

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/13/2026
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of personnel files, staff interview and policy review, the facility failed to implement their policy to ensure all newly hired staff were checked on the nurse aide registry (NAR) to verify eligibility for employment prior to working with residents. This had the potential to affect all residents in the facility. The facility census was 82. Findings include: Review of the personnel file for the Administrator revealed a hire date of 03/09/26. Further review revealed no evidence the Administrator was checked on the NAR for findings of abuse, neglect, exploitation, or misappropriation of property prior to working in the facility. Interview on 07/08/26 at 4:30 P.M. with Human Resources Director (HRD) #268 revealed she performed NAR registry checks for Certified Nursing Assistants (CNA) prior to interviewing them for employment at the facility. HRD #268 stated she did not perform NAR checks for any other applicants at the facility, including administrative staff, dietary, housekeeping, and maintenance. HRD #268 stated she believed the NAR was checked through the corporation's outsourced comprehensive background check. HRD #268 stated the facility began using the outsourced company approximately one year ago. A follow-up interview on 07/09/26 at approximately 8:00 A.M. with HRD #268 revealed 37 non-CNA staff had been hired since 06/05/25 and had background checks completed by the outsourced company. HRD #268 verified the 37 staff were not checked on the NAR for findings of abuse, neglect, exploitation, or misappropriation of personal property and currently worked at the facility. Interview on 07/09/26 at 9:46 A.M. with [NAME] #288, and a review of the list of staff hired since 06/05/25, confirmed [NAME] #286, [NAME] #287, Dietary Aide (DA) #279, DA #280, DA #282, DA #284, and DA #285 were all hired after the date the outsourced company began completing the facility's background checks and went in resident areas in the facility. A follow-up interview on 07/09/26 at approximately 11:00 A.M. with HRD #268, and review of an electronic mail (e-mail) dated 06/05/25, revealed the facility began using the outsourced company for background checks beginning on 06/05/25. Review of the facility provided list of staff hired, excluding CNAs, since 06/05/25 revealed 37 staff, including the Administrator, the Director of Nursing (DON), Housekeeping Supervisor (HS) #269, Social Services Director (SSD) #231, Minimum Data Set Coordinator (MDSC) #246, Admissions Director (AD) #292, Medical Records Clerk (MRC) #244, Maintenance Technician (MT) #248, Registered Nurse (RN) #232, RN #234, RN #235, RN #236, RN #237, RN #240, RN #241, Licensed Practical Nurse (LPN) #252, LPN #254, LPN #257, LPN #258, LPN #259, LPN #260, LPN #261, LPN #262, LPN #263, LPN #264, Housekeeping Aide (HA) #270, HA #271, HA #274, HA #275, [NAME] #286, [NAME] #287, DA #279, DA #280, DA #282, DA #284, and DA #285. Review of the undated facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, revealed it was the facility's policy to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks and to screen prospective residents for appropriateness of admission. Additionally, the facility would do the following prior to hiring a new employee: check the nurse aide registry (and attempt to (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	check other state registries if the individual was known to have worked in another state) for all potential new employees (licensed and unlicensed) and new volunteers to determine if there was a finding of abuse, neglect or misappropriation of property against the individual prior to the use of that individual. This was an incidental finding discovered during the complaint investigation.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, resident interview, staff interview and policy review, the facility failed to ensure the main dining room floor was free of debris and refuse at the time of meal service. This affected five (#10, #25, #57, #82, and #89) of five residents reviewed for homelike environment. The facility census was 82. Findings include: Observation on 07/07/26 at 11:01 A.M. revealed residents in the main dining room gathering for the noon meal. On the floor were pieces of toast crust, two ketchup packets, two sugar packets, an irregularly shaped yellowish dried substance approximately three inches in diameter, and white paper debris on the floor throughout the main dining room. A follow-up observation on 07/07/26 at 11:17 A.M. revealed the main dining room floor remained littered with debris. Resident #57 was seated at a table in his wheelchair. Resident #57 asked the surveyor, Did you look at the floor? Concurrent interview with Resident #57 revealed the debris on the main dining room floor bothered him. Additional interviews with residents seated in the main dining room, including Resident #82, Resident #25, Resident #10, and Resident #89, revealed the debris on the floor bothered them. Additional observations on 07/07/26 between 11:17 A.M. and 11:28 A.M. revealed residents continued to enter the dining room and seat themselves around tables. Continued observation on 07/07/26 at 11:28 A.M. revealed Dietary Aide (DA) #281 was serving fruit and beverages to residents in the main dining room. Concurrent interview with DA #281 confirmed