

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365737	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Heatherdowns Rehab & Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Cass Rd Toledo, OH 43614	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451</p> <p>Based on medical record review, resident interview, staff interview and review of facility policy the facility failed to ensure residents were repositioned in bed in a safe manner to prevent falls. This affected one resident (#11) of three residents reviewed for falls. The facility census was 77.</p> <p>Findings include:</p> <p>Review of Resident #11's medical record revealed an admitted [DATE]. Diagnoses included paraplegia, chronic osteomyelitis, stage four pressure ulcer of sacral region, stage four pressure ulcer of right buttock, depression, insomnia, and osteoarthritis.</p> <p>Review of Resident #11's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #11 was cognitively intact. Resident #11 required extensive assistance with bed mobility and was totally dependent on staff for transfers and toilet use. Resident #11 displayed no behaviors during the review period.</p> <p>Review of Resident #11's care plan revised 11/20/24 revealed supports and interventions for nutritional problem, insomnia, potential for alteration in comfort, self-care deficit, and risks for alteration in mood and behaviors and falls Fall interventions included anticipate and meet my needs, ensure call light was within reach, encourage use of call light, turning and repositioning with two caregivers (11/20/24), and follow the fall protocol.</p> <p>Review of Resident #11's Fall Risk Evaluations revealed on 11/11/24 Resident #11 scored a three indicating Resident #11 was at risk for falls. Resident #11 had no falls in the last three months and was alert and orientated. Resident #11 required the use of assistive devices and was incontinent which increased his risk for falls.</p> <p>Review of Resident #11's Fall Risk Evaluation completed 11/21/24 revealed a fall risk score of nine indicating Resident #11 was at a higher risk for falls. Resident #11 had one to two falls in the last three months, was alert and orientated, and continued to be incontinent and required the use of assistive devices.</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #11's post fall evaluation dated 11/20/24 revealed Resident #11 had a witnessed fall in his room. It was noted Resident #11 was being assisted by the aide when he lost his balance. Resident #11 was lowered to the floor by the help of the bar that was on the bed. Resident #11, in bed, was being assisted by the aide, and when the aide turned him to his right side, Resident #11 lost his balance and was lowered to the floor using the bar on the bed. Resident #11's vitals were taken and were within normal limits. Resident #11 reported no pain and had no observed injuries. Notifications were made and Resident #11's care plan was updated to include a two person assist.</p> <p>Review of the Resident #11's fall investigation dated 11/20/24 revealed Resident #11 had a witnessed fall in his room. It was noted Resident #11 was being taken care of by the aide. The aide was turning Resident #11 on his right side when his weak leg gave out on him. Resident #11 was able to grab hold of the bar on the side of the bed and slide himself down to the floor. It was noted Resident #11 was paralyzed and his legs went over the side of the bed. Resident #11 was assessed and no injuries were observed at the time of the incident. Notifications were made.</p> <p>Review of Resident #11's progress notes revealed on 11/22/24 the facility's Interdisciplinary Team (IDT) met and discussed Resident #11's fall that occurred on 11/20/24 at 9:16 P.M. The Certified Nursing Assistant (CNA) was providing care to Resident #11 when the fall occurred. Resident #11 was rolled onto his right side and his feet went over too far on the bed. Resident #11 was able to lower himself to the floor by holding onto the enabler bars. Resident #11 was assessed for injuries none were noted at the time. Resident #11 was assisted up from the floor back into the bed. Upon further evaluation it was noted Resident #11 had no control from waist down due to being a paraplegic. Due to Resident #11's paraplegia diagnosis he required additional assistance with bed mobility. A new fall intervention was implemented for bed mobility to be performed with two caregivers at all times.</p> <p>Interview on 12/31/24 at 9:00 A.M. with CNA #112 revealed Resident #11 required assistance with bed mobility and transfer. CNA #112 reported one person assistance was required for Resident #11 being repositioned and being provided care in the bed and two staff were needed for transfer. CNA #112 reported Resident #11 was cooperative with care. CNA #112 reported she was not working at the time of Resident #11's fall but reported she had been informed Resident #11 was receiving care and fell off the side of the bed. CNA #112 stated she was not aware of what care was being provided but was aware the CNA who was providing care was currently off on maternity leave.</p> <p>Interview on 12/31/24 at 9:06 A.M. with Resident #11 found him to be alert and aware. Resident #11 reported the CNA assisted him into the bed and was turning him to provide incontinence care. Resident #11 reported CNA had not made sure he was positioned properly in the bed and when he was turned, he was too far to the side of the bed. Resident #11 stated when the CNA flopped his leg over for him to be turned, he rolled right out of the bed toward the window. Resident #11 reported he hung on to his mobility bar and was able to hold himself up, so he didn't fall all the way down, but stated it was the CNA who was responsible for him rolling out of bed. Resident #11 also reported the aides continued to provide repositioning and care with one staff other than when he was transferred using the mechanical lift device (Hoyer). Resident #11 reported two staff assisted him with transfer in the lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/31/24 at 10:17 A.M. with the Director of Nursing (DON) revealed the CNA who was witness to Resident #11's fall on 11/20/24 was no longer working. The DON reported she had taken her statement during the fall review. The CNA reported she had been providing care to Resident #11, who was paraplegic, when the momentum of his top leg being moved over his bottom leg caused Resident #11 to go over the side of the bed. The DON verified Resident #11 went over the side of the bed and had caught himself using his mobility bar so he did not fall to the floor. The DON reported Resident #11 then lowered himself to the floor and was transferred back to bed by two staff using a mechanical lift device (Hoyer). Resident #11 was examined and had no injuries at the time.</p> <p>Follow up interview on 12/31/24 at 10:37 A.M. with the DON verified Resident #11 had been documented as being repositioned 63 times in the last thirty days by one staff person when he should have been repositioned by two staff.</p> <p>Review of the facility policy titled, Managing Falls and Fall Risk, revised August 2024 revealed the facility would identify interventions related to the resident's risk and try to prevent the resident from falling.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160604.</p>		