she had a label maker and iron for resident clothing and opened a drawer to show the label maker. Receptionist #228 revealed the nursing assistants and residents would bring her clothing items to label.Interview on 02/17/26 at 9:02 A.M., the Director of Nursing (DON) revealed upon admission the nursing assistant, the nurse, or a manager would complete an inventory sheet of the resident's belongings. The DON revealed the inventory sheet was also updated when additional belonging come in. The DON revealed the staff tried to catch the important things. The DON revealed the facility had completed an audit and the residents' inventory sheets were all recently updated. The DON revealed family members were educated on labeling the resident's clothing if they were present during the admission. The DON revealed the nursing assistants would also label the clothing. The DON revealed missing items were reported using concern forms for tracking. The DON revealed the social worker had a rack of unlabeled clothing and if the item could be described then they would try and find it. The DON also revealed activities would also bring out unlabeled clothing for the residents to look through. The DON revealed the managers were supposed to ensure the inventory sheets were getting done upon admission. Interview on 02/17/26 at 9:26 A.M., CNA #215 revealed inventory sheets of the resident's belongings were completed upon admission. CNA #215 revealed staff do not indicate the size of the resident's clothing but should include the color of the clothing items. CNA #215 revealed the receptionist up front labeled the resident's clothing. CNA #215 revealed the residents' clothing should not be sent to laundry until labeled. CNA #215 revealed if the resident was missing a clothing item the laundry staff would be notified verbally and they say they would look for it.Interview on 02/17/26 at 11:52 A.M., CNA #332 revealed inventory sheets were completed upon admission. CNA #332 revealed the quantity of each item should be noted on the inventory sheet. CNA #332 revealed items not pre populated on the inventory sheet should be listed under other or in the notes section. CNA #332 revealed they were not required to note the color or size of clothing items. CNA #332 revealed the nurse or the social worker were notified when a resident reported a missing item. CNA #332 revealed when the residents clothing was not<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | labeled then staff should get a permanent marker to label the clothing. CNA #332 also revealed when a resident admits to the facility with soiled clothing then a piece of paper with their name should be placed in the bag before sending the items to laundry. Observation on 02/17/26 at 1:33 P.M., with Assistant Director of Nursing (ADON) #290 revealed Resident #2 had ten shirts, two leggings with no labels, one coat, one pair of pants, two pairs of underwear, one pair of shorts, one wig, one brassiere, one pair of socks, and two shoes. At the time of the observation, Resident #2 revealed she had not received any new items in the past couple weeks. Interview on 02/17/26 at 1:33 P.M., ADON #290 revealed the resident's inventory was probably done on the day of admission. ADON #290 verified the inventory form was not signed or dated, and several clothing items had not been labeled. ADON #290 revealed the form had not included all the resident's clothing items. ADON #290 revealed families would bring in more items and the nursing assistants need to be checking for new items and labeling the new items. ADON #290 revealed no one pays attention to the inventory sheets after admission.3. Review of the medical record for Resident #11 revealed an admission date of 09/17/21. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, schizoaffective disorder, generalized anxiety disorder, bipolar disorder, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision with dressing and partial moderate assistance with footwear. Review of the nurses notes from 12/01/25 through 02/10/26 revealed no documentation of missing items.Review of the concern logs from 10/01/25 through 02/10/26 revealed no documentation of Resident #11 with missing items. Review of Resident #11's inventory of personal effects form dated 01/22/26 and signed by the facility social worker revealed the resident had two canes, a cell phone, charger, tablet, blouses/shirts, two pair of shoes, and slacks. There were no quantities documented except for the canes and the shoes. Interview on 02/11/26 at 1:52 P.M. Resident #11 revealed she was missing a pair of shoes (Crocs), black leggings, black, blue, and grey jogging pants, a sentimental t-shirt of her parents with grease stains, and a blue hoodie with grease stains on the elbow. Resident #11 revealed she had reported the missing items to staff and the staff had not followed back up with her about the missing items. Observation on 02/17/26 at 1:12 P.M., with ADON #290 revealed Resident #11 had six brassieres, one coat, 11 shirts, two sweaters, three dresses, four pants, two pairs of