the main dining room floor was littered with paper and food debris. DA #281 stated dietary staff was not responsible for cleaning the floors between meals. DA #281 stated this was not the first time she had observed the floor being dirty during meal service. DA #281 stated she had not reported concerns regarding the main dining room floor because she did not know who to report it to. Interview on 07/07/26 at 11:30 A.M., an concurrent observation of the main dining room, with the Administrator confirmed there was food and paper debris on the floor throughout the room. The Administrator confirmed it was not a homelike environment. Interview on 07/09/26 at 3:43 P.M. with Environmental Services Supervisor (ESS) #269 confirmed it was the housekeeping department's responsibility to clean the main dining room floor between meals. Review of the facility policy titled, Quality of Life - Homelike Environment, revised May 2017, revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included: clean, sanitary and orderly environment. This deficiency represents non-compliance investigated under Complaint Number 3030546 and Complaint Number 3026897.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and policy review, the facility failed to prepare meals in a sanitary manner. This had the potential to affect all residents, except one (#97), identified by the facility as receiving no food by mouth. Furthermore, the facility failed to ensure meal trays were transported in a sanitary manner. This affected 30 (#30, #47, #48, #49, #51, #52, #53, #54, #55, #56, #58, #59, #60, #61, #63, #66, #68, #69, #70, #72, #74, #77, #78, #79, #81, #83, #84, #86, #88 and #90) residents whose meal trays were transported on the North Hall Tray Cart (NHTC). Lastly, the facility failed to ensure foods were prepared and served at appropriate temperatures to prevent foodborne illness. This had the potential to affect all residents, except one (#97), identified by the facility as being NPCO. The facility census was 82. Findings include: 1. Observation on 07/06/26 at 7:45 A.M. of breakfast preparation revealed [NAME] #288 donned gloves, applied oven mitts applied over the gloves, removed a tray of eggs from the oven and set it on the preparation table, removed the oven mitts from the gloved hands, checked the temperature of the eggs with a thermometer, placed the tray of eggs on the steam table, and removed the gloves. Further observation revealed [NAME] #288 removed butter from the refrigerator and then donned new gloves without performing hand hygiene. [NAME] #288 held the butter in one hand while using a knife with the other hand to cut butter onto the griddle. Without removing the gloves, [NAME] #288 picked up a large frying pan and set it on the stove. [NAME] #288 then picked up the butter and knife and cut more pieces of butter onto the griddle. [NAME] #288 then walk to preparation area, opened a bag of bread with the same gloves on, grabbed approximately five slices of bread, set the slices of bread on the griddle, grabbed an additional five slices of bread from the bag and set them on the griddle. [NAME] #288 then removed the gloves. Concurrent interview with [NAME] #288 verified hand hygiene was not performed between glove changes and further confirmed multiple non-food surfaces were touched with the same gloves that were used to touch the bread. Review of the facility policy titled, Sanitation and Food Safety, dated 07/07/23, revealed hands should be washed immediately before engaging in food preparation including working with exposed food, clean equipment or service utensils. Additionally, hands should be washed during food preparation as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. Review of the facility policy titled, Standard Precautions, dated August 2025 revealed staff were to perform hand hygiene after removing personal protective equipment (PPE), including gloves. 2. Observation on 07/06/26 at 12:28 P.M. revealed staff were passing lunch meal trays down the North Hall from a kitchen cart that did not have doors. Further observation revealed 11 meal trays inside the food cart that had desert in an uncovered bowl. Continued observation revealed Certified Nursing Assistant (CNA) #300 removed a tray containing an uncovered desert bowl and walked down the hallway to deliver the food tray to a resident's room. Interview on 07/06/26 at 12:33 P.M. with CNA #300 verified there were no doors on the cart containing resident meal trays, exposing any uncovered foods as they were transported from the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen to the hall. Further interview with CNA #300 confirmed the desert bowls were uncovered. CNA #300 confirmed the 30 residents who had meal trays on the NHTC. 3. Observation during the noon meal service on 07/07/26, beginning at 12:00 P.M., revealed a metal cart filled with resident meal trays leaving the kitchen. An uncovered bowl of mandarin oranges was on each resident's tray. There were no doors on the cart. Five additional resident trays were placed on an open cart (no sides) with uncovered mandarin oranges. Continued observation revealed the carts were transported from the kitchen and through the lobby near the front door to the North Hall. During transport, a lid fell off one of the resident's plates and landed on the floor at the beginning of North Hall. Staff began passing trays to residents who were eating in