STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365737	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heatherdowns Rehab & Residential Care Center	2401 Cass Rd Toledo, OH 43614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure resident dignity was maintained. This affected two (#42 and #43) of two residents reviewed for dignity. The facility census was 71. Findings include: 1. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including dementia, traumatic brain injury, and encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had mild cognitive impairment and was continent of bladder. Review of the current care plan revealed Resident #42 was independent with toileting, required one staff supervision with personal hygiene, and required staff set up assistance for eating and meals. Observation on 02/03/25 at 9:11 A.M. revealed Resident #42 was in bed. Sitting on the overbed table was a urinal full of dark colored urine. Continued observation revealed staff delivered Resident #42's breakfast tray and placed it on the overbed table, next to the full urinal. Concurrent interview with Resident #42 revealed it bothered him that the full urinal was on the table where he ate his breakfast. Interview on 02/03/25 at 9:16 A.M. with Certified Nursing Assistant (CNA) #711 verified Resident #42's the full urinal of dark colored urine and the breakfast tray both sitting the overbed table for Resident #42. 2. Review of the medical record for Resident #43 revealed an admitted [DATE] with a diagnosis of Alzheimer's disease. Review of the annual MDS assessment dated [DATE] revealed Resident #43 was cognitively impaired and dependent on staff for dressing. Review of the current care plan revealed Resident #43 was dependent on staff for dressing. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/03/25 at 9:23 A.M. revealed CNA #654 was sitting at Resident #43's bedside, providing feeding assistance to the resident. Continued observation, which lasted approximately five minutes, revealed Resident #43 was wearing a purple sweatshirt and her left breast was exposed. Further observation revealed Resident #43 was in a semi-private room and her roommate was in bed. The privacy curtain was not pulled between Resident #43 and her roommate and the resident's exposed breast was visible to her roommate. Interview on 02/03/25 at 9:28 A.M. with CNA #654 verified Resident #43's breast was exposed during breakfast and she did not cover her up. Review of the facility policy titled Dignity, revised August 2024, revealed the facility would treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life. The facility would protect and promote the rights of the resident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51529 Based on resident interview, staff interview, medical record review, and review of facility policy, the facility failed to ensure policies and procedures related to reporting and investigating allegations of misappropriation were implemented. This affected one (#16) of three residents reviewed for misappropriation. The facility census was 71. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included: hypertension, hyperlipidemia, chronic kidney disease, gastroesophageal reflux disease (GERD), schizoaffective disorder, psychotic disorder with delusions to own physiological condition, dysphagia, protein calorie malnutrition, muscle wasting, and localized osteoporosis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, revealed Resident #16 was cognitively intact. Interview on 02/03/25 at 12:15 P.M. with Resident #16 revealed the resident reported $2.00 was stolen from her room within the past six months. Resident #16 stated she informed Certified Nursing Assistant (CNA) #614 about the stolen $2.00 but stated no resolution was offered and the money was not returned to her. Interview on 02/03/25 at 2:27 P.M. with the Director of Nursing (DON) revealed she was not aware Resident #16 reported $2.00 had been stolen from her room. Further interview confirmed there was no evidence CNA #614, or any other staff, reported the allegation to administration or that the allegation was investigated. A follow-up interview on 02/03/25 at 5:20 P.M. with the DON revealed, after the survey team reported the allegation of misappropriation, an investigation was initiated. The DON confirmed she verified CNA #614 and Licensed Practical Nurse (LPN) #630 were aware of the allegation and did not report it to administration for investigation. Review of the facility policy titled, Abuse, Neglect and Exploitation, dated 07/01/20, revealed upon hire and annually, staff received education regarding misappropriation including the definition, identification, and the reporting process. Further review revealed alleged violations of misappropriation should be reported to the administrator within 24 hours and the administrator should report final investigation results within five business days.