shoes, and one pair of slippers. Interview on 02/17/26 at 1:12 P.M., ADON #290 verified the inventory form was not accurate and had not reflected the numbers of each clothing item at the time the inventory was completed, and staff should be documenting the number of each item. ADON #290 also revealed the resident had clothing items which had not been labeled.4. Review of the medical record for Resident #37 revealed an admission date of 01/25/26. Diagnoses included a fracture of the left femur, hypertension, anxiety, and depressive disorder. Review of the admission MDS dated [DATE] revealed the resident had intact cognition. The resident required substantial/maximal assistance for lower body dressing and applying footwear.Review of the nurses notes from 01/25/26 through 02/10/26 revealed no documentation the resident had missing items.Review of the concern log from 01/25/26 through 02/10/26 revealed no documentation of missing items on the concerns log for the resident. Review of Resident #37's undated and unsigned inventory of personal effects form revealed the resident had one shirt, one coat, one hat, one pair of shoes, one slacks, one cell phone and charger, ten plus pair of socks, a wallet, and a full set of dentures. Interview on 02/11/26 at 2:14 P.M., Resident #37 revealed recently he was missing three pairs of pajamas. Resident #37 revealed he notified the laundry staff and the staff had not followed back up with him.Observation on 02/17/26 at 1:41 P.M. with ADON #290 of Resident #37's clothing items revealed the resident had five pairs of pants, three shirts, three socks, one coat, one pair of<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | work boots, one belt, one sweater, three boxer shorts, socks, and two bags. Most of the resident's clothing was not labeled. Interview on 02/17/26 at 1:41 P.M., ADON #290 revealed she had completed Resident #37's inventory sheet at the time of his admission. ADON #290 verified she had not dated or signed the inventory form. ADON #290 verified the majority of the resident's clothing had not been labeled and were not identified on the inventory form. ADON #290 revealed inventory forms were completed upon admission and clothes brought in by the families after admission had not been added to the inventory form or labeled. ADON #290 revealed there needed to be follow up checks of new items because a lot of residents would not remember to tell staff when family brought in new items needing labeling and added to the inventory form. 5. Review of the medical record for Resident #55 revealed an admission date of 11/11/24. Diagnoses included cerebral infarction, bipolar disorder, and chronic obstructive pulmonary disease.Review of the annual MDS assessment dated [DATE] revealed the resident had intact cognition. The resident was independent with dressing. Review of the nurses notes from 12/01/25 through 02/11/26 revealed no documentation of missing items. Review of the concern log from 10/01/25 through 02/10/26 revealed no documentation of missing items for Resident #55. Review of Resident #55's inventory of personal effects form dated 01/22/26 and signed by therapy staff revealed the resident had a wallet, books, a watch, broken glasses, leather coat, shirts, socks, slacks, two pairs of shoes, a cell phone, and a charger. No item quantities were documented except for the shoes. Interview on 02/12/26 at 10:34 A.M. Resident #55 revealed he was missing a pair of red and black pajama pants and undershorts, brown dress pants, and shirts. Resident #55 revealed he told the aides and the social worker about his missing clothing. Resident #55 revealed staff told him he would need to sort through bags of clothes to look for his missing items. Resident #55 stated he was not going to sort through bags of clothes and should not have to sort through bags of clothes. Resident #55 revealed he had a black marker and was going to start labeling his own clothes.Observation on 02/17/26 at 1:23 P.M., with ADON #290 revealed Resident #55 had six shirts, one sweater, one sweatpants, two unlabeled pants the resident stated he had received at Christmas, one leather coat, three tank tops, four ties, 19 socks, and four hats. Interview on 02/17/26 at 1:23 P.M., ADON #290 verified the resident had unlabeled clothing items and an inaccurate inventory form. ADON #290 revealed staff were not required to put clothing sizes, colors, or descriptions on the inventory form. Observation on 02/18/26 at 7:51 A.M. with Social Worker (SW) #260 revealed four racks of clothing items in her office. Two racks of clothing were labeled with a sign as donated items. Two racks were noted as unlabeled clothing items. Further observation revealed there were 150 clothing items on the two racks of unlabeled clothing. Further observation revealed on the unlabeled clothing rack were black and red flannel pajama pants as described by Resident #55. The surveyor notified SW #260 that Resident #55 had reported missing a pair of black/red pajama pants. Interview on 02/18/26 at 7:56 A.M., Social Worker (SW) #260 revealed