their rooms. Interview on 07/07/26 at 12:05 P.M. with CNA #223 confirmed the mandarin oranges were uncovered on the carts. A follow-up interview on 07/07/26 at 12:10 P.M. with CNA #223 revealed Resident #30's plate was without a lid after it fell at the beginning of the hallway. Concurrent observation revealed CNA #223 poured some juice into a glass, placed it on Resident #30's tray, carried it down the rest of the North Hall, turned right at the nurses' station, walked through the assisted dining room, filled with residents, through the activity room, past the South Hall nurses station, and turned down the South Hall to provide Resident #30 with the meal tray. Subsequent interview with CNA #223 on 07/07/26 at 12:14 P.M. confirmed she carried Resident #30's uncovered plate, fruit, and beverage through the halls and past common areas before providing it to Resident #30. Continued observations on 07/07/26 between 12:26 P.M. and 12:35 P.M. revealed CNA #218 and CNA #203 carrying trays from the North Hall to the assisted dining room with uncovered servings of mandarin oranges. Interview on 07/09/26 at approximately 2:00 P.M. with CNA #203 confirmed four (#53, #63, #78 and #79) resident meals trays were on the NHTC with uncovered mandarin oranges and were transported through the North Hall to the assisting dining room. Review of the undated facility policy, Dining Room Service & Using Tray Service revealed no guidance regarding covering of food during transport from the kitchen to other areas of the facility. 4. Observation on 07/07/26 at 11:01 A.M. revealed [NAME] #286 taking temperatures of food for the noon meal. [NAME] #286 obtained a temperature of 125 degrees Fahrenheit (F) for the mashed potatoes. Concurrent interview with [NAME] #286 revealed the mashed potatoes were instant and stated she used the hottest tap water mixed with instant mashed potato flakes to prepare the mashed potatoes. [NAME] #286 stated she did not heat the water or the mashed potatoes on the stove. [NAME] #286 stated the mashed potatoes normally had a higher temperature and asked the Surveyor if they should be reheated on the stove. [NAME] #286 stated the turkey for the meal was still in the oven. Further observation revealed the snap peas had a temperature of 145 degrees F. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/07/26 at 11:20 A.M. with [NAME] #286 revealed the turkey was 147 degrees F. [NAME] #286 stated she had reheated the mashed potatoes on the stove burner and rechecked the temperature, obtaining a temperature of 126 degrees F. [NAME] #286 proceeded to serve the noon meal. Observation 07/08/26 at 9:56 A.M. of the box of instant mashed potatoes, with the Administrator, revealed the directions were to mix boiling water with the mashed potato flakes and stir. Review of the facility's recipes for the noon meal served on 07/07/26 revealed the turkey should have been heated to 165 degrees F. Review of the recipe for green peas indicated the peas should be steamed for four to six minutes or until tender and held at 140 degrees F or above for service. Review of the recipe for mashed potatoes revealed instant potatoes should be prepared according to package directions. Review of the facility's undated policy titled, Food Temperatures, revealed hot food should be cooked to a minimum temperature or greater for product of 165 degrees F. Food that was not cooked to the correct temperature was returned to the heating element until temperature was reached. Food should be held at 135 degrees F throughout the service process. This deficiency represents non-compliance investigated under Complaint Numbers 3030331, 3030546 and 3026897.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview, family interview, local police department (LPD) interview, review of the LPD report, review of the facility initiated Self-Reported Incident (SRI), review of the facility's investigation and review of facility policy, the facility failed to ensure residents were free from misappropriation. This affected one (#92) of five residents reviewed for misappropriation. The facility census was 82. Findings include: Review of the closed medical record for Resident #92 revealed an admission date of 10/29/25. Diagnoses included acute respiratory failure with hypoxia, congestive heart failure, end stage renal disease, and bipolar disorder. Resident #92 discharged to the hospital on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/04/26, revealed Resident #92 had intact cognition. Review of Resident #92's nursing progress notes dated 12/04/25 through 02/12/26 revealed no documentation of missing personal items. Review of a Grievance/Complaint Report, dated 12/02/26, revealed Resident #92 reported his sister brought him a blank money order in the amount of \$450.00 to pay his rent. Resident #92 stated he put it in his wallet but did not remember if he took it out later to fill it out and now he was unable to find it. Review of a Grievance/Complaint Report, dated 12/05/26, revealed the Administrator spoke with Resident #92, who believed the missing money order was taken. Review of the facility's SRI, number (#) 268265 and initiated on 12/05/25, revealed Resident #92 reported a missing money order in the amount of \$450.00. Further review revealed the facility concluded there was no evidence the money order was taken by staff. A report was filed with the LPD, and the money order company was