

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 09/18/2025
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)
F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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<p>F 0627</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff, resident, health insurance provider and waiver service provider interviews, review of an Emergency Medical Services (EMS) run report, review of hospital documents, and review of facility policy, the facility failed to ensure a safe resident discharge to home. This resulted in Actual Harm on 07/24/25 at approximately 10:44 A.M. when Resident #62, who was dependent on others for care and required the use of a mechanical lift for transfers, was discharged to home without the needed equipment and services to meet her care needs. Subsequently, Resident #62 remained in a standard wheelchair for approximately six hours without any care provided, including incontinence care, resulting in the development of a pressure ulcer. This affected one (#62) of three residents reviewed for discharge. The facility census was 82. Findings include: Review of the medical record revealed Resident #62 was admitted on [DATE], left for a therapeutic leave on 07/24/25, and returned to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, muscle weakness, schizophrenia, acute respiratory failure with hypoxia, chronic atrial fibrillation, essential hypertension, Type II diabetes mellitus, and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment, dated 05/29/25, revealed Resident #62 was cognitively intact and dependent on staff assistance for toileting, lower body dressing, applying footwear, and transfers. Review of the physician orders, dated 05/23/25, revealed Resident #62 had an order for oxygen at two liters per minute (lpm) via nasal cannula, wean as tolerated, every shift. Review of the care plan, dated 07/07/25, revealed Resident #62 was at risk/had an activities of daily living (ADL) self-performance deficit due to deconditioning/weakness and was dependent for transfers. Review of a weekly skin assessment, dated 07/20/25, revealed Resident #62 did not have a pressure ulcer. There was no evidence that Resident #62 had any skin conditions on the coccyx or buttock area. Review of the Discharge summary, dated [DATE], revealed Resident #62 had a planned discharge scheduled for 07/23/25. The summary stated the resident needed physical assistance of two people to complete ADL care, and total care for incontinence of bowel and bladder. Resident #62 made progress in therapy by increasing sitting tolerance when sitting up in a Broda chair (specialized wheelchair to promote proper posture and reduce falls and skin breakdown) to engage in daily activities. A follow-up appointment with the resident's primary care physician (PCP) was scheduled for 08/05/25. Resident #62 required home health services (HHS). Physical therapy (PT) and occupational therapy (OT) were recommended, and a referral was made for HHS. Durable medical equipment (DME) was documented as not required. Review of an EMS run report, dated 07/24/25 at 5:26 P. M., revealed Resident #62's case worker requested a check on the resident after she had been discharged from an extended care facility that day. On arrival, Resident #62 was sitting in a wheelchair. The resident was conscious, alert, and oriented. Vitals were obtained and within normal ranges. The resident stated that she had to go to the hospital because she could not get around her apartment and could not care for herself. EMS services attempted to assist Resident #62 back to bed, but she could not even stand on her own. Resident #62 was transported to the emergency room (ER). Review of the hospital records, dated 07/24/25, revealed the case worker called to report concern for Resident #62's safety after being discharged (from a skilled nursing facility [SNF]) to her home residence earlier today. It was reported that the resident's husband was also ill and unable to care for himself. Resident #62 reported shortness of breath (SOB) and reported improvement after receiving a breathing treatment. The resident reported pain involved bilateral chest pain and pain on her buttocks. An open wound on her coccyx and the anterior, proximal right upper leg were identified and present upon admission [to the ER]. The resident's brief was saturated with urine. Concerns related to home care were identified. Resident #62 discharged from the hospital back to the facility. Review of a weekly skin assessment, dated 07/25/25, revealed Resident #62 had a rash on the chest, groin, and left buttock. The left buttock area measured 0.7 centimeters (cm) by 0.5 cm. Review of the weekly wound assessment, dated 07/29/25, revealed Resident #62 had a stage three left buttock pressure ulcer measuring 0.6 cm by 0.5 cm by 0.2 cm. During an interview on 09/15/25 at 4:25 P.M. with the Director of Nursing (DON) verified Resident #62 was discharged home without oxygen, no working hospital bed, and no Hoyer lift, all of which were needed to provide care for the resident. The DON verified Resident #62's husband was ill and unable to provide needed care for the resident at home. During an interview on 09/16/25 at 8:10 A M</p>		