she was not aware of what staff should document on the inventory forms. SW #260 revealed missing items should be noted on concerns forms which were outside her office and at the nurse's stations. SW #260 verified she had not had any concern forms regarding missing clothing items for Resident #37, Resident #2, Resident #55, and Resident #11.Interview on 02/18/26 at 9:27 A.M., Resident #22 revealed she was the Resident Council President. Resident #22 revealed the facility had ongoing issues with missing clothing items. Resident #22 revealed resident clothes go to the laundry and all do not get returned. Review of the undated facility policy Personal Property, revealed resident were permitted to retain and use personal possessions, including furniture and clothing, as space permits, unless doing so would infringe on the rights or health and safety of other residents. Resident belongings would be treated with respect by facility staff, regardless of perceived value.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Further review of the policy revealed the residents' personal belonging and clothing would be inventoried and documented upon admission and updated as necessary. The facility would promptly investigate any complaints of misappropriation or mistreatment of resident property. Further review of the policy revealed no guidelines for identifying resident clothing or the procedure for documenting the inventory of personal belongings. Review of the facility policy Lost and Found, revised 01/2008, revealed the facility would assist all personnel and residents in safeguarding their personal property. Resident or family complaints of missing items must be reported to the Director of Nursing. Lost and found records would be maintained for one year. Reports of misappropriation or mistreatment of resident property would be immediately investigated. This deficiency represents non-compliance investigated under Master Complaint Number 2740834 and Complaint Number 2726162. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of facility Self-Reported Incidents (SRIs), staff interview, and policy review, the facility failed to ensure an allegation of misappropriation was timely reported to the state agency. This affected one (#68) of four residents reviewed for abuse, neglect, and misappropriation. The facility census was 74. Findings include:Review of the medical record for Resident #68 revealed an admission date of 10/22/25. Diagnoses included malignant carcinoid tumor of the bronchus and lung, chronic obstructive pulmonary disease, malignant neoplasm of the liver, depressive disorder, neoplasm of the brain, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition.Review of a nurse's note dated 02/14/26 at 11:00 A.M. revealed the resident was in his room going through his belongings. The hospice nurse had arrived to evaluate the resident. The resident was in the hallway with some of his belongings on his rollator saying he was leaving and his accounts were hacked and all his money was stolen. The resident continued to yell and was not redirectable. The hospice nurse, the facility nurse, and the therapy director tried to calm the resident down. The resident shoved his belongings to the ground and stated he was leaving. The resident proceeded to head out of the front doors of the facility with the hospice nurse and a facility nurse following him. The police and emergency medical services were called. The police arrived and the resident was combative with officers. The resident was arrested. The nurse practitioner, the hospice provider, the Administrator, the regional on call, and the Director of Nursing (DON) were notified of the situation. Review of the facility Self-Reported Incidents (SRI) dated through 02/15/26 revealed the facility had not reported the allegation of misappropriation to the stage agency and had not started an investigation for the allegation. Interview on 02/17/26 at 6:31 A.M., the Director of Nursing (DON) revealed the resident had behaviors toward staff and was hallucinating and could not be redirected. The DON revealed the resident had called the sheriff and said his account had been hacked. The DON revealed the resident was combative with an officer, was arrested, and had not yet returned to the facility. Interview on 02/17/26 at 6:45 A.M., the Administrator revealed she was not notified Resident #68 had alleged his accounts were hacked and his money was stolen. Further interview on 02/17/26 at 8:02 A.M., the Administrator verified a self-reported incident had not been submitted to the state agency. The Administrator stated again staff had not reported a hacked account or missing money. The Administrator stated she would have filed an SRI had she been aware. Interview on 02/17/26 at 7:03 A.M., the Assistant Director of Nursing (ADON) #290 revealed on 02/14/26 Resident #68 was having increased aggressive behaviors. ADON #290 revealed the resident had stated his account was hacked and his money was gone. ADON #290 revealed the hospice nurse was present and we were trying to calm the