notified to put a stop on cashing the money order. The SRI was closed on 12/11/25. The Ohio Department of Health (ODH) requested the facility complete an addendum if the money order was cashed or if any additional information was received from the LPD, with the facility acknowledging and agreeing to complete an addendum if either of those things occurred. Further review of the SRI revealed the facility did not submit an addendum to the investigation. Review of the LPD report, dated 12/05/25, revealed a theft report was filed. The report stated Resident #92's sister provided him with a money order for \$450.00 on Monday, 12/01/25, and he put it in his wallet, which he kept on his tray at bedside. Resident #92 noticed Tuesday morning, 12/02/25, that it was missing. The resident notified staff, who searched his room thinking it may have been thrown away. It was not found, making them believe it may have been taken but it was unknown by who at the time of the report. Review of the facility's investigation file revealed evidence staff were interviewed regarding the missing money order, with each denying any knowledge of it. Further review revealed a copy of the police report dated 12/05/25. Also, the investigation file included a copy of the cashed money order that was made payable to Former Employee (FE) #400. The posted clearing date of the money order was 12/11/25. The file contained no additional information regarding the date the cashed money order was provided to the facility, the date the police were contacted regarding the cashed money order, the date the police came to the facility to get a copy of the cashed money order, who from the LPD came to the facility, or the results of the police visit. Further review revealed no evidence the facility reopened their investigation once a copy of the cashed money order was received that showed it was made payable to FE #400. Interview on 07/07/26 at 3:01 P.M. with the Administrator revealed SRI #268265 was reported by Former Administrator (FA) #305 and additional investigation was completed by Interim Administrator (IA) #298. A telephone interview on 07/08/26 at 9:18 A.M. with IA #298 revealed he worked in the facility in approximately February 2026. IA #298 stated Resident #92's missing money order was reported by a previous administrator in December 2025, and the (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation was closed out due to lack of evidence. Further interview revealed Resident #92's family member brought in a copy of the cashed money order to IA #298. IA #298 stated he notified the LPD and the police came to the facility and met with him. IA #298 stated he provided a copy of the cashed money order to the LPD, and the police officer provided him with a business card. IA #298 further stated the police officer stated they were familiar with the person who cashed the money order and IA #298 stated the police took it from there. IA #298 confirmed the facility did not investigate further once the identity of the individual who cashed the money order was known. IA #298 stated, to my knowledge there was no connection between the individual who cashed the money order and a current facility staff. Interview on 07/08/26 at 10:28 A.M. with Human Resources Director (HRD) #268 revealed Resident #92's missing money order was discussed during a morning meeting at the facility. HRD #268 stated, to her knowledge, the missing money order did not involve facility employees. HRD #268 stated there was speculation that there was a romantic relationship between FE #400 and current Licensed Practical Nurse (LPN) #320. HRD #268 stated she was not aware of LPN #320 being questioned about the money order and IA #298 and the previous Director of Nursing (DON) stated the facility would not be investigating because the LPD would be investigating. Interview on 07/08/26 at 12:29 P.M. with the Administrator revealed the individual who cashed Resident #92's money order was the boyfriend of an aide, but she did not know who the aide was. The Administrator stated when she started at the facility, she was told the issue was under investigation by the LPD and the facility was told not to investigate. The Administrator was unable to recall who gave her that information. A telephone interview on 07/08/26 at 12:40 P.M. with Regional Director of Operations (RDO) #450 revealed he knew bits and pieces of the situation regarding Resident #92's missing money order and there was speculation that the person who cashed it was affiliated with a current facility staff member. RDO #450 stated the LPD instructed IA #298 to not alert the staff that they were looking into it. RDO #450 stated, to his knowledge, there was no follow-up from the LPD or additional action taken by the facility. Telephone interviews on 07/08/26 at 12:54 P.M. and 2:52 P.M. with LPD Records Clerk (RC) #315 revealed there was no evidence of a follow-up to the police's initial investigation and report on 12/05/25. RC #315 stated the case was not assigned to a detective. Additionally, RC #315 stated there was no subsequent information when searching for more information under Resident #92's name, under Resident #92's family member's name, or under the name of the person who cashed the money order. RC #315 stated there was no evidence the police returned to the facility in reference to Resident #92's money order after 12/05/25. A follow-up telephone interview