

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 145 Olive St Akron, OH 44310	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy, the facility failed to ensure the physician and resident's responsible party were notified when lab draws were not completed according to the physician/certified nurse practitioner (CNP) orders. This affected one (Resident #66) of three residents reviewed for notification. The facility census was 111.</p> <p>Findings include:</p> <p>Record review for Resident #66 revealed an admission date of 04/01/24. Diagnoses included vascular dementia, cerebral infarction, personal history of transient ischemic attack (TIA), and acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was severely cognitively impaired.</p> <p>Review of the care plan dated 04/13/24 revealed Resident #66 had a cerebral vascular accident (CVA/Stroke) related to embolism. Interventions included administering medications as ordered by the physician.</p> <p>Review of the Pharmacy Medical Record Review dated 04/16/25 completed by Consultant Pharmacist #610 revealed Resident #66 was currently receiving Eliquis (blood thinner) 5 milligrams (mg) two times a day (BID). Although the resident's age and weight supported a 5 mg BID dose, renal function may not. Creatinine clearance was estimated to be between 15-29 milliliters per minute (ml/min) for which there was evidence to suggest a 2.5 mg BID dose should be considered. Physician Response documented on the Pharmacy Medical Record Review dated 04/23/25 completed by CNP #516 revealed an order for a complete metabolic panel (CMP), complete blood count (CBC), and renal function panel.</p> <p>Medical Record Review for Resident #66 revealed the CMP, CBC, and renal function panel ordered 04/23/25 was not available in the medical record and there was no documented evidence available in the medical record to indicate why the ordered labs were not completed.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/05/25 at 8:48 A.M. with Assistant Director of Nursing (ADON) #429 revealed the order for Resident #66 for a CMP, CBC, and renal function panel was ordered 04/23/25. The lab was scheduled to complete the blood draw on 05/02/25. Review of the lab requisition for Resident #66 dated 05/02/25 revealed the blood specimen was not collected, Resident (#66) was combative/refused. No qualified personnel were available. The reschedule date/signature on the lab requisition was left blank. ADON #429 revealed the lab tech came to the facility on [DATE] (untimed) and attempted to draw Resident #66's blood for the ordered labs. Resident #66 refused. The lab tech should have gone to the floor nurse and the floor nurse would go with the lab tech and attempt to obtain the lab. This never occurred so the nurse was not aware the lab was not obtained and did not document the lab was not completed or reattempted. The labs orders were not followed up on, and there was no documented evidence that the physician/CNP and responsible party were notified.</p> <p>Review of the undated facility policy titled, Notification of Changes revealed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there was a change requiring such notification. Circumstances requiring notification include circumstances that require a need to alter treatment.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to ensure residents had a safe, clean, homelike environment. This affected two (Residents #3 and #6) reviewed for their bedroom environment and had the potential to affect an additional 78 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #11, #12, #13, #14, #17, #18, #20, #21, #22, #23, #24, #26, #27, #28, #29, #30, #32, #33, #34, #37, #38, #39, #40, #41, #42, #44, #45, #47, #49, #50, #52, #53, #56, #58, #59, #60, #61, #62, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #77, #78, #82, #85, #86, #87, #88, #89, #90, #91, #92, #93, #96, #97, #103, #104, #112, #211, #212, #213, and #311) residing on the second and third floor of the facility. The facility census was 111.</p> <p>Findings include:</p> <p>1. Record review for Resident #3 revealed an admission date of 07/03/24. Diagnosis included Alzheimer's disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was moderately cognitively impaired. Resident #3 required set up/clean up assistance with meals, toileting hygiene, bathing and personal hygiene.</p> <p>Observation on 06/02/25 at 8:58 A.M. revealed Resident #3 was resting in bed. Resident #3's closet door had a broken panel, the floor was covered with potato chip crumbs and other food crumbs, a buildup of dirt and grime throughout, toilet paper, and soiled clothing. The bedside table had a thick buildup of dust. There were dried spills of colored liquids on the arm and leg of the table. The bedside stand had a thick buildup of dust. The privacy curtain was pink with the bottom half discolored from dirt, food and liquid spills. The window curtains were soiled with multiple dried spills and dust buildup. The air conditioner unit had multiple dried spills, and a thick dirt/dust buildup. The dresser had multiple dried spills, and the bottom drawer was broken and unusable. The bathroom had a foul odor. There was dried stool on the inside of the toilet bowl and on the lid. The floor and sink had a large amount of dirt and grime buildup. Resident #3 stated, No one cleans. Licensed Practical Nurse (LPN) #458 confirmed each identified concern at the time of the observation.</p> <p>2. Record review for Resident #6 revealed an admission date of 03/05/20. Diagnoses included attention deficit hyperactivity disorder (ADHA) and dementia.</p> <p>Review of the annual MDS assessment dated [DATE] revealed Resident #6 was severely cognitively impaired. Resident #6 required set up or clean up assistance with eating and bathing.</p> <p>Observation on 06/02/25 at 9:18 A.M. revealed Resident #6 was lying in bed. The top dresser drawer was broken and unusable. There were multiple dried liquid spills down the front of the dresser. The air conditioning unit had multiple dried liquid spills and dust/grime buildup. The window curtain was soiled and dangling from the rod. The recliner had multiple stains and dried spills. There was a large brown substance on the seat of the chair. The footboard of the bed was broken and unsecured.</p> <p>Observation and interview on 06/02/25 at 9:24 A.M. with LPN #429 of Resident #6's room confirmed each identified item. LPN #429 revealed, I see it dirty every day.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/05/25 at 8:05 A.M. with Housekeeper #442 revealed rooms were cleaned daily. The facility only deep cleaned rooms if a major mess. Housekeeper #442 revealed he had been doing housekeeping at the facility for nine months, and they never clean the edges of floors to remove buildup.</p> <p>Interview on 06/05/25 at 8:19 A.M. with Lead Housekeeper #436 revealed there was no schedule or routine cleaning for wall or privacy curtains.</p> <p>Observation on 06/05/25 at 8:22 A.M. with Certified Nursing Assistant (CNA)/Scheduler #420 of the shower room on the second floor revealed the shower stall ceiling had a large brown/gray area that appeared wet. The floors were very dirty throughout with thick scum buildup that was worse on all edges and corners. The bedside commode had rusted peeling legs. CNA #420 confirmed residents used the bedside commode. The floor around the toilet bowl had scum/grime buildup. The ceiling in the corner near the linen had a large brown/black area and the paint was peeling large strips. CNA #420 revealed all residents on the second floor used the shower room.</p> <p>Observation on 06/05/25 at 8:28 A.M. with Housekeeper #442 verified the condition of the shower room and shower room ceiling. Housekeeper #442 revealed the shower room ceilings had been in the same condition since he started working at the facility nine months ago and revealed the black on the ceiling was mold.</p> <p>3. Observation of the third-floor resident's lounge revealed two sitting chairs that were very worn with material that was ripped on the arms and the seats of the chairs.</p> <p>Interview on 06/05/25 at 10:34 A.M. with Maintenance Director #422 verified the chairs were very worn. He agreed he would not have those in his own home.</p> <p>Review of the undated facility policy titled Safe and Homelike Environment revealed the environment was defined as any area frequented by the residents. Staff were to report any furniture in disarray to maintenance and report any unresolved environmental concerns to the Administrator. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.</p> <p>The deficiency represents noncompliance investigated under Master Complaint Number OH00165919 and Complaint Numbers OH00163815 and OH00163417.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, self-reported incident (SRI) review, interview and facility policy review, the facility failed to prevent resident-to-resident between Residents #48 and #214. This affected two (Residents #48 and #214) of four residents reviewed for abuse. The facility census was 111.</p> <p>Findings Include:</p> <p>1. Resident #48 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes, heart disease, major depressive disorder, post-traumatic stress disorder (PTSD), a left below the knee amputation, and an internal cardiac defibrillator.</p> <p>Review of the comprehensive quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was cognitively intact, refused aspects of care daily, and needed no assistance with personal care.</p> <p>Review of SRI tracking number 260710, dated 05/21/25, filed with the State agency for an allegation of physical abuse. Resident #48 and Resident #214 were in the facility's lobby waiting for the elevator after a smoke break. Too many residents attempted to get on the elevator at the same time, and Resident #214 attempted to pull a female resident in a wheelchair out of the elevator so he could get his own wheelchair on the elevator. Resident #48 attempted to stop Resident #214 from removing the female, and Resident #214 swung and hit Resident #48. Resident #48 hit Resident #214 back and both residents ended up on the floor hitting each other. Staff separated the two residents, and both residents were placed on one-to-one supervision. Another staff member called the police, and Resident #214 was transported to a local hospital by the police after Nurse Practitioner (NP) #517 wrote an order for a mandatory psychiatric admission. The Administrator went to the hospital to give Resident #214 an immediate discharge notice due to being a threat to himself, other residents, and staff. Resident #214 refused to see the Administrator, so the discharge notice was sent to him by certified mail. Resident #214 signed himself out of the hospital against medical advice (AMA) and returned to the facility. The police were called again and escorted the resident from the property. Review of the SRI revealed the facility did not list any witnesses to the incident nor any perpetrator. The facility unsubstantiated the allegation of abuse.</p> <p>Interview with the Administrator on 06/04/25 at 4:00 P.M. revealed the facility did not substantiate the allegation of abuse as they were unable to determine who started the resident-to-resident altercation.