resident down. ADON #290 revealed the police were called and the resident was arrested. ADON #290 revealed she reported the incident and the resident's allegation of his account being hacked and his money being gone to the Administrator, Director of Nursing, and the Regional on call. Review of the facility policy Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, revealed the facility would ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, would be reported within required timeframes per federal and state statutes and regulations. The facility would investigate any allegation made alleging abuse, neglect, exploitation of residents, and misappropriation of resident property. This deficiency represents non-compliance investigated under Complaint Number 2726162. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366041 | A. Building<br>B. Wing | 02/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Addison Heights Health and Rehabilitation Center | 3600 Butz Rd<br>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) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, and policy review, the facility failed to ensure enhanced barriers precautions were implemented per physician orders. This affected one (#18) of three residents reviewed for infection control. The facility identified 14 residents on enhanced barrier precautions (EBPs). The facility census was 74. Findings include:Review of the medical record for Resident #18 revealed an admission date of 02/17/23. Diagnoses included paraplegia, hypertension, neuromuscular dysfunction of the bladder, and stage four pressure ulcers to the right and left hips.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition. The resident had an indwelling urinary catheter, an ostomy, and two stage four pressure ulcers present on admission. Review of the physician orders dated 08/05/25 revealed the resident had orders for enhanced barrier precautions (EBP). Staff were to use gowns and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene, toileting, changing linens, changing briefs, dressing changes, and care of any device (wound, catheter, ostomy) for reducing the spread of infection. Review of Resident #18's care plan revealed the resident required enhanced barrier precautions related to wounds, colonostomy, and an indwelling urinary catheter. Interventions included EBP as ordered for staff, to be worn during high-contact resident care activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assistance with toileting, device care or use and wound care. Observation on 02/18/26 beginning at 1:14 P.M. revealed Resident #18 was in bed. Further observation revealed a sign on the door of the resident's room indicating the resident was on enhanced barrier precautions and staff were to wear a gown and gloves during care. There was a plastic bin outside the room with drawers containing personal protective equipment including gowns. Continued observations revealed Certified Nursing Assistant (CNA) #356 was providing care for the resident. CNA #356 was wearing gloves but was not wearing a gown. CNA #356 first assisted the resident with oral care. CNA #356 then placed a pillowcase on one of the resident's pillows. CNA #356 then repositioned the resident in the bed. CNA #356 then emptied the resident's urinary catheter drainage bag. Interview on 02/18/26 at 1:25 P.M., CNA #356 verified she had provided oral care, repositioned the resident, adjusted the bed linens, and emptied the urinary catheter drainage bag. CNA #356 was asked if the resident was on enhanced barrier precautions. CNA #356 revealed she was unaware if the resident was on EBP. CNA #356 was asked if she saw the sign on the door indicating wearing a gown. CNA #356 revealed nobody was in the habit of wearing a gown when providing care. CNA #356 was asked if she was aware why EBP was important. CNA #356 revealed she was not aware why EBP was needed and further revealed she had not received training on EBP. Interview on 02/18/26 at 1:45 P.M., the Director of Nursing (DON) verified staff should be wearing personal protective equipment (PPE) for residents on EBP during high contact care. Review of the facility policy Enhanced Barrier Precautions, revised 12/2024, revealed enhanced barriers precautions (EBPs) were used to prevent the spread of multi-drug-resistant organisms to residents during high contact resident care activities. EBPs apply when a resident has a wound or indwelling medical devices. EBP's require gown and glove use in addition to standard precautions applied prior to performing high contact resident care activities including dressing, bathing, providing hygiene/grooming, changing briefs/toileting, transferring, bed mobility, changing linens, and device care including urinary catheters. Further review of the policy revealed staff were trained prior to caring for residents on EBPs. Signs posted on the door or wall outside the residents' rooms would communicate the type of precautions and PPE required. This deficiency represents non-compliance investigated under Complaint Number 2726162. |