on 07/08/26 at 3:00 P.M. with IA #298 revealed he was advised by the police officer, who came to the facility and obtained a copy of the cashed money order, to not pursue any further investigation at the facility. IA #298 stated the police did not want anyone tipped off while the police proceeded with their investigation. IA #298 stated he was awaiting further instructions from the police before taking any additional action. IA #298 stated he provided Resident #92's family's contact information to the police officer and notified Resident #92's family member about providing them the contact information. IA #298 verified he did not speak with or interview any additional staff or take any additional action once the identity of the person who cashed the money order was known. A telephone interview on 07/08/26 at 3:20 P.M. with Resident #92's family member revealed they were never contacted by the police, never received a copy of the police report and did not have the report number regarding the missing money order. Resident #92's family member stated they provided a copy of the cashed money order to IA #298 and received a voicemail from IA #298, who stated he provided her contact information to the police. Resident #92's family member stated she has heard nothing back from either the facility or the LPD. Review of the undated facility policy titled, Abuse, (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Further review revealed to ensure the resident or other residents were protected. If a staff member was accused or suspected, the facility would immediately remove that staff member from the schedule pending outcome of the investigation. Additional review revealed allegations would be investigated and the investigation would be documented in accordance with Quality Assurance Protocols. This deficiency represents non-compliance investigated under Complaint Number 3026897.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of the facility's investigation, staff interview, local police department (LPD) interview, review of the Ohio Department of Health's (ODH) Certification and Licensure (CALS) system and policy review, the facility failed to ensure a complete and thorough investigation into an allegation of misappropriation. This affected one (#92) of five residents reviewed for misappropriation. The facility census was 82. Findings include: Review of the closed medical record for Resident #92 revealed an admission date of 10/29/25. Diagnoses included acute respiratory failure with hypoxia, congestive heart failure, end stage renal disease, and bipolar disorder. Resident #92 discharged to the hospital on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/04/26, revealed Resident #92 had intact cognition. Review of Resident #92's nursing progress notes dated 12/04/25 through 02/12/26 revealed no documentation of missing personal items. Review of the facility's SRI, number (#) 268265 and initiated on 12/05/25, revealed Resident #92 reported a missing money order in the amount of \$450.00. Further review revealed the facility concluded there was no evidence the money order was taken by staff. A report was filed with the LPD, and the money order company was notified to put a stop on cashing the money order. The SRI was closed on 12/11/25. The Ohio Department of Health (ODH) requested the facility complete an addendum if the money order was cashed or if any additional information was received from the LPD, with the facility acknowledging and agreeing to complete an addendum if either of those things occurred. Further review of the SRI revealed the facility did not submit an addendum to the investigation. Review of the facility's investigation file revealed evidence staff were interviewed regarding the missing money order, with each denying any knowledge of it. Further review revealed a copy of the police report dated 12/05/25. Also, the investigation file included a copy of the cashed money order that was made payable to Former Employee (FE) #400. The posted clearing date of the money order was 12/11/25. The file contained no additional information regarding the date the cashed money order was provided to the facility, the date the police were contacted regarding the cashed money order, the date the police came to the facility to get a copy of the cashed money order, who from the LPD came to the facility, or the results of the police visit. Further review revealed no evidence the facility reopened their investigation once a copy of the cashed money order was received that showed it was made payable to FE #400. Interview on 07/07/26 at 3:01 P.M. with the Administrator revealed SRI #268265 was reported by Former Administrator (FA) #305 and additional investigation was completed by Interim Administrator (IA) #298. A telephone interview on 07/08/26 at 9:18 A.M. with IA #298 revealed he worked in the facility in approximately February 2026. IA #298 stated Resident #92's missing money order was reported by a previous administrator in December 2025, and the investigation was closed out due to lack of evidence. Further interview revealed Resident #92's family member brought in a copy of the cashed money order to IA #298. IA #298 stated he notified the LPD and the police came to the facility and met with him. IA #298 stated he provided a copy of the cashed money order to the LPD, and the police officer provided him with a business card. IA #298 further stated the police officer stated they were familiar with the person who cashed the money order and IA #298 stated the police took it from there. IA #298 confirmed the facility did not investigate further once the identity of the individual who cashed the money order was known. IA #298 stated, to my knowledge there was no connection between the individual who cashed the money order and a current facility staff. Telephone interviews on 07/08/26 at 12:54 P.M. and 2:52 P.M. with LPD Records Clerk (RC) #315 revealed there was no evidence of a follow-up to the police's initial (continued on next page)		