</p> <p>Review of the nurse's notes revealed on 05/21/25 at 11:59 P.M. Licensed Practical Nurse (LPN) #454 documented Resident #48 attempted to stop Resident #214 from attempting to remove a female resident in a wheelchair from the elevator so he could go to his room first. Resident #214 then swung his fist at Resident #48 and both residents fell out of their wheelchairs and continued their altercation on the floor. On 05/22/25 at 7:10 A.M. Licensed Social Worker (LSW) #419 met with Resident #48 to provide psychosocial-emotional support. The resident said he had no concerns or distress after the previous night's altercation with Resident #214.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #214 was admitted to the facility on [DATE] with diagnoses including paraplegia and male erectile dysfunction. He was discharged from the facility and sent for an involuntary psychiatric admission on [DATE] where he was given an immediate discharge from the facility.</p> <p>Review of the comprehensive admission MDS dated [DATE] revealed Resident #214 was cognitively intact. The resident had numerous behaviors including physical aggression towards others four to six times during the seven-day assessment period. He was also verbally aggressive on a daily basis. Resident #214's behaviors significantly interfered with the resident's care and participation in daily activities. His behaviors put others at significant risk of physical injury, significantly intruded on other residents' privacy and daily activities, and significantly disrupted care and the living environment. He rejected care daily.</p> <p>Review of the progress notes from admission through discharge for Resident #214 revealed he was physically aggressive, verbally threatening, and disrespectful of other residents and staff daily. The resident refused counseling with the psychiatric services and refused to take his medication. He frequently requested pain medication which was not ordered for him. When staff were working with others, Resident #214 would interrupt and insist his needs be dealt with immediately.</p> <p>Review of Resident #214's care plans revealed the resident had behaviors of aggression, attacking staff, trapping staff in rooms, anger, and foul language.</p> <p>Interview with the Administrator on 06/04/25 at 4:00 P.M. revealed despite Resident #214's continuous verbal threats and physical aggression, they did not place him on the secured unit as he was his own responsible party and he refused to agree to be placed on the secured unit. The facility was going to present him with a behavior contract at his care plan conference which was scheduled for the day the resident was discharged to the psychiatric unit of a local hospital. The Administrator said she took an immediate discharge notice to the hospital to present it to him, but he refused to see her and called security to have her removed from the hospital. They sent the immediate discharge notice to him via certified mail. The Administrator said a few days later, Resident #214 returned to the facility after leaving the hospital AMA demanding to be allowed to return. The police were called and again escorted the resident off facility grounds.</p> <p>Interview with the Administrator on 06/09/25 at 2:00 P.M. revealed there was a hearing on Resident #214's immediate discharge appeal, and they maybe should have admitted the resident to the secured unit due to his behaviors towards residents and staff.</p> <p>Review of the facility's undated Abuse, Neglect and Exploitation policy revealed the facility must protect the residents from abuse. The Quality Assessment and Performance Improvement (QAPI) committee will review the risk factors that contributed to the abuse (a history of aggressive behaviors, environmental factors) and if there is a need for further systemic action such as tracking patterns of similar occurrences.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to report an allegation of resident-to-resident sexual abuse to the State agency for one (Resident #58) of four residents reviewed for abuse. The facility census was 111.</p> <p>Findings include:</p> <p>Resident #58 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, major depression disorder, schizophrenia, high blood pressure, and mood disorder.</p> <p>Review of the comprehensive annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was severely cognitively impaired, had delusions, and had behaviors which significantly interfered with the resident's care and social interaction, significantly intruded on the privacy or activities of others, and had behaviors that significantly disrupted the living environment.</p> <p>Review of the nursing progress notes for Resident #58 revealed on 05/28/25 at 10:56 A.M. Nurse Practitioner (NP) #517, who is the facility's psychiatric NP, evaluated the resident. Resident #58 reported to NP #517 that she lifted her shirt up and a peer touched her breast. The resident denied being assaulted in any fashion.</p> <p>Interview with the Administrator on 06/04/25 at 2:00 P.M. revealed she was unaware of NP #517's evaluation as neither the nurse or NP #517 said anything to her about the allegation of sexual abuse, so it had not been reported to the State agency, had not been investigated, and Resident #58's guardian was not notified.</p> <p>A self-reported incident (SRI) was filed by the facility to the State agency on 06/06/25 at 10:12 A.M.</p> <p>Review of the facility's undated Abuse, Neglect and Exploitation policy revealed the facility must report all allegations of abuse to the State agency, the police if required, and investigate while keeping the resident safe from further abuse.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163815.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, self-reported incident (SRI) review and policy review, the facility failed to thoroughly investigate allegations of abuse. This affected four (Residents #48, #50, #58, #214) of four residents reviewed for abuse. The facility census was 111.</p> <p>Findings include:</p> <p>1. Resident #48 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, heart disease, major depressive disorder, post-traumatic stress disorder (PTSD), left below the knee amputation, and an internal cardiac defibrillator.</p> <p>Review of the comprehensive quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was cognitively intact, refused aspects of care daily, and needed no assistance with personal care.</p> <p>Review of SRI tracking number 260710, dated 05/21/25, was filed with the State agency for an allegation of physical abuse. Resident #48 and Resident #214 were in the facility's lobby waiting for the elevator after a smoke break. Too many residents attempted to get on the elevator at the same time, and Resident #214 attempted to pull a female resident in a wheelchair out of the elevator so he could get his own wheelchair on the elevator. Resident #48 attempted to stop Resident #214 from removing the female, and Resident #214 swung and hit Resident #48. Resident #48 hit Resident #214 back and both residents ended up on the floor hitting each other. Staff separated the two residents and both residents were placed on one-to-one supervision. Another staff member called the police, and Resident #214 was transported to a local hospital by the police after Nurse Practitioner (NP) #517 wrote an order for a mandatory psychiatric admission. The Administrator went to the hospital to give Resident #214 an immediate discharge notice due to being a threat to himself, other residents, and staff. Resident #214 refused to see the Administrator, so the discharge notice was sent to him by certified mail. Resident #214 signed himself out of the hospital against medical advice (AMA) and returned to the facility. The police were called again and escorted the resident from the property. Review of the SRI revealed the facility did not list any witnesses to the incident nor any perpetrator. The facility unsubstantiated the allegation of abuse.</p> <p>Interview with the Administrator on 06/04/25 at 4:00 P.M. revealed the facility did not substantiate the allegation of abuse as they were unable to determine who started the resident-to-resident altercation.</p> <p>Review of the nurse's notes revealed on 05/21/25 at 11:59 P.M. Licensed Practical Nurse (LPN) #454 documented Resident #48 attempted to stop Resident #214 from attempting to remove a female resident in a wheelchair from the elevator so he could go to his room first. Resident #214 then swung his fist at Resident #48 and both residents fell out of their wheelchairs and continued their altercation on the floor. On 05/22/25 at 7:10 A.M. Licensed Social Worker (LSW) #419 met with Resident #48 to provide psychosocial-emotional support. The resident said he had no concerns or distress after the previous night's altercation with Resident #214.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #214 was admitted to the facility on [DATE] with diagnoses including paraplegia and male erectile dysfunction. He was discharged from the facility and sent for an involuntary psychiatric admission on [DATE] where he was given an immediate discharge from the facility.</p> <p>Review of the comprehensive admission MDS assessment dated [DATE] revealed Resident #214 was cognitively intact. The resident had numerous behaviors including physical aggression towards others four to six times during the seven-day assessment period. He was also verbally aggressive daily. Resident #214's behaviors significantly interfered with the resident's care and participation in daily activities. His behaviors put others at significant risk of physical injury, significantly intruded on other residents' privacy and daily activities, and significantly disrupted care and the living environment. He rejected care daily.</p> <p>Review of the progress notes from admission through discharge for Resident #214 revealed he was physically aggressive, verbally threatening, and disrespectful of other residents and staff daily. The resident refused counseling with the psychiatric services and refused to take his medication. He frequently requested pain medication which was not ordered for him. When staff were working with others, Resident #214 would interrupt and insist his needs be dealt with immediately.</p> <p>Review of Resident #214's care plans revealed the resident had behaviors of aggression, attacking staff, trapping staff in rooms, anger and foul language.</p> <p>Interview with the Administrator on 06/04/25 at 4:00 P.M. revealed despite Resident #214's continuous verbal threats and physical aggression, they did not place him on the secured unit as he was his own responsible party, and he refused to agree to be placed on the secured unit. The Administrator said she took an immediate discharge notice to the hospital to present it to him, but he refused to see her and called security to have her removed from the hospital. The facility sent the immediate discharge notice to him via certified mail. The Administrator said a few days later, Resident #214 returned to the facility after leaving the hospital against medical advice demanding to be allowed to return. The police were called and again escorted the resident off facility grounds.</p> <p>Interview with the Administrator on 06/09/25 at 2:00 P.M. revealed there was a hearing on Resident #214's immediate discharge appeal, and they maybe should have admitted the resident to the secured unit due to his behaviors towards residents and staff and to protect the residents from Resident #214.