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, medical record review and review of facility policy, the facility failed to provide adequate hygiene assistance for a dependent resident. This affected one (#31) of one resident reviewed for activities of daily living (ADLs) care. The facility census was 71. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses included paraplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, revealed Resident #31 was cognitively intact, was always incontinent of bowel and bladder, and was staff dependent for for toileting and personal hygiene. Review of the current care plan revealed Resident #31 had an ADL self-care deficit related to paraplegia. Interventions included staff assistance with cleaning following toilet use. Interview on 02/03/25 at 9:43 A.M. with Resident #31 revealed he had been incontinent of urine and soaked through his bedding. Resident #31 stated when staff brought in his breakfast, they changed his brief and his chux pad (incontinence pad), but left all of the bedding wet underneath him. Concurrent observation revealed the pad and bottom sheet underneath Resident #31 were wet. The bottom sheet had a yellow stain extending out from under the resident toward the edge of the bed. Interview on 02/03/25 at 9:50 A.M. with Licensed Practical Nurse (LPN) #630 verified the wet pad and bottom sheet, and the yellow stain on the bottom sheet. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, revised August 2024, revealed appropriate care and services would be provided for residents who were unable to carry out ADLs independently in accordance with the care plan, including appropriate support and assistance with elimination (toileting, incontinence care.)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure podiatry needs were met. This affected one (#33) of one resident reviewed for podiatry services. The facility census was 71. Findings include: Review of the medical record revealed Resident #33 was admitted on [DATE]. Diagnoses included acute kidney failure, essential hypertension, bipolar disorder, anxiety disorder, bilateral primary osteoarthritis of hip, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/13/24, revealed Resident #33 was cognitively intact. Interview on 02/03/25 at 4:47 P.M. with Resident #33 revealed her toenails were long and thick with fungus, causing her pain. Resident #33 reported she was unable to trim them herself and staff were aware of the condition of her toenails. Concurrent observation revealed all ten of Resident #33's toenails were long, thick and yellowed. Interview on 02/04/25 at 12:24 P.M. with the Director of Nursing (DON) verified Resident #33's toenails were long and need to be trimmed by a podiatrist. The DON instructed the resident to not attempt to trim them herself and she would schedule her an appointment as soon as possible. Review of policy, Ancillary Services, revised August 2024, verified the facility will assist residents in obtaining prompt podiatry care.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure a medication error rate of less than five percent. Observation of 26 medication administration opportunities revealed two medication errors, resulting in a medication error rate of seven percent. This affected two residents (#1 and #51) of three observed for medication administration. The facility census was 71. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included hypertension (high blood pressure). Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/08/24, revealed Resident #1 was cognitively intact. Review of the current physicians orders for February 2025 revealed Resident #1 was ordered lasix 40 milligrams (mg), give one tablet by mouth one time daily related to essential hypertension. Observation on 02/05/25 at 8:18 A.M. of medication administration for Resident #1 revealed Licensed Practical Nurse (LPN) #668 dispensed and administered lasix 20 mg to the resident. Interview on 02/05/25 at 10:23 A.M. with LPN #668 verified Resident #1's current physician order was for lasix 40 mg and further confirmed she only administered 20 mg of lasix. 2. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included osteoarthritis of the right knee. Review of the quarterly MDS assessment, dated 11/09/24, revealed Resident #51 was cognitively intact and had frequent pain. Review of the current physician orders for February 2025 revealed Resident #1 had an order for Tylenol eight hour arthritis pain oral tablet extended release 650 mg, give two tablets two times a day for osteoarthritis. Observation on 02/05/25 at 7:30 A.M. of medication administration for Resident #51 revealed LPN #634 dispensed and administered Tylenol 500 mg, two tablets, to the resident. Interview on 02/05/25 at 9:54 A.M. with LPN #634 verified Resident #51's current physician order was for Tylenol 650 mg, two tablets, and she administered Tylenol 500 mg, two tablets, to the resident. Review of the undated facility policy titled, Medication Dispensing System, revealed prior to medication administration, verify each medication is the right drug at the right dose, the right route, the right time, and the right customer.