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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.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation on 12/05/25. RC #315 stated the case was not assigned to a detective. Additionally, RC #315 stated there was no subsequent information when searching for more information under Resident #92's name, under Resident #92's family member's name, or under the name of the person who cashed the money order. RC #315 stated there was no evidence the police returned to the facility in reference to Resident #92's money order after 12/05/25. A follow-up telephone interview on 07/08/26 at 3:00 P.M. with IA #298 revealed he was advised by the police officer, who came to the facility and obtained a copy of the cashed money order, to not pursue any further investigation at the facility. IA #298 stated the police did not want anyone tipped off while the police proceeded with their investigation. IA #298 stated he was awaiting further instructions from the police before taking any additional action. IA #298 stated he provided Resident #92's family's contact information to the police officer and notified Resident #92's family member about providing them the contact information. A telephone interview on 07/08/26 at 3:20 P.M. with Resident #92's family member revealed they were never contacted by the police, never received a copy of the police report and did not have the report number. Resident #92's family member stated they provided a copy of the cashed money order to IA #298 and received a voicemail from IA #298 who stated he provided her contact information to the police. Resident #92's family member stated they called back to the facility and thanked IA #298 for providing the information to the police, and stated the police had not yet made contact with her. Interview on 07/08/26 at 3:40 P.M. with the Administrator revealed she could find the business card for the police officer that IA #298 stated he provided a copy of the cashed money order to. Review of the undated facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property revealed evidence of the investigation should be documented in accordance with Quality Assurance protocols. This deficiency represents non-compliance investigated under Complaint Number 3026897.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on medical record review, staff interview, resident interview and policy review, the facility failed to ensure residents received fortified foods as ordered. This affected one (#41) of one resident identified on fortified foods. The facility census was 82. Findings include: Review of the medical record for Resident #41 revealed an admission date of 09/04/25, with diagnoses of moderate protein-calorie malnutrition, encephalopathy, vitamin D deficiency, muscle wasting and atrophy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/30/26, revealed Resident #41 had intact cognition and was able to eat independently. Review of the physician order dated 09/04/25, and revised on 02/08/26, revealed Resident #41 received a regular diet with fortified foods with all meals; fortified cereal with breakfast and fortified soup or potatoes with lunch and dinner. Review of a nutrition progress note, dated 02/06/26, revealed Resident #41 was identified with a significant weight loss since the previous month. Interventions included fortified food at all meals. Observation during the noon meal service on 07/07/26 revealed no evidence [NAME] #286 prepared any fortified foods. Interview on 07/07/26 at 5:00 P.M. with [NAME] #289, who was serving the evening meal, revealed she was unaware of any residents who required fortified foods, and did not prepare any fortified foods for the evening meal. Interview on 07/08/26 at 8:15 A.M. with Resident #41 revealed she was worried about her weight. She said the facility offered her nutrition supplements but she did not like them. She said the facility encouraged her to eat more, and said she was able to get extra servings of food when she wanted them. She said she had not heard of fortified foods. Interview on 07/08/26 at 9:56 A.M. with [NAME] #288 revealed no residents in the facility had an order for fortified foods and she was not serving any fortified foods. A telephone interview on 07/08/26 at 2:34 P.M. with Registered Dietitian (RD) #310 revealed he began working at the facility at the end of May 2026 and worked 12 hours per week. RD #310 stated fortified foods were foods prepared with extra butter, whole milk, or extra milk, whatever the recipe called for, to add calories to regular foods. RD #310 estimated fortified foods at all meals could provide approximately an additional 200 calories per meal (600 calories per day). RD #310, who was unable to access his computer at the time of the interview, stated he was not aware Resident #41 had a physician order for fortified foods. Review of the facility's undated policy titled, Fortified Food Program Policy, revealed the purpose was to enhance the nutritional intake of the residents through natural consumption of food. This deficiency represents non-compliance investigated under Complaint Number 3030331 and Complaint Number 3026897.