</p> <p>Review of the facility's undated Abuse, Neglect and Exploitation policy revealed the facility must protect the residents from abuse. The Quality Assessment and Performance Improvement (QAPI) committee will review the risk factors that contributed to the abuse (a history of aggressive behaviors, environmental factors) and if there is a need for further systemic action such as tracking patterns of similar occurrences. The facility must protect the residents from further abuse.</p> <p>2. Resident #50 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, major depressive disorder, convulsions, panic disorder, vascular dementia with mood disturbance, high blood pressure, traumatic brain injury (TBI), and anxiety disorder.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the comprehensive annual MDS assessment dated [DATE] revealed Resident #50 was moderately cognitively impaired, had behaviors which significantly interfered with the resident's participation in activities or social interactions, behaviors which significantly intrude on the privacy or activity of others, and rejected care daily.</p> <p>Review of the progress notes for Resident #50 revealed on 04/03/25 at 5:42 P.M. the resident made sexually explicit comments toward LSW #419. On 04/11/25 at 5:15 P.M. LPN #452 documented that Resident #50 became irritate with another resident on the unit and attempted to hit him. Staff separated the residents and talked to Resident #50 until he was calmer. Staff kept the two residents apart for the rest of the shift. On 04/24/25 at 12:51 P.M. LPN #515 documented that Resident #50 was waiting for a smoke break and became agitated with an activity staff member and threw his cigarette and towel at the staff member. LPN #515 attempted to redirect the resident to his room, and he grabbed the wall railing and punched the wall three times. Assistant Director of Nursing (ADON) #429 also responded and notified psychiatric Nurse Practitioner (NP) #517 who ordered the antipsychotic medication Haldol to be administered every 12 hours intramuscularly (IM) as needed for aggressive behavior. On 05/13/25 at 1:51 P.M. the Director of Nursing (DON) documented Resident #50 was separated and emotional support was given.</p> <p>Interview with the Administrator on 06/06/25 at 1:00 P.M. revealed the facility did not file an SRI for the incident which occurred on 05/13/25. The Administrator said LPN #515 documented the incident incorrectly in the nurses' notes.</p> <p>Review of the facility's Physical Aggression Report dated 05/13/25 indicated the incident occurred at 12:30 P. M. LPN #515 authored the report. Resident #50 was sitting in his wheelchair in front of the elevator waiting for smoke break. Resident #6 was also at the elevator waiting for smoke break and accidentally spit on Resident #50 while he was talking. Resident #50 believed Resident #6 spit on him on purpose. Resident #50 became angry and pursued Resident #6, grabbed his shirt and attempted to punch him. Resident #50 was removed from the area by a nurse who explained Resident #6 did not purposefully spit on him. Staff kept Residents #50 and #6 apart from each other for the rest of the shift. The staff took the residents down for smoke break in two separate groups with Resident #50 in one group and Resident #6 in the other. The predisposing situational factors of the incident were listed as a resident-to-resident altercation in which physical contact was made. The Administrator interviewed Resident #50 on 05/13/25 who said he thought Resident #6 had spit on him on purpose, but the nurse spoke with him and he now thinks it was not on purpose. The only documentation on the incident was the DON documenting the residents were separated and all parties made aware. Both residents lived on the same floor.</p> <p>Review of the facility's undated Abuse, Neglect and Exploitation policy revealed all allegations of abuse must be investigated and the resident must be protected from abuse during the investigation.</p> <p>3. Resident #58 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, major depression disorder, schizophrenia, high blood pressure, and mood disorder.</p> <p>Review of the comprehensive annual MDS dated [DATE] revealed Resident #58 was severely cognitively impaired, has delusions, and had behaviors which significantly interfere with the resident's care and social interaction, they significantly intrude on the privacy or activity of others, and behaviors that significantly disrupt the living environment.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the nursing progress notes for Resident #58 revealed on 05/28/25 at 10:56 A.M. NP #517, who is the facility's psychiatric nurse practitioner, evaluated the resident. The resident reported to NP #517 that she lifted her shirt up, and a peer touched her breast. The resident denied being assaulted in any fashion.</p> <p>Interview with the Administrator on 06/04/25 at 2:00 P.M. revealed she was unaware of NP #517's evaluation and staff did not inform her about the allegation of sexual abuse, so it had not been investigated.</p> <p>Review of the facility's undated Abuse, Neglect and Exploitation policy revealed the facility revealed all allegations of abuse must be investigated and the resident protected during the investigation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163815.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of facility policies, the facility failed to ensure comprehensive care plans were in place relative to residents' medical, psychosocial and mental needs. This affected five (Residents #6, #46, #69, #102 and #107) out of 37 resident records reviewed. The facility census was 111.</p> <p>Findings include:</p> <p>1. Review of Resident #107's medical record revealed an admission date of 04/08/25 with diagnoses including malignant neoplasm of prostate, chronic obstructive pulmonary disease, anxiety and hypertension.</p> <p>Review of an admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #107 was cognitively intact and receiving hospice services. Oxygen was not coded on the MDS assessment.</p> <p>Review of Resident #107's care plans as of 06/02/25 revealed no plan of care was in place for the use of oxygen.</p> <p>Observation on 06/02/25 at 2:00 P.M. revealed Resident #107 was up and awake in his bed. Oxygen was in use, and no date was noted on the tubing connected to Resident #107.</p> <p>Follow-up observation on 06/04/25 at 7:58 A.M. of Resident #107 with Licensed Practical Nurse (LPN)/Unit Manager (UM) #416 revealed Resident #107 was lying in bed and his oxygen cannula was in his nose with the oxygen concentrator noted to be in use.</p> <p>Follow-up interview on 06/04/25 at 8:54 A.M. with LPN/UM #416 verified Resident #107 did not have a care plan in place for the use of oxygen, and he should have.</p> <p>Review of the policy, Oxygen Administration, dated 2025, revealed oxygen was administered under the orders of a physician, except in the case of an emergency. The resident's care plan shall identify the interventions for therapy, based on the resident's assessment and orders, such as but not limited to a) the type of oxygen delivery system, b) when to administer, such as continuous or intermittent and/or when to discontinue, c) equipment setting for the prescribed flow rates, d) monitoring of oxygen saturation levels and/or vital signs as ordered and e) monitoring for complications associated with the use of oxygen.</p> <p>2. Review of Resident #102's medical record revealed an admission date of 12/15/24 with diagnoses including bilateral osteoarthritis of hip, muscle weakness, anemia, acute kidney failure, and hypertension.</p> <p>Review of a quarterly MDS assessment dated [DATE] revealed Resident #102 was moderately cognitively intact, was dependent on staff for bathing, required set up for eating and required partial assistance for personal hygiene. Resident #102 received anticoagulant, antiplatelet, anticonvulsant and opioid medications.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #102's physician's orders as of 06/04/25 revealed an order dated 12/15/24 for apixaban oral tablet 5 milligrams (mg) by mouth twice a day for deep vein thrombosis (DVT) and an order dated 12/16/24 for anticoagulant-monitor for side effects (blood in urine/stool, black stool, severe bruising, prolonged nosebleeds, bleeding gums, vomiting/coughing up blood) every shift and complete documentation in progress note if side effects noted.</p> <p>Review of Resident #102's care plans as of 06/04/25 revealed no plan of care in place for his high-risk anticoagulant medication.</p> <p>Interview on 06/04/25 at 5:31 P.M. with the Director of Nursing (DON) verified Resident #102 received anticoagulant medication and monitoring but no plan of care relative to his high-risk medication was in place as required.</p> <p>3. Review of Resident #46's medical record revealed an admission date of 10/09/23 with diagnoses including depression, human immunodeficiency virus (HIV), chronic hepatitis C, insomnia, paraplegia, anxiety, colostomy, post-traumatic stress disorder and neuromuscular dysfunction of bladder.</p> <p>Review of a quarterly MDS assessment dated [DATE] revealed Resident #46 was cognitively intact, had a colostomy and a catheter, utilized a wheelchair and was independent with toileting.</p> <p>Review of Resident #46's plan of care dated 10/18/23 in place for colostomy revealed interventions including change colostomy bag once a week and as needed (PRN); apply skin barrier, center the pouch over stoma and apply to skin, press area directly around stoma to ensure adherence and apply closure clip to bag; empty ostomy bag each shift and PRN; observe stoma and surrounding skin for irritation and notify nurse; and odor control: rinse pouch, keep pouch tail free of stool and avoid creating pinholes in pouch.</p> <p>Review of Resident #46's plan of care dated 10/18/23 in place for suprapubic catheter revealed interventions including position catheter bag and tubing below the level of the bladder and away from entrance room door; provide catheter care as ordered; change catheter drainage bag monthly and PRN; change suprapubic catheter monthly and PRN if dislodged or plugged and unable to clear with irrigation; check tubing for kinks PRN/as indicated; monitor and document urine output; monitor/document for pain/discomfort due to catheter; and monitor/record/report to physician for signs/symptoms of urinary tract infection (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns).</p> <p>Interview on 06/02/25 at 1:56 P.M. with Resident #46 revealed he had a catheter which he cleaned himself daily as well as a colostomy.</p> <p>Interview on 06/05/25 at 12:13 P.M. with Licensed Practical Nurse (LPN) #448 revealed when she cared for Resident #46, he completed his own colostomy and catheter care.</p> <p>Interview on 06/05/25 at 12:18 P.M. with LPN/UM #416 verified Resident #46 completed his own catheter and colostomy care at the facility. Nursing staff would provide catheter supplies, and Resident #46 would change out his catheter with nurse oversight. LPN/UM #416 confirmed Resident #46's care plans related to his colostomy and suprapubic catheters did not reflect his self-management of these areas and should have.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record review for Resident #6 revealed an admission date of 03/05/20. Diagnoses included attention deficit hyperactivity disorder and dementia.</p> <p>Review of the annual MDS assessment dated [DATE] revealed Resident #6 was severely cognitively impaired.