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, medical record review and review of facility policy, the facility to label multiuse insulin pens and vials with the date opened to ensure medication integrity. This affected four (#5, #39, #62, and #137) of four residents reviewed for medication storage. The facility census was 71. Findings include: 1. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included diabetes mellitus (DM). Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/09/25, revealed Resident #5 was cognitively impaired. Review of the current physician orders for February 2025 revealed Resident #5 was ordered insulin glargine (Lantus) 35 units at bedtime. 2. Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included DM. Review of the quarterly MDS assessment, dated 12/26/24, revealed Resident #39 was cognitively intact. Review of the current physician orders for February 2025 revealed Resident #39 was ordered Humalog KwikPen (multiuse insulin pen) to be administered per sliding scale (dependent on blood sugar value): blood sugar zero to 150 equaled no insulin; blood sugar 151-200, give two units of insulin; blood sugar 201-250, give four units of insulin; blood sugar 251-300, give six units of insulin; blood sugar 301-350, give eight units of insulin; blood sugar 351-400 give 10 units of insulin; and blood sugar 401-450 give 12 units of insulin and notify the physician. 3. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included DM. Review of the quarterly MDS assessment dated [DATE] revealed Resident #62 was cognitively intact. Review of the current physician orders for February 2025 revealed Resident #62 was ordered insulin glargine 20 units two times daily. 4. Review of the medical record for Resident #137 revealed an admitted [DATE]. Diagnoses included DM. Review of the admission MDS assessment, dated 01/30/25, revealed Resident #137 was cognitively impaired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current physician orders for February 2025 revealed Resident #137 was ordered Humalog Subcutaneous Solution Cartridge (used with a reusable insulin pen), to be administered based on a sliding scale: for blood sugar zero to 150 equaled no insulin; blood sugar 151-200 give one unit of insulin, for blood sugar 201-250 give two units of insulin, for blood sugar 251-300 give three units of insulin, for blood sugar 301-350 give four units of insulin, for blood sugar 351-400 give five units of insulin and notify the physician. Observation on 02/05/25 at 7:30 A.M. of the medication cart on the back north unit revealed an opened, undated Lantus insulin pen for Resident #62, an opened, undated Humalog insulin pen for Resident #137, and an opened, undated Lantus multiuse vial for Resident #5. Interview at the time of the observation with LPN #634 verified the opened and undated insulin pens and insulin vial. Observation on 02/05/25 at 8:50 A.M. of the medication cart on the back south unit revealed an opened, undated Humalog insulin pen for Resident #39. Concurrent interview with Licensed Practical Nurse (LPN) #668 verified the opened, undated Humalog insulin pen for Resident #39. Review of the undated facility policy titled, Medication Storage, revealed medications would be stored in a manner that maintained the integrity of the product, to ensure the safety of the residents, and is in accordance with Ohio Department of Health guidelines.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44815 Based on observation, review of the menu, review of the menu spreadsheet, staff interview and review of the United States Department of Agriculture (USDA) resources, the facility failed to ensure adequate meal portions were served. Additionally, the facility failed to ensure all components of a meal were provided. This had the potential to affect all residents in the facility except one (#137) resident identified by the facility as receiving no nutrition from the kitchen. The facility census was 71. Findings include: Review of the menu for the lunch meal on 02/04/25 revealed residents would be served pork vegetable stir fry, white rice, and wheat bread. Review of the menu spreadsheet for the pork vegetable stir fry revealed the serving portion was a #6 scoop (approximately five and one-third ounces). Further review revealed mechanical soft and pureed diets would be served a #6 scoop of pork chops, instead of the pork and vegetable stir fry. Observation on 