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, policy review and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure the use of personal protective equipment (PPE) for residents on contact precautions. This affected two (#13 and #49) of six residents reviewed for infection control. Additionally, the facility failed to ensure appropriate hand hygiene was performed after contact with a resident with Clostridium difficile (C-diff). This affected one (#49) of six residents reviewed for infection control. The facility census was 82. Findings include: Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure with hypoxia, cerebral infarction, and chronic obstructive pulmonary disease. Resident #13 also tested positive for Acinetobacter Baumanni in 03/2026 which the facility is currently in an active outbreak of. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/05/26, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Review of a physician order dated 03/27/26 revealed Resident #13 and an order for contact precautions due to history of multi-drug resistant organism (MDRO). Review of the care plan revised 03/28/26 revealed contact precautions (CP) were to be implemented due to a history of MDRO, Acinetobacter baumannii (drug resistant bacteria). Observation on 07/06/26 at 8:33 A.M. revealed contact precautions signage on the door of Resident #13's room as well as a three-drawer container on the outside of the room containing PPE. The sign stated that providers and staff must put on gloves and a gown prior to room entry. Continued observation revealed Certified Nursing Assistant (CNA) #209 was inside Resident #13's room at the foot of the bed holding onto a bundle of linen. CNA #209 was not wearing PPE Interview on 07/06/26 at 8:33 A.M. with CNA #209 verified that Resident #13 was in contact precautions and she was in the resident's room without PPE. CNA #209 stated she was only delivering a meal tray. CNA #209 asked if PPE needed to be worn to deliver a meal tray. CNA #209 then donned a yellow gown, but no gloves, and re-entered the resident's room. Interview on 07/09/26 at 3:20 P.M. with the Director of Nursing (DON) verified PPE should be worn upon entering the room of a resident on contact precautions, even if just delivering a meal tray. 2. Review of the medical record for Resident #49 revealed an admission date of 06/22/26 with diagnoses of osteomyelitis, multiple sclerosis, and neuromuscular dysfunction of the bladder. Review of the comprehensive admission MDS assessment, dated 06/26/26, revealed Resident #49 had intact cognition. Review of the current physician orders for Resident #49 revealed no order for contact precautions. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed an order dated 07/02/26 for Vancomycin HCl (hydrochloride) oral capsule 125 milligrams (mg), give one capsule by mouth four times a day for C-diff for 37 administrations. Observation on 07/07/26 at 12:08 P.M. revealed contact precautions signage on the door of Resident #49's room and a three-drawer container on the outside of the room containing PPE. The sign stated that providers and staff must put on gloves and a gown prior to room entry. Continued observation revealed CNA #223 carried a lunch tray into Resident #49's room without donning PPE. Concurrent interview with CNA #223 confirmed Resident #49 was in contact precautions. CNA #233 confirmed she did not wear PPE to deliver Resident #49's lunch tray. Observation on 07/09/26 at 10:47 A.M. revealed Human Resources Director (HRD) #268 knocking on Resident #49's closed door. HRD #268 had a cup of coffee from a fast-food restaurant. Further observation revealed HRD #268 entered the resident's room without donning PPEC and placed the cup on Resident #49's overbed table. Concurrent interview with HRD #268 confirmed Resident #49 was in contact precautions and staff were expected to wear PPE prior to entering the room. HRD #268 confirmed she did not wear a gown or gloves prior to entering Resident #49's room. Further observation revealed HRD #268 performed hand hygiene with an alcohol-based hand sanitizer. Continued interview with HRD #268 revealed she was unaware of the reason Resident #49 was in contact precautions. Interview on 07/09/26 at 11:14 A.M. with the DON confirmed Resident #49 was in contact precautions due to a diagnosis of C. diff. Review of the CDC guidelines titled, C.diff. Facts for Clinicians, dated 04/13/26, revealed to wear gloves and a gown when treating patients with C.diff infection, even during short visits. Gloves are important because hand sanitizer does not kill C.diff. Review of the facility policy titled, Standard Precautions, reviewed/revised August 2025, revealed contact precautions were intended to prevent transmission of infections that were spread by direct or indirect contact with the resident or environment and required the use of appropriate PPE, including a gown and gloves upon entering the room. This deficiency represents non-compliance investigated under Complaint Number 3030383.		