</p> <p>Record review of the physician orders dated 04/01/25 revealed Resident #6 received an order for enhanced barrier precautions (EBP) due to chronic wounds. Check signage and personal protective equipment (PPE) every shift. Resident #6 received an order dated 05/30/25 to cleanse the right shin with normal saline, apply oil emulsion, cover with island dressing daily and as needed.</p> <p>Record reviews of the medical record revealed there was no care plan for EBP for Resident #6.</p> <p>Interview on 06/03/25 at 5:07 P.M. with the DON revealed Resident #6 should have a care plan for EBP, and DON confirmed Resident # 6 did not have a care plan in the medical record for EBP.</p> <p>5. Review of the medical record for Resident #69 revealed an admission date of 02/16/24. Diagnoses included chronic respiratory failure, dementia, post-traumatic stress disorder (PTSD) and depression.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #69 was cognitively impaired.</p> <p>Review of the psychiatric note dated 04/22/25 revealed current stressor as being at the nursing home and an alleviating factor was watching television.</p> <p>Review of the care plan for Resident #69 revealed PTSD was not fully addressed. The goal was blank and there was only one intervention of allowing a quiet area alone to calm down when overwhelmed dated 11/12/24. The care plan did not indicate the triggers of PTSD or what may alleviate his symptoms.</p> <p>Interview on 06/09/25 at 10:51 A.M. with Licensed Social Worker (LSW) #419 verified the care plan was incomplete by not personalizing his triggers and what helped him specifically.</p> <p>Review of the policy, Comprehensive Care Plans, dated 2025, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and time frames to meet a resident's medical, nursing and medical and psychosocial needs and ALL services that are identified in a resident's comprehensive assessment and meet professional standards of quality.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** Based on record reviews, interviews and facility policy review, the facility failed to timely assess and/or accurately assess residents for smoking. This affected four (Residents #22, #58, #64 and #86) of four residents reviewed for smoking. The census was 111.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #22 revealed an admission date of 03/30/12. Diagnoses included alcoholic cirrhosis of liver, asthma, anemia and viral hepatitis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively impaired. The Brief Interview for Mental Status (BIMS) score was six out of 15, indicating severe cognitive impairment.</p> <p>Review of the June 2025 orders revealed Resident #22 was okay to smoke without supervision. The order was dated 06/04/25 at 7:00 P.M.</p> <p>Review of the smoking safety screen for Resident #22 dated 06/04/25 revealed the question Does resident have cognitive loss? with an answer marked as No.</p> <p>Review of the care plan initiated on 04/12/12 revealed: 1) Resident #22 was able to use tobacco products without supervision, last revised on 04/29/25; 2) Resident #22 was at risk for delirium due to disease process as evidenced by inattention and disorganized thinking and 3) Resident #22 had a self-care deficit where his activities of daily living could fluctuate.</p> <p>2. Review of the medical record for Resident #86 revealed an admission date of 08/04/23. Diagnoses included chronic obstructive pulmonary disease, alcohol-induced dementia and viral hepatitis.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #86 was cognitively impaired. The BIMS score was four out of 15, indicating severe cognitive impairment.</p> <p>Review of the June 2025 orders revealed Resident #86 was okay to smoke without supervision. The order was dated 06/04/25 at 7:00 P.M.</p> <p>Review of the smoking safety screen for Resident #86 dated 06/04/25 revealed the question Does resident have cognitive loss? with an answer marked as No.</p> <p>Review of the care plan initiated on 09/08/23 and revised on 04/10/25 revealed: 1) Resident #86 does not need to be supervised for tobacco use, 2) Resident is/has potential to be physically aggressive related to history of harm to others and poor impulse control, and 3) Resident has impaired cognitive function, decision making and short-term memory loss.</p> <p>3. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, major depression disorder, schizophrenia, high blood pressure, and mood disorder.</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 - Some</p>	<p>Review of the comprehensive annual MDS assessment dated [DATE] revealed Resident #58 was severely cognitively impaired, has delusions, and has behaviors which significantly interfere with the resident's care and social interaction, they significantly intrude on the privacy or activity of others, and behaviors that significantly disrupt the living environment.</p> <p>Review of Resident #58's smoking assessment revealed a smoking assessment had not been completed for the previous 12 months. The resident was listed as a supervised smoker.</p> <p>Review of the progress note dated 04/10/25 at 7:59 A.M. revealed Licensed Social Worker (LSW) #419 documented Resident #58 was a supervised smoker as determined by the nursing smoking assessment.</p> <p>4. Review of the medical record for Resident #64 revealed an admission date of 10/10/21. Diagnoses included cardiac arrhythmia, major depressive disorder and hypertension.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #64 was cognitively intact. The BIMS score was 14 out of 15, indicating intact cognition.</p> <p>Review of the assessments tab revealed the last smoking safety screen was completed on 05/05/23 for Resident #64.</p> <p>Review of a Social Service progress noted dated 04/10/25 at 8:39 A.M. revealed Resident #64 was currently a smoker and was determined by the nursing staff assessment not needing to be supervised for safety reasons at this time.</p> <p>Interview on 06/05/25 at 11:03 A.M. with Registered Nurse (RN) #416 revealed they did smoking assessments quarterly. When she was shown there was no assessment for two years for Resident #64, she stated they had not been getting done. Her expectation of completing smoking assessments was at least annually. A subsequent interview at 12:27 P.M. with RN #416 revealed she assessed residents for the smoking safety screen. When asked why smoking assessments were marked as no for cognitive impairment for Resident #22, Resident #58 and Resident #86, RN #416 stated I know them. When asked about the cognitive status, based on information in the MDS, which reflected cognitive impairment, she stated another cognitive test was more accurate. When asked to see a copy of the other test, she stated Speech Therapy will sometimes do the more detailed test. No other cognitive test was provided for Resident #22, Resident #58 or Resident #86.</p> <p>Interview on 06/05/25 at 11:21 A.M. with Licensed Social Worker #419 revealed smoking assessments were reviewed at risk meetings which was where she got the information for her progress note dated 04/10/25 via verbally and review of assessment. When shown that Resident #64's last assessment was from 2023, she responded oops, you caught us.</p> <p>Interview on 06/05/25 at 1:42 P.M. with the Administrator revealed what the BIMS scores meant: 13-15 cognitively intact, eight-12 moderately cognitively impaired and seven or below was severely cognitively impaired.</p> <p>Review of the undated facility policy titled Resident Smoking revealed all residents will be asked about tobacco use during admission process and each quarterly or comprehensive MDS assessment. Residents who smoke would be further assessed using Resident Safe Smoking assessment.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor Resident #66's daily fluid intake and daily urine output related to a diagnosis of urinary retention requiring the use of an indwelling urinary catheter and discontinuation of the indwelling urinary catheter. This affected one (Resident #66) of two residents reviewed for indwelling catheters. The facility census was 111.</p> <p>Findings include:</p> <p>Record review for Resident #66 revealed an admission date of 04/01/24. Diagnoses included vascular dementia, cerebral infarction, neuromuscular dysfunction of bladder, and retention of urine.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was severely cognitively impaired. Resident #66 had an indwelling urinary catheter and required set up or clean up assistance with personal hygiene.</p> <p>Review of the progress note dated 12/31/24 at 6:19 A.M. revealed Resident #66 was observed coming to the nurse's station to speak with the nurse. Resident #66 then went back towards his room when a loud noise was heard. Resident #66 was found lying on the floor. The documentation included that the resident was assessed with a change in condition. The Nurse Practitioner (NP) was notified, and Resident #66 was sent to the emergency room (ER).</p> <p>Review of the progress note dated 12/31/24 at 6:45 P.M. revealed Resident #66 returned from ER. He was noted to have urinary retention, and a Foley (indwelling) urinary catheter was in place.</p> <p>Review of the care plan dated 01/02/25 revealed Resident #66 had an indwelling urinary catheter due to neurogenic bladder. Interventions included monitoring and documenting intake and output per facility policy.</p> <p>Review of the progress note dated 01/30/25 at 3:31 P.M. completed by Unit Manager #416 revealed Resident #66 was observed in the hallway holding the Foley catheter in hand. Resident #66 refused to have the catheter replaced at this time. The NP was notified, and orders were received to discontinue (d/c) the Foley catheter and monitor input and output at this time.</p> <p>Review of the medical record for Resident #66 from 12/31/24 through 06/05/25 revealed Resident #66's daily fluid intake and daily urine output was not documented to assure Resident #66 had adequate output due to urinary retention diagnosis.</p> <p>Record review and interview on 06/05/25 at 10:33 A.M. with the Director of Nursing (DON) confirmed Resident #66's amount of daily fluid intake and daily urine output was not documented and should have been documented and monitored, both while having the indwelling urinary catheter and after discontinuing the indwelling urinary catheter, to ensure Resident #66 had adequate output due to a diagnosis of urinary retention.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure Resident #67 received all nutritional interventions recommended by the registered dietitian to treat and prevent significant weight loss. This affected one resident (Resident #67) of three residents reviewed for nutrition. The facility census was 111.</p> <p>Findings include:</p> <p>Record review for Resident #67 revealed an admission date of 06/13/24. Diagnoses included Alzheimer's disease, type one diabetes mellitus, and dysphagia.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 was severely cognitively impaired. Resident #67 required set up or clean up assistance with meals, had weight loss and was not on a prescribed weight loss regimen.</p> <p>Review of the care plan for Resident #67 dated revised 04/17/25 revealed the resident had nutritional problem or potential nutritional problem related to forgetfulness related to Alzheimer's/dementia. Diagnoses including type one diabetes mellitus, hypothyroidism, dysphagia, unspecified psychosis, and anxiety which may affect nutritional status. Interventions included to provide and serve diet as ordered. Monitor intake and record every meal, regular texture, thin liquids, plus sugar substitute, prefers side of soup with lunch and dinner.