02/04/25 at 10:44 A.M. revealed [NAME] #620 pureed six pork chops for six residents on a pureed diet. Observation during meal service on 02/04/25, beginning at 11:30 A.M., revealed [NAME] #620 plating trays for the lunch meal. [NAME] #620 provided residents on a regular diet with a four-ounce scoop of pork vegetable stir fry and a four-ounce scoop of rice. Additional observation revealed [NAME] #620 provided residents on a mechanical soft diet two, two-ounce scoops of mechanical soft pork chops (four-ounces total), a four-ounce scoop of mashed potatoes, and used a slotted spoon to serve broccoli. Further observation revealed [NAME] #620 provided residents on a pureed diet one two-ounce scoop of pureed pork chops, a four-ounce scoop of mashed potatoes and a slotted spoon was used to serve pureed broccoli. Interview on 02/04/25 at approximately 1:00 P.M. with [NAME] #620 confirmed she used a four-ounce scoop for the pork vegetable stir fry, used two two-ounce scoops for mechanical soft pork chops (for a total of a four-ounce serving), and served one two-ounce scoop of pureed pork chops to the six residents on a pureed diet. Continued interview with [NAME] #620, and coinciding observation, confirmed at least two two-ounce scoops of pureed pork chops remained in the pan at the conclusion of meal service. [NAME] #620 further confirmed the slotted spoons used for the broccoli and pureed broccoli were serving utensils with no measurement lines and, therefore, [NAME] #620 could not measure the portion of broccoli provided to residents. Interview on 02/05/25 at 1:25 P.M. with Dietary Manager (DM) #609 confirmed the facility did not provide wheat bread with the lunch meal served on 02/04/25. DM #609 could provide no explanation why the menu was not followed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up interview on 02/06/25 at 11:03 A.M. with DM #609 confirmed the spreadsheet for the lunch meal served on 02/04/25 indicated staff should have used a #6 scoop for the pork vegetable stir fry and the mechanical soft and pureed pork chops. DM #609 was unable to determine the number of ounces in a #6 scoop. Further interview with DM #609 verified residents on a regular diet did not receive an adequate portion of pork vegetable stir fry and residents on a mechanical soft and pureed diets did not receive an adequate portion of pork chops. Review of the USDA Food and Nutrition Service documented titled Food Buying Guide, last updated 09/19/24 and located at https://foodbuyingguide.fns.usda.gov/Home/ResourceCenter#:~:text=Scoops%20(sometimes%20called%20dishers%20or,weight%2C%20use%20a%20scale.), revealed a #6 scoop is 2/3 cup (approximately 5 and 1/3 ounces).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44815 Based on observation, staff interview, review of the dishwasher monitoring logs and review of facility policy, the facility failed to practice proper hand hygiene during meal service. Additionally, the facility failed to label and date food items in the resident refrigerators. Lastly, the facility failed to test and monitor proper sanitation of the dishwasher. This had the potential to affect all residents in the facility except one (#137) resident identified by the facility as receiving no nutrition by mouth. The facility census was 71. Findings include: 1. Observation on 02/03/25 at approximately 12:25 P.M. in the dining room revealed Certified Nursing Assistant (CNA) #611 providing assistance to Resident #237 who stood up from his wheelchair at the table. CNA #611 held Resident #237's arm, put an arm around his waist, and guided him back to his wheelchair. CNA #611 touched Resident #237's wheelchair to return him to the dining table. CNA #611 then walked directly to sit with Resident #18 and picked up silverware and began to assist Resident #18 with eating. Interview on 02/03/25 at 12:28 P.M. with CNA #611 confirmed she did not perform hand hygiene between providing hands-on assistance to Resident #237 and before beginning to feed Resident #18. CNA #611 confirmed she should have performed hand hygiene and identified a hand sanitizer dispenser in the dining room. 2. Observations on 02/04/25 beginning at 11:35 A.M. revealed [NAME] #620 preparing peanut butter and jelly sandwiches for meal service. [NAME] #620 put on disposable gloves, opened a cabinet and removed a loaf of bread. [NAME] #620 opened the loaf of bread, pulled out two slices of bread, opened a drawer and pulled out a knife, then opened the peanut butter jar and the jelly jar wearing the same disposable gloves. [NAME] #620 then picked up one slice of bread and used the knife to spread peanut butter on the piece of bread. [NAME] #620 then wore the same gloves to turn on the faucet and rinse the knife under hot water before she turned off the faucet, shook the water off the knife, and put the knife into the jelly jar. [NAME] #620 picked up the other slice of bread and spread jelly on the piece of bread. [NAME] #620 placed the sandwich into a baggy, then reached into the loaf of bread and took out two additional pieces of bread. [NAME] #620, wearing the same pair of gloves, then returned to the sink, turned on the faucet and rinsed the knife under hot water to remove the jelly. [NAME] #620 turned off the faucet, put the knife into the peanut butter and picked up a slice of bread and spread the peanut butter on it. [NAME] #620 returned to the sink, turned on the faucet, rinse the knife under hot water again, turned off the faucet, put the knife into the jelly jar, picked up the other slice of bread, and spread jelly on it. Interview on 02/04/25 at 11:40 A.M. with [NAME] #620 confirmed she did not wash her hands before donning gloves, touched multiple unsanitary surfaces (the cabinet handle, the drawer handle, and the faucet) with the same pair of gloves she used to touch the ready-to-eat peanut butter and jelly sandwiches. [NAME] #620 further confirmed she did not properly clean or sanitize the knife before putting it into the jelly, back into the peanut butter, or back into the jelly. [NAME] #620 was not aware of any residents with a peanut allergy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additional observation during meal service on 02/04/25 at approximately 12:05 P.M. revealed [NAME] #620, with bare hands, entered the walk-in refrigerator and collected lunch meat and cheese. [NAME] #620 then donned gloves, opened the package of lunch meat, removed the plastic wrap from the cheese, reached into a loaf of bread, pulled out two slices of bread, and began to make a lunch meat and cheese sandwich. Interview with [NAME] #620 confirmed she wore the same pair of gloves while unwrapping the lunch meat and cheese and before touching the bread or preparing the sandwich by picking up individual slices of meat and cheese with the same gloves she used to touch the packaging taken from the walk-in refrigerator. Review of the facility policy titled, Handwashing During Meal Service, reviewed August 2024, revealed nursing and caregiver staff must wash hands before assisting residents with meals, feeding, or helping with personal care during meal times. Additional review revealed hands should be washed after touching potentially contaminated surfaces (for example, door handles and equipment). Further review revealed gloves do not replace handwashing. Hands must be washed before putting on gloves and immediately after removing them and gloves should be changed between tasks. 3. Observation on 02/06/25 at 10:48 A.M. of the North Hall residents' refrigerator revealed food items, which were undated and unlabeled, including an unlabeled leftover container, two bags of unlabeled hard boiled eggs, undated chicken strips on a paper plate, a leftover fast-food bag with no name, undated and unlabeled orange juice, and undated prune juice. Coinciding interview with Medical Records Director (MRD) #666 verified the unlabeled and undated items in the refrigerator. Observation on 02/06/25 at 10:51 A.M. of the South Hall residents' refrigerator revealed unlabeled rice, honey ham dated 01/18/25, an unlabeled grilled cheese sandwich, undated bologna, and an opened jar of undated and unlabeled black eyed peas. Concurrent interview with Licensed Practical Nurse (LPN) #668 confirmed the undated and unlabeled items. Further interview with LPN #668 confirmed items should be labeled and dated and that refrigerators were cleaned out every Monday. Review of the facility policy titled, Food Brought in from Outside Sources and Personal Food Storage, dated 2021, revealed foods and beverages brought in from outside sources that required refrigeration or freezing should be labeled with the patient/resident's name and date. 4. Observation on 02/04/25 at 2:15 P.M. revealed the facility's dishwasher (dish machine) was a low temperature dishwasher (meaning dishes were sanitized with a chlorine solution rather than hot water). Review of the dish machine monitoring logs dated January 2025 and February 2025 revealed staff should document the water temperature and the chlorine concentration in PPM (parts per million). Further review revealed the only documentation on the logs were temperatures. Continued observation, upon request to determine the chlorine concentration, revealed Dietary Manager (DM) #609 retrieved a brand new chlorine test strip container from her desk. DM #609 obtained the chlorine solution concentration three times, after consecutive running of the dish machine. DM #609 confirmed the concentration of the chlorine solution was 10 PPM. DM #609 confirmed the dish machine log indicated the PPM should be at least 50. Further interview at that time with DM #609 revealed she had not yet trained staff on how to use the strips to monitor and document the chlorine concentration of the dish machine and confirmed the dish machine logs for January 2025 and February 2025 only reflected water temperatures, not chlorine concentration, and there was no evidence the chlorine levels were monitored to ensure adequate sanitization. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365737	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heatherdowns Rehab & Residential Care Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Dish Machine Temperature/Sanitizer Records, revised August 2008, revealed all employees shall be trained on the appropriate method of completing the Low Temperature Dish Machine log.

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	365737	A. Building B. Wing	02/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure open wounds were covered during food preparation and meal service. This had the potential to affect all residents, except one (#137) resident identified by the facility as receiving no food from the kitchen. Additionally, the facility failed to ensure appropriate hand hygiene during wound care. This affected one (#53) of one resident reviewed for wound care. The facility census was 71. Findings include: 1. Observation during meal preparation and service on 02/04/25, beginning at approximately 11:45 A.M., revealed [NAME] #620 was not wearing disposable gloves and prepared to portion cooked broccoli to puree. Continued observation revealed [NAME] #620's right hand was actively bleeding and blood was on the serving utensil being used to portion the broccoli. Concurrent interview with [NAME] #620 revealed she was aware she had cut her hand but did not realize she was bleeding. [NAME] #620 proceeded to wash her hands and applied a bandage. [NAME] #620 then returned to the broccoli and began to pick up the handle of the utensil, which had blood on it, to continue with the preparation of pureed broccoli. At this point, the surveyor intervened and [NAME] #620 removed the utensil from service, washed her hands, donned disposable gloves and used a new utensil to portion the broccoli. Further observation during the lunch meal service on 02/04/25 at 12:11 P.M. revealed [NAME] #620 portioning prepared salad from a large pan onto a dinner plate using tongs in her right hand. [NAME] #620 was not wearing disposable gloves and her right hand had a bandage covering the area previously observed bleeding during preparation of pureed broccoli. Interview with [NAME] #620 confirmed the bandage covering her thumb was not covered by a disposable glove while she plated food. Review of the undated facility policy titled, Personal Hygiene revealed employees with open sores shall wear appropriate personal protective equipment. 47057 2. Review of the medical record for Resident #53 revealed and admitted [DATE]. Diagnoses included Alzheimer's disease and fractured acetabulum (part of the hip joint). Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/14/25, revealed Resident #53 was cognitively impaired and had an unhealed pressure ulcer. Review of the current physician orders for February 2025 for Resident #53 revealed he had an order for wound care to the left heel to cleanse with wound cleaner, pat dry, apply skin prep to peri wound, apply silver alginate, and cover with a border foam. Review of the current care plan revealed Resident #53 had care plan interventions for skin alterations to the left heel, which included heel protective boots. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of wound care on 02/05/25 at 9:35 A.M., provided by Licensed Practical Nurse (LPN) #662, revealed LPN #662 donned gloves to remove the old, soiled dressing from Resident #53's left heel and discarded the dressing. Without removing or changing her gloves, LPN #662 obtained wound cleaner and cleansed the resident's left heel wound. LPN #662 then, without removing or changing her gloves, obtained the new treatment supplies, including silver alginate and new, clean border foam and applied the new dressing to Resident #53's left heel wound. Interview on 02/05/25 at 9:51 A.M. with LPN #662 verified she did not change her gloves between removing the old, soiled dressing, cleansing Resident #53's heel wound, and applying the new, clean dressing. Review of the facility policy titled, Wound Care, revised August 2024, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Procedure steps included: don gloves, loosen tape, remove dressing and discard, wash and dry hands thoroughly, put on gloves, cleanse the wound, and apply the treatment as ordered. Review of the facility policy titled, Standard Precautions, revised August 2024, revealed staff must perform hand hygiene before performing an aseptic task, after contact with blood, body fluids, visibly contaminated surfaces, or after contact with objects in the resident's room.