

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  11/26/2025
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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interview, review of facility policy, and review of the Certified Nursing Assistant (CNA) procedure regulations, the facility failed to ensure urinary catheter care was completed per approved procedures. This affected one (#26) of three residents reviewed for urinary catheters. The facility identified six residents (#1, #9, #19, #26, #36, and #78) that utilized urinary catheters. The facility census was 78. Findings include: Review of the medical record for Resident #26 revealed an admission date of 11/21/25. Diagnoses included urinary tract infection (UTI), urine retention, and hydronephrosis (blockage in the urinary system that causes back up of urine in the kidney). Review of the admission assessment dated [DATE] revealed Resident #26 was cognitively intact. Review of the October 2025 physician orders revealed Resident #26 had orders for a urinary catheter, 16 French (Fr) (size of the catheter) with a 10 milliliter (ml) balloon (the balloon holds the catheter into position for drainage) and urinary catheter care every shift and as needed. Review of the care plan, initiated 11/25/25, revealed Resident #26 was care planned for a urinary catheter. Interventions included to maintain universal precautions when providing care. Observation on 11/25/25 at 1:26 P.M. of catheter care provided for Resident #26 by Certified Nursing Assistant (CNA) #320 revealed CNA #320 donned Personal Protective Equipment (PPE), placed a barrier under the graduated cylinder, proceeded to empty the contents of the urinary drainage bag into the graduated cylinder, wiped the tip of the spout of the catheter bag with a wet wash cloth, and then placed the tip of the spout back into the holder. Interview on 11/25/25 at 1:33 P.M. with CNA #320 verified the procedure for cleaning the urinary bag spout was to use an alcohol pad. CNA #320 confirmed she did not clean the urinary bag spout with an alcohol pad and used soap and water. Interview on 11/26/25 at 7:42 A.M. with the Director of Nursing (DON) revealed she started education this morning on catheter care with all nursing staff and stated the aides were all aware of the requirement (to clean the spout with an alcohol pad). Review of the facility policy titled, Catheter Care, revised April 2025, revealed staff were to use standard infection control standards when handling or manipulating the drainage system (urinary catheter). Review of a facility resource document titled, Ohio State Tested Nursing Assistant (STNA, also known as CNA) Procedure Regulations, undated, revealed once the urinary bag was empty, clamp the tube and wipe the spout with an alcohol wipe. This deficiency represents non-compliance investigated under Complaint Number 2666853.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 365737	If continuation sheet Page 1 of 1