</p> <p>Review of the physician orders revised 04/29/25 for Resident #67 revealed regular diet, regular texture, thin consistency provide soup on tray with lunch and dinner.</p> <p>Review of Resident #67's weight history revealed from 03/05/25 through 06/02/25 Resident #67 had a 6.72 % weight loss.</p> <p>Interview on 06/05/25 at 11:54 A.M. with Certified Nursing Assistant (CNA) #508 revealed Resident #67 always ate his meals in the dining room and was able to feed himself.</p> <p>Observation on 06/05/25 at 12:06 P.M. revealed Resident #67 ambulated independently to the dining room. Resident #67 was served the lunch tray of rice, vegetable, chicken, roll and cake. No soup was observed on the tray. CNA #508 confirmed there was no soup on Resident #67's lunch tray and revealed, He normally don't get soup with his meals. CNA #508 revealed she worked routinely with Resident #67 for the past several weeks. Resident #67 ate one bite of rice then stood to leave the dining room. Licensed Practical Nurse (LPN) #455 asked Resident #67 if he was done. Resident #67 said yes. LPN #455 did not say anything more, picked up Resident #67's lunch tray while Resident #67 returned to his room. LPN #455 never offered Resident #67 soup and never encouraged Resident #67 to eat his lunch.</p> <p>Interview on 06/05/25 at 12:58 P.M. with Registered Dietitian (RD) #426 confirmed Resident #67 had a significant weigh loss of 6.72 %. RD #426 revealed she had been working with the Speech Therapist due to Resident #67's weight loss. Through discussion and assessment due to weight loss, RD #426 stated we added soup every lunch and dinner. RD #426 revealed she would expect staff to encourage Resident #67 to eat his meals and offer an alternative if he did not eat what was served.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 145 Olive St Akron, OH 44310	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/05/25 at 5:17 P.M. revealed Resident #67 was sitting in the dining room. At 5:20 P.M. Resident #67 was served the dinner meal by CNA #508. Observation revealed there was no soup on the tray. CNA #508 confirmed there was no soup on Resident #67's meal tray and confirmed Resident #67 had a ticket on the tray revealing soup with lunch and dinner. CNA #508 revealed she don't read the tickets.</p> <p>Interview on 06/05/25 at 5:24 P.M. with LPN #455 who was located at a different dining room revealed she was not sure if Resident #67 was to get soup with lunch and dinner. LPN #455 revealed she did not have a computer right now but will check into it.</p> <p>Review of the facility policy titled, Nutritional Management undated revealed the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A systemic approach was used to optimize each resident's nutritional status. A comprehensive nutritional assessment will be completed by the dietitian within 72 hours of admission, annually, and upon significant change in condition. Follow up assessments will be completed as needed. The dietitian shall use data gathered from the nutritional assessment to estimate the resident's nutritional needs. The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care. Interventions will be individualized to address the specific needs of the resident.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to ensure orders were in place for the administration of oxygen and failed to date oxygen tubing as required. This affected one resident (#107) of one resident reviewed for oxygen and had the potential to affect an additional 13 residents (#1, #57, #65, #69, #74, #80, #84, #89, #97, #99, #106, #262 and #311) the facility identified as receiving oxygen in the facility. Facility census was 111.</p> <p>Findings include:</p> <p>Review of Resident #107's medical record revealed an admission date of 04/08/25 and diagnoses including malignant neoplasm of prostate, chronic obstructive pulmonary disease, anxiety and hypertension.</p> <p>Review of an admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #107 was cognitively intact and receiving hospice services. Oxygen was not coded on the MDS assessment.</p> <p>Review of Resident #107's physician's orders as of 06/02/25 revealed no orders were in place relative to oxygen.</p> <p>Observation on 06/02/25 at 2:00 P.M. revealed Resident #107 was up and awake in his bed. Oxygen was in use and no date was noted on the tubing connected to Resident #107.</p> <p>Interview on 06/02/25 at 2:00 P.M. with Resident #107 revealed he recently got oxygen.</p> <p>Interview on 06/04/25 at 7:54 A.M. with Licensed Practical Nurse (LPN)/Unit Manager (UM) #416 verified Resident #107 did not have orders for oxygen in place in the paper or electronic medical records and indicated there were always to be orders relative to oxygen administration.</p> <p>Follow-up observation on 06/04/25 at 7:58 A.M. of Resident #107 with LPN/UM #416 revealed Resident #107 was laying in bed and his oxygen cannula was in his nose with the oxygen concentrator noted to be in use. The oxygen tubing connected to Resident #107 lacked a date.</p> <p>Follow-up interview on 06/04/25 at 7:58 A.M. with LPN/UM #416 verified Resident #107's oxygen tubing should have been dated.</p> <p>Review of the policy, Oxygen Administration, dated 2025 revealed oxygen was administered under the orders of a physician, except in the case of an emergency. Staff shall document the initial and on-going assessment of the resident's condition warranting oxygen and the response to oxygen therapy .other infection control measures include change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain communication from the dialysis provider after each dialysis treatment. This affected one resident (Resident #94) of one resident reviewed for dialysis. The facility census was 111.</p> <p>Findings Include:</p> <p>Review of the medical record revealed Resident #94 was admitted to the facility on [DATE] with diagnoses including acute osteomyelitis of the left ankle and foot, diabetes with diabetic neuropathy, end stage renal disease dependent on dialysis, congestive heart failure, high blood pressure, Tourette's disorder, schizophrenia, and anxiety.</p> <p>Review of the physician's orders revealed Resident #94 attended dialysis on Mondays, Wednesdays, and Fridays. The resident was on a fluid restriction of 2000 milliliters (ml) per 12 hour shift.</p> <p>Review of the comprehensive annual Minimum Data Set (MDS) 3.0 , dated 05/20/25, revealed Resident #94 was cognitively intact, received daily insulin medications and diuretics, and received dialysis.</p> <p>Review of the pre and post dialysis assessments for Resident #94 revealed the facility was completing the assessments on each day the resident received dialysis.</p> <p>Review of the nurses' notes for Resident #94 revealed he was noncompliant with care including attending dialysis appointments and with his fluid restrictions.</p> <p>Interview with the Assistant Director of Nursing (ADON on 06/04/25 at 4:35 P.M. revealed the facility did not receive communication from the dialysis center after each treatment. The ADON was not certain how often the facility received communication from dialysis but it was not after each visit.</p> <p>Interview with Resident #94 on 06/04/25 at 4:40 P.M. revealed the dialysis center had never given him any paperwork to give to the facility upon completion of his treatment.</p> <p>On 06/05/25 at 12:00 P.M. a request for the dialysis information provided to the facility after each dialysis treatment was made to the Administrator. On 06/05/25 at 5:00 P.M. no information had been provided.</p> <p>On 06/09/25 at 7:30 A.M. the facility provided a monthly summary of Resident #94's lab work and his weights. No communication was provided indicating the facility was being updated by the dialysis center after each treatment.</p> <p>The facility's dialysis policy was requested for review but the policy was never provided throughout the survey process.</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of the facility policy, the facility failed to ensure a safe environment for Resident #212. This affected one (Resident #212) of one resident reviewed for suicidal ideations. The facility census was 111.</p> <p>Findings include:</p> <p>Record review for Resident #212 revealed an admission date of 05/02/25 and a readmission date of 05/16/25. Diagnoses included anxiety disorder, depression, post-traumatic stress disorder, gender identity disorder, and borderline personality disorder.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #212 was cognitively intact. Resident #212 had little interest or pleasure in doing things, feeling down, depressed or hopeless, feeling bad about herself/himself or a failure or have let herself/himself or her/his family down, and had trouble concentrating on things such as reading the newspaper or watching television. Resident #212 used a manual wheelchair, had no impairments of the upper or lower extremity, was independent with bed mobility, sit-to-stand and wheelchair mobility.</p> <p>Review of the Progress Note for Resident #212 dated 05/12/25 at 12:45 P.M. completed by Nurse Manager #416 revealed, This nurse was called to therapy gym d/t (due to) Resident #212 having a tearful anxious episode. While speaking with the resident, the resident verbalized wanting to die stating I don't want to do this anymore, I don't have a purpose, there is no point to me being here. All I need is 3-5 (three to five) minutes alone in my room. This writer asked the resident, if she had a plan resident verbalized I was researching on my phone things I could use to sharpen my butter knives with or different ways to end my life with the limited resources I have in here. Psych NP (Nurse Practitioner) was notified and orders received to send the resident to the ED (Emergency Department) for suicidal ideations with intent. Resident was notified and agreeable.</p> <p>Review of the Progress Note dated 05/16/25 at 6:50 P.M. completed by Licensed Practical Nurse (LPN) #455 revealed Resident #212 return from the hospital. Resident states she has recently had thoughts of harming self but currently does not and was feeling ok at this time. Resident #212 was alert and oriented to person, place and time.</p> <p>Interview on 06/05/25 at 2:59 P.M. with Resident #212 revealed, I want to hurt myself, but if I do, I will be without a place to live. I think about it all the time, I got a razor upstairs, all I have to do is tear it apart and I can use that.</p> <p>On 06/05/25 at 3:12 P.M. the Administrator was notified of Resident #212's statement.</p> <p>Interview on 06/05/25 at 3:44 P.M. with the Director of Nursing (DON) confirmed three disposable razors were removed from Resident #212's room. The DON revealed the hospital cleared her, so she has rights.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 145 Olive St Akron, OH 44310	
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/05/25 at 4:09 P.M. with Certified Nursing Assistant (CNA) #512 confirmed he worked with Resident #212 and revealed he was unaware of any precautions used for Resident #212 due to suicidal thoughts.</p> <p>Interview on 06/05/25 at 4:11 P.M. with CNA #485 confirmed she worked with Resident #212 and revealed she didn't know her very well. CNA #485 confirmed Resident #212 had asked her for razors, but she only gave them to her when she showered then disposed of them.</p> <p>Interview on 06/05/25 at 4:18 P.M. with LPN #461 confirmed she was Resident #212's primary charge nurse. LPN #461 revealed Resident #212 had suicidal tendencies. LPN #461 revealed, I don't know of any interventions. LPN #461 revealed nursing staff was to store and administer all Resident #212's medications. Observation with LPN #461 revealed there was an albuterol inhaler (bronchodilator) visible on Resident #212's bedside table. In the top drawer of the nightstand was a trelegy (once daily inhaler that includes three drug classes including corticosteroid, long-acting muscarinic antagonist, and a long-acting beta 2 adrenergic agonist) inhaler. In the bathroom was a full sharps container that was filled with used needles and syringes to the top, above the fill line. LPN #212 confirmed the inhalers and sharps container revealing she should not have the inhalers in her room then left the room leaving the inhalers on the bedside table.</p> <p>Interview on 06/05/25 at 4:23 P.M. with CNA #476 confirmed she also worked with Resident #212. CNA #476 revealed she helped transfer Resident #212 to the shower and washed her back, but she pretty much did everything else herself.</p> <p>Interview on 06/05/25 at 4:27 P.M. with DON confirmed the sharps container in Resident #212's room was full above the full line. Per DON that was not appropriate, and the sharps container should have been emptied.</p> <p>Interview on 06/05/25 at 5:27 P.M. with Certified Nurse Practitioner (CNP) #517 revealed Resident #212 was admitted for taking too much hormone therapy, she stated she wanted the transition process to progress faster. After she came, she had chronic suicidal ideation's and should not have medications, including inhalers, razors, or sharps containers unsecured in her room.</p> <p>Interview on 06/09/25 at 8:30 A.M. with the DON who revealed the sharps container was hanging on the wall in Resident #212's bathroom it was full, but it was not the facilities. The DON revealed he was unsure how it got there. Also, the inhalers that were in her room were hers from home and staff cannot take them without her permission.</p> <p>Observation and interview on 06/09/25 at 9:13 A.M. with LPN #461 confirmed the sharps container that was in Resident #212's room was the same container as when she was admitted to the room. Observation revealed LPN #212 had the key to unlock the sharps containers to remove it from the walls. Observation revealed LPN #212 unlocked the sharps container in a nearby room stating all the rooms have sharps containers, you cannot remove them or replace them without the key, the nurses carry the key on their key ring with other facility keys. LPN #461 revealed residents did not have access to the keys to remove the sharps containers.</p> <p>Interview on 06/09/25 at 9:25 A.M. with the DON to review the observation with LPN #461 which required a key to hang or remove a sharps container. DON stated, Oh.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy titled, Behavioral Health Services revealed Behavioral Health encompasses a resident's whole emotional and mental well-being, which includes but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goal for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to ensure blood sugar results were obtained prior to eating the breakfast meal for Resident #72 and failed to prime the insulin pen prior to administering the insulin injection for residents #72 and #19. This affected two (Residents #19 and #72) observed for blood sugar assessments and insulin administration and had the potential to affect an additional 24 (Resident #2, #5, #16, #17, #21, #23, #24, #25, #29, #34, #44, #48, #51, #53, #55, #62, #67, #68, #69, #83, #211, #212, #262, and #311) identified by the facility as requiring a blood sugar assessment prior to meals and or requiring insulin via insulin pen. The facility census was 111.</p> <p>Findings include:</p> <p>1. Record review for Resident #72 revealed an admission date of 07/27/22. Diagnoses included diabetes mellitus (DM) with diabetic nephropathy.</p> <p>Review of the care plan dated 07/29/24 revealed Resident #72 had diabetes mellitus. Interventions included diabetes medication as ordered by doctor.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was moderately cognitively impaired. Resident #72 had DM and received insulin injections seven days a week.</p> <p>Review of the physician orders for Resident #72 revealed an order dated 05/15/25 for Humalog injection solution (insulin) 100 units per milliliter (ml), which included to inject as per sliding scale: the sliding scale included if the blood sugar results were 151 to 200 give one unit; 201 to 250 give two units; 251 to 300 give three units; subcutaneously with meals for diabetes mellitus and inject six units subcutaneously one time a day for DM with breakfast.</p> <p>Observation on 06/03/25 at 8:06 A.M. of Licensed Practical Nurse (LPN) #455 assessing Resident #72's blood sugar and administering insulin revealed Resident #72 was sitting up in bed. Resident #72's breakfast tray was in front of with all the food was consumed. Resident #72 confirmed he ate pancakes with syrup, rice crispies and milk, and he finished his breakfast consuming 100%. LPN #455 assessed Resident #72's blood sugar with a result of 272. LPN #455 returned to the medication cart to prepare Resident #72's insulin injection. LPN #455 obtained the Humalog Kwik pen for Resident #72 and set the insulin pen at nine units. LPN #455 revealed six units were the routine order and three were for the sliding scale order for a total of nine units. LPN #455 did not prime the needle prior to administering the insulin injection. LPN #455 confirmed she assessed Resident #72's blood sugar after breakfast and confirmed she never primed Resident #72's insulin pen. LPN #455 revealed she had been doing this for 20 plus years and never primed the insulin pen unless it was a new pen and the first injection from the pen. LPN #455 confirmed she worked on all residential floors of the facility and worked with all residents.</p> <p>2. Record review for Resident #19 revealed an admission date of 10/10/14. Diagnoses included type two DM with diabetic neuropathy.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 145 Olive St Akron, OH 44310	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan updated 05/13/20 revealed Resident #19 was at risk for hypo/hyperglycemia related to type two diabetes mellitus. Interventions included to monitor blood sugar levels as ordered.</p> <p>Review of the care plan updated 05/24/23 for Resident #19 revealed the resident had DM and was at risk of complications. Interventions included diabetes medication as ordered by doctor.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #19 was moderately cognitively impaired. Resident #19 had DM and received insulin injections seven days a week.</p> <p>Review of the physician orders for Resident #19 revealed an order revised 04/29/24 for Humalog solution 100 units per ml, inject 10 units subcutaneously two times a day related to type two DM with diabetic neuropathy. Hold if the blood sugar is less than 100. An additional insulin order dated 05/19/25 included insulin glargine inject 30 units subcutaneously two times a day.</p> <p>Observation on 06/03/25 at 8:30 A.M. with LPN #453 of Resident #19's blood sugar assessment and medication administration for Resident #19 revealed Resident #19 was sitting up in bed. The breakfast tray sitting in front of Resident #19 revealed the food and fluids were all consumed. Resident #19 confirmed she had pancakes with syrup, cereal, apple juice, orange juice, and milk. Resident #19 confirmed she finished her breakfast a while ago and ate and drank everything. LPN #453 assessed Resident #19's blood sugar via fingerstick with a result of 136. LPN #453 administered Resident #19's Humalog 10 units and glargine 30 units. LPN #453 confirmed she assessed Resident #19's blood sugar after breakfast and administered the Humalog insulin per the results of the blood sugar. LPN #453 confirmed she worked on all residential floors of the facility and worked with all residents.</p> <p>Interview on 06/03/25 at 9:35 A.M. with the Director of Nursing (DON) confirmed blood sugar assessments were to be completed prior to meals.</p> <p>Review of the undated facility policy titled, Insulin Pen included the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing. Insulin pens contain multiple doses of insulin; a new needle will be used for each injection; insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir; Screw the pen needle onto the insulin pen; Dial two units by turning the dose selector clockwise, push the plunger and watch to see that at least one drop appears; turn the dose selector to ordered dose.</p> <p>The deficiency represents noncompliance investigated under Master Complaint Number OH00165919 and Complaint Number OH00163185.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>4. Review of the medical record for Resident #48 revealed an admission date of 01/25/23 with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure, and diabetes mellitus.</p> <p>Review of the MDS assessment for Resident #48 dated 04/01/25, revealed the resident was cognitively intact.</p> <p>Review of the MAR for Resident #48 dated May 2025 revealed medications were administered several hours after the medication was ordered: metoprolol, Entresto, Lasix, Ativan, gabapentin, spironolactone, Macrobid scheduled for 05/04/25 at 9:00 A.M. were given at 11:27 A.M., Macrobid, Colchicine, Eliquis, trazodone scheduled for 05/04/25 at 9:00 P.M. were given at 11:27 P.M., insulin Lispro scheduled for 05/04/25 at 8:00 A.M. was given at 10:46 A.M., Depakote, metoprolol, Entresto, Tamsulosin scheduled for 05/04/25 at 9:00 P.M. were given at 11:24 P.M., insulin Glargine scheduled for 05/05/25 at 9:00 A.M. was given at 11:23 A.M., Gabapentin, Tamsulosin, Entresto, metoprolol, Depakote, trazodone, Eliquis, Colchicine, Macrobid and insulin Glargine scheduled for 05/05/25 at 9:00 P.M. were given at 11:36 P.M., insulin Lispro and insulin Glargine scheduled for 05/06/25 at 8:00 A.M. were given at 10:26 A.M., insulin Lispro scheduled for 05/07/25 was given at 11:31 A.M., insulin Lispro scheduled for 05/07/25 at 12:00 P.M. was given at 2:29 P.M., insulin Lispro scheduled for 05/08/25 at 12:00 P.M. was given at 1:48 P.M., insulin Lispro and Gabapentin scheduled for 05/10/25 at 5:00 P.M. was given at 7:23 P.M., insulin Lispro scheduled for 05/17/25 at 12:00 P.M. was given at 2:34 P.M., Gabapentin, metoprolol, Depakote, Entresto, Tamsulosin, Colchicine, Eliquis, trazodone, and insulin Glargine scheduled for 05/17/25 at 9:00 P.M. were given 05/18/25 at 12:34 A.M., insulin Lispro and Gabapentin scheduled for 05/18/25 at 5:00 P.M. were given at 7:45 P.M., Gabapentin, Entresto, Tamsulosin, metoprolol, Depakote, trazodone, Colchicine, and insulin Glargine scheduled for 05/19/25 at 9:00 P.M. were given on 05/20/25 at 3:31 A.M., Depakote, Entresto, Lasix, Eliquis, Colchicine, Ativan, Gabapentin, metoprolol, and Tamsulosin scheduled for 05/23/25 at 9:00 P.M. were given at 11:25 P.M., metoprolol, Gabapentin, trazodone, Ativan, Colchicine, and Eliquis scheduled for 05/24/25 at 9:00 P.M. were given on 05/25/25 at 12:19 A.M. , insulin Lispro scheduled for 05/26/25 at 8:00 A.M. was given at 11:51 A.M., insulin Lispro scheduled for 05/26/25 at 12:00 P.M. was given at 2:06 P.M., Entresto, Lasix, Gabapentin, Eliquis, Ativan, and Colchicine scheduled for 05/30/25 at 9:00 A.M. were given at 1:02 P.M., insulin Lispro scheduled for 05/30/25 at 12:00 P.M. was given at 3:45 P.M., trazodone, Depakote, Tamsulosin, Entresto, Ativan, insulin Glargine, Colchicine, Gabapentin scheduled for 05/30/25 at 9:00 P.M. were given on 05/31/25 at 5:56 A.M.</p> <p>Interview on 06/04/25 at 4:10 P.M. with the DON confirmed multiple medications for Resident #48 were administered over an hour late on 05/04/25, 05/05/25, 05/06/25, 05/07/25, 05/08/25, 05/10/25, 05/17/25, 05/18/25, 05/19/25, 05/20/25, 05/23/25, 05/25/25, 05/26/25, 05/30/25, 05/31/25.</p> <p>5. Review of the medical record for Resident #102 revealed an admission date of 12/15/24 with diagnoses including bilateral osteoarthritis of hip, muscle weakness, anemia, acute kidney failure and hypertension.</p> <p>Review of the MDS assessment for Resident #102 dated 03/24/25 revealed the resident was moderately cognitively intact and was dependent on staff assistance with activities of daily living (ADLs.)</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 145 Olive St Akron, OH 44310	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MAR for Resident #102 dated May 2025 and June 2025 revealed the following medications were administered late: Eliquis and Gabapentin scheduled for 05/04/25 at 9:00 A.M. were given at 11:28 A.M., Eliquis and Gabapentin scheduled for 05/05/25 at 9:00 P.M. were given at 10:46 P.M., Eliquis and Gabapentin scheduled for 05/06/25 at 9:00 A.M. were given at 10:41 A.M., Eliquis and Gabapentin scheduled for 05/14/25 at 9:00 A.M. were given at 11:05 A.M., Eliquis and Gabapentin scheduled for 05/16/25 at 9:00 P.M. were given on 05/17/25 at 12:30 A.M., Robaxin scheduled for 05/16/25 at 10:00 P.M. was given on 05/17/25 at 12:30 A.M., Eliquis and Gabapentin scheduled for 05/17/25 at 9:00 P.M. were given on 05/18/25 at 12:43 A.M., Robaxin scheduled for 05/17/25 at 10:00 P.M. was given on 05/18/25 at 12:43 A.M., Eliquis and Gabapentin scheduled for 05/20/25 at 9:00 A.M. were given at 11:01 A.M., Eliquis and Gabapentin scheduled for 05/23/25 the 9:00 A.M. were given at 10:51 A.M., Eliquis and Gabapentin scheduled for 05/23/25 at 9:00 P.M. were given at 11:28 P.M., Robaxin scheduled for 05/23/25 at 10:00 P.M. was given at 11:28 P.M., Eliquis and Gabapentin scheduled for 05/24/25 at 9:00 P.M. were given at 10:43 P.M., Eliquis and Gabapentin scheduled for 05/26/25 at 9:00 P.M. were given at 11:19 P.M., Robaxin and Gabapentin scheduled for 05/31/25 at 2:00 P.M. were given at 3:42 P.M., Robaxin scheduled for 06/01/25 at 6:00 A.M. was given at 9:02 A.M., Eliquis and Gabapentin scheduled for 06/02/25 at 9:00 P.M. were given on 06/03/25 at 4:47 A.M., Robaxin scheduled for 06/02/25 at 10:00 P.M. was given on 06/03/25 at 4:47 A.M.</p> <p>Interview on 06/02/25 at 11:22 A.M. with Resident #102 confirmed his medications were often late, and at times he would get his 6:00 A.M. medications with his 9:00 A.M. medications.</p> <p>Interview on 06/04/25 at 4:10 P.M. with the DON confirmed Resident #102's Eliquis, Gabapentin, and Robaxin were late on multiple dates in May and June 2025.</p> <p>Review of the facility policy titled Medication Administration undated revealed medications should be administered within 60 minutes prior to or after the scheduled time.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00165919 and Complaint Number OH00163185.</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure residents were free of significant medication errors. This affected five (Residents #19, #48, #72, #102, #111) of nine residents reviewed for medication administration. The facility census was 111 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #72 revealed an admission date of 07/27/22 with a diagnosis of diabetes mellitus with diabetic nephropathy.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #72 dated 04/02/25 revealed the resident was moderately cognitively impaired, had diabetes mellitus, and received insulin injections seven days per week.</p> <p>Review of the care plan for Resident #72 dated 07/29/24 revealed the resident had diabetes mellitus. Interventions included staff to administer diabetes medication as ordered by doctor.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the physician's orders for Resident #72 revealed an order dated 05/15/25 for Humalog insulin inject per sliding scale (one unit for a blood sugar of 151 to 200, two units for a blood sugar of 201 to 250, three units for a blood sugar of 251 to 300) subcutaneously with meals and inject six units one time a day with breakfast.</p> <p>Observation on 06/03/25 at 8:06 A.M. of medication administration for Resident #72 per Licensed Practical Nurse (LPN) #455 revealed the resident was in bed and had consumed his entire breakfast meal. Resident #72 told LPN #455 he had consumed 100 percent (%) of his breakfast. LPN #455 administered 9 units of Humalog insulin to Resident #72 and did not prime the insulin pen prior to administration.</p> <p>Interview on 06/03/25 at 8:16 A.M. with LPN #455 confirmed she administered 9 units of Humalog insulin to Resident #7 based on the six units ordered at breakfast and 3 units per sliding scale. LPN #455 confirmed she did not check the resident's blood sugar before the resident consumed his breakfast, and she also did not prime the insulin pen prior to administration.</p> <p>2. Review of the medical record for Resident #19 revealed an admission date of 10/10/14 with a diagnosis of type two diabetes mellitus with diabetic neuropathy.</p> <p>Review of the care plan for Resident #19 updated 05/13/20 revealed the resident was at risk for hypo/hyperglycemia related to type two diabetes mellitus. Interventions included staff to monitor blood sugar levels as ordered.</p> <p>Review of the care plan for Resident #19 updated 05/24/23 for Resident #19 revealed the resident had diabetes mellitus and was at risk for complications. Interventions included staff to administer diabetes medication as ordered by doctor.</p> <p>Review of the physician's orders for Resident #19 revealed an order dated 04/29/24 for Humalog insulin inject 10 units subcutaneously two times a day and to hold if the blood sugar was less than 100.</p> <p>Review of the MDS assessment for Resident #19 dated 05/02/25 revealed the resident was moderately cognitively impaired, had diabetes mellitus, and received insulin injections seven days a week.</p> <p>Observation of medication administration for Resident #19 on 06/03/25 at 8:30 A.M. per LPN #453 revealed Resident #19 told LPN #453 she had consumed 100% of her breakfast. LPN #453 checked Resident #19's blood sugar at 136 and administered 10 units of Humalog insulin.</p> <p>Interview on 06/03/25 at 9:35 A.M. with the Director of Nursing (DON) confirmed blood sugar checks should be completed prior to meals.</p> <p>Review of the facility policy titled Insulin Pen undated revealed insulin pens should be primed prior to administration of each dose.</p> <p>3. Review of the medical record for Resident #111 revealed an admission date of 01/20/24, a readmission date of 02/22/24 and a discharge date of 02/26/25 with diagnoses including hypertension, chronic obstructive pulmonary disease (COPD), anxiety disorder, and insomnia.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the physician's orders for Resident #111 dated February 2025 included orders for the following medications: trazodone 50 milligram (mg) one time a day at 9:00 P.M., Mucinex 1200 mg two times a day at 9:00 A.M. and 9:00 P.M., Atorvastatin 80 mg one tablet at 9:00 P.M., Montelukast 10 mg one time a day at 9:00 P.M., Primidone 50 mg two times a day at 9:00 A.M. and 9:00 P.M., metoprolol tartrate 12.5 mg two times a day at 9:00 A.M. and 9:00 P.M.</p> <p>Review of the Medication Administration Record (MAR) for Resident #111 dated February 2025 revealed the following medications were scheduled for administration at 9:00 P.M. but were not administered timely: trazodone, Mucinex, Atorvastatin, Montelukast, Primidone, metoprolol tartrate. Medications scheduled for on 02/03/25 at 9:00 P.M. were given on 02/04/25 at 1:33 A.M., medications scheduled for 02/04/25 at 9:00 P.M. were given on 02/05/25 at 3:19 A.M., medications scheduled for 02/06/25 at 9:00 P.M. were given on 02/07/25 at 12:15 A.M., medications scheduled for 02/18/25 at 9:00 P.M. were given on 02/19/25 at 3:04 A.M. , medications scheduled for 02/25/25 at 9:00 P.M. were given on 02/26/25 at 1:13 P.M.</p> <p>Interview on 06/04/25 at 4:10 P.M. with the Director of Nursing (DON) confirmed medications should be administered one hour before or after the scheduled time. The DON confirmed if a medication were given outside of that two-hour window this was considered a medication error. The DON confirmed Resident #111 had multiple medication errors due to late administration of medications (9:00 P.M. doses of trazodone, Mucinex, Atorvastatin, Montelukast, Primidone, and metoprolol tartrate) on 02/03/25, 02/04/25, 02/06/25, 02/18/25, and 02/25/25.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure medications were securely stored. This affected one resident (Resident #212) and had the potential to affect all residents residing at the facility. The facility also failed to discard expired medications. This had the potential to affect all of the residents residing in the facility. The facility census was 111 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #212 revealed an admission date of 05/02/25 and a readmission date of 05/16/25 with diagnoses including anxiety disorder, depression, post-traumatic stress disorder, and borderline personality disorder.</p> <p>Review of the Minimum Data Set (MDS) dated for Resident #212 dated 05/23/25 revealed the resident was cognitively intact and was independent with mobility.</p> <p>Record the medical record for Resident #212 revealed it did not include a physician's order or other documentation indicating the resident was capable of self-administration of medications.</p> <p>Observation of Resident #212's room on 06/05/25 at 4:18 P.M. with Licensed Practical Nurse (LPN) #461 revealed there was an albuterol inhaler and a Trelegy inhaler unsecured at the resident's bedside.</p> <p>Interview on 06/05/25 at 4:19 P.M. with LPN #461 confirmed nursing staff were to store and administer all of Resident #212's medications and the inhalers should not be left at the resident's bedside.</p> <p>Interview on 06/05/25 at 5:27 P.M. with Certified Nurse Practitioner (CNP) #517 confirmed Resident #212 should not have medications, including inhalers, unsecured in her room.</p> <p>2. Observation of the 200-hall medication storage room on 06/04/25 at 8:37 A.M. with the Director of Nursing (DON) revealed the following: a COVID-19 test with an expiration date of 11/09/24, four boxes of glucose test strips with an expiration date of 02/01/25, a bottle of magnesium with an expiration date of December 2024.</p> <p>Observation of the medication room on the third floor with the DON revealed the following: an opened bottle Bisacodyl tablets with an expiration date of March 2025, an opened box of guaifenesin with an expiration date of April 2024, a container of omeprazole with an expiration date of January 2025.</p> <p>Interview on 06/04/25 at 8:50 A.M. with the DON confirmed the 200 Hall medication storage room and the third-floor medication room contained expired house stock items which should have been discarded.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy titled Medication Storage undated revealed all drugs and biologicals would be stored in locked compartments under proper temperature controls. The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued or outdated medications.</p> <p>The deficiency represents noncompliance investigated under Master Complaint Number OH00165919.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, pharmacy medical record review and lab requisition review, revealed the facility failed to ensure the physician ordered labs were completed timely for Resident #66. This affected one (Resident #66) of five residents reviewed for unnecessary medications. The facility census was 111.</p> <p>Findings include:</p> <p>Record review for Resident #66 revealed an admission date of 04/01/24. Diagnoses included vascular dementia, cerebral infarction, personal history of transient ischemic attack (TIA), and acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was severely cognitively impaired. Resident #66 did not receive an anticoagulant.</p> <p>Review of the physician orders for Resident #66 revealed an order for Eliquis (anticoagulant) five milligram (mg) tablet, take one tablet by mouth twice daily, ordered on 04/01/24.</p> <p>Interview on 06/09/25 at 10:50 A.M. with Corporate MDS Nurse #513 confirmed an error on the MDS dated [DATE]. Resident #66 did receive the anticoagulant, Eliquis, at the time the MDS dated [DATE] was completed.</p> <p>Review of the care plan dated 04/13/24 revealed Resident #66 had a cerebral vascular accident (CVA/Stroke) related to embolism. Interventions included to give medications as ordered by the physician.</p> <p>Review of the pharmacy medical record review dated 04/16/25 completed by Consultant Pharmacist #610 revealed Resident #66 was currently receiving Eliquis in a five mg two times a day (BID) dose. Although the resident's age and weight support a five mg BID dose, renal function may not. Creatinine clearance is estimated to be between 15-29 milliliters/minute (ml/min) for which there is evidence to suggest a 2.5 mg BID dose should be considered. The physician response documented on the pharmacy medical record review dated 04/23/25 completed by Certified Nurse Practitioner (CNP) #516 revealed orders to complete a complete metabolic panel (CMP), complete blood count (CBC), and renal function panel.</p> <p>Medical record review for Resident #66 revealed the CMP, CBC, and renal function panel ordered 04/23/25 was not available in the medical record for review.</p> <p>Interview on 06/05/25 at 8:48 A.M. with Assistant Director of Nursing (ADON) #429 revealed the order for Resident #66 for a CMP, CBC, and renal function panel was ordered 04/23/25. The lab was scheduled to complete the blood draw on 05/02/25. ADON #429 revealed she was unsure why the lab was not scheduled until 05/02/25.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the lab requisition for Resident #66 dated 05/02/25 revealed the blood specimen was not collected because Resident #66 was combative/refused; no qualified personnel were available. The reschedule date/signature on the lab requisition was left blank. ADON #429 revealed the lab tech came to the facility on [DATE] (untimed) and attempted to draw Resident #66's blood for the ordered labs. Resident #66 refused. The lab tech should have gone to the floor nurse, and the floor nurse would go with the lab tech and attempt to obtain the lab. This never occurred, so the nurse was not aware the lab was not obtained and did not follow up on the ordered lab, notify the physician the lab was not completed, or document the lab was not completed or reattempted.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, menu review and review of the menu spreadsheet, the facility failed to provide food items at the designated portions as written. This affected 101 residents receiving food from the kitchen as three residents (#63, #104 and #106) were ordered nothing-by-mouth (NPO) and seven residents (#9, #10, #24, #54, #74, #95 and #112) were observed to receive alternate meals during the observation. The facility census was 111.</p> <p>Findings include:</p> <p>Review of the menu for week three, dated as Spring/Summer 2025, revealed for lunch on Tuesday (06/03/25), the meal to be served included Polish sausage, potato wedges, sauteed peppers and onions, choice of roll, choice of cookie, milk and coffee/tea.</p> <p>Review of the menu spreadsheet for the lunch meal on 06/03/25 revealed the following portions were to be served: Polish sausage, one each; potato wedges, three ounces; sauteed peppers and onions, four ounces; choice of roll, one each; choice of cookie; one each. The diet extension for mechanical soft diets revealed these residents were to receive a #6-scoop (two thirds of a cup) of ground Polish sausage with two ounces of gravy.</p> <p>An interview on 06/02/25 at 11:22 A.M. with Resident #102 revealed the facility portions were not what they should be and residents did not get enough food to eat at times.</p> <p>Observation on 06/03/25 starting at 11:15 A.M. revealed [NAME] #409 took the temperatures of the foods to be served using an analog stick thermometer. Utensils and portions were observed at this time to be as follows: Polish sausage, one each; potato wedges, a large tongs grab (three ounces); onions and peppers, three-ounce spoodle; buns, one each; mechanically ground sausage, one #12-scoop (one third of a cup); green beans, four ounces; gravy, two ounces; and mashed potatoes, #8-scoop (a half of a cup). Trayline started at 11:23 A.M. Observations during this time revealed [NAME] #409 used a tan-gray three-ounce spoodle to serve peppers and onions and used a green #12-scoop for the ground sausage. [NAME] #409 was not observed to provide multiple scoops of food on plates unless the resident was ordered double protein at meals but continued to use the utensils identified above.</p> <p>During an interview on 06/03/25 at 12:06 P.M. Dietary Manager (DM) #425 verified [NAME] #409 did not serve the correct portions of onions and peppers (one ounce short per serving) and ground sausage (one third of a cup short per serving). DM #425 accompanied the surveyor to re-check the serving utensils used for the lunch meal which included a green #12-scoop for the ground sausage and a tan-gray three-ounce spoodle for the main vegetable as observed above and caused the facility to under-serve food at the lunch meal.</p> <p>Review of the facility diet list dated 06/02/25 identified three residents (Residents #63, #104 and #106) as NPO.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number OH00165919.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, review of the facility policy and record review the facility failed to ensure foods in unit refrigerators were labeled, dated and not retained when expired and stored in a clean environment. This had the potential to affect 108 residents receiving meals from the kitchen as three residents (#63, #104 and #106) were ordered nothing-by-mouth (NPO). Facility census was 111.</p> <p>Findings include:</p> <p>Observation on 06/02/25 with Dietary Manager (DM) #425 starting at 9:58 A.M. revealed the following areas of concern:</p> <p>&bull;</p> <p>In the third floor nourishment refrigerator, there was an expired bottle of soy sauce dated 11/29/24, an expired container of 2% milk dated 05/04/25, an undated bowl of mashed potatoes, an undated bowl containing a piece of cake, a bag labeled with Resident #112's name and the date 05/19/25, a container with Resident #32's name and no date, three bags of various takeout/fast foods with no name and no date, a wilted salad with no date, an expired container of apples dated 05/23/25, an expired container of potato salad dated 04/07/25 and a expired Trix yogurt dated 05/25/25. The base of the refrigerator was moderately stained with an unidentifiable pink substance.</p> <p>&bull;</p> <p>In the fourth floor nourishment refrigerator, there was a red sticky substance and crumbs inside along with an expired bottle of hot sauce dated 04/09/25 and two containers of takeout/fast food dated 05/24/25. In the freezer compartment there was an expired frozen entr&eacute;e dated 04/18/25.</p> <p>&bull;</p> <p>In the second floor nourishment refrigerator, there was an expired bowl of cut cantaloupe dated 05/21/25, a bag of cut watermelon with no date, an undated lunch bag with brown apples and an undated bag of takeout/fast food. There was an unidentifiable spilled substance on the base of the refrigerator. A sign posted to the exterior of the refrigerator read that every Sunday, the refrigerator would be cleaned and foods would be thrown out.</p> <p>Interviews with DM #425 verified the above findings at the time of observation. DM #425 stated foods should be labeled, dated and not retained when expired.</p> <p>Interview on 06/02/25 at 10:26 A.M. with the Administrator and Quality Assurance Registered Nurse (QARN) #513 present revealed it was housekeeping staff's task to clean the unit refrigerators every three days. The Administrator and QARN #513 were made aware of the condition of the three unit refrigerators at the time of the interview.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 145 Olive St Akron, OH 44310	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy, Use of Storage of Food Brought in by Family or Visitors, dated 2025 revealed all food items that are already prepared by the family or visitor brought in must be labeled with content and dated. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. The prepared food must be consumed by the resident within three days and if not consumed, will be thrown away by facility staff. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative.</p> <p>Review of the facility policy, Date Marking for Food Safety, dated 2025 revealed foods shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. Prepared foods that are delivered to the nursing units shall be discarded within two hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified.</p> <p>Review of the facility diet list dated 06/02/25 identified three residents (Residents #63, #104 and #106) as NPO.</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>Based on review of personnel files and interviews with staff, the facility failed to ensure employees received the required annual training. This affected 13 of 13 employees reviewed for personnel files and had the potential to affect all 111 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the personnel files with Human Resource Director (HRD) #423 revealed the employees were receiving two packets of in-services. One was titled Yearly In-services listing 9.5 hours' worth of in-services. By signing, employees acknowledged they had read and reviewed all in-services listed above. The other one was titled Annual Inservice Packet with 12.5 hours. By signing, employees acknowledged they had read and reviewed all in-services listed above. The second page of this packet stated This packet of annual mandatory in-services has been developed to help remind you of important policies and practices. Please take time to read them and sign the forms included.</p> <p>Review of the personnel files for the Administrator, Dietary #404, Dietary #410, Maintenance #422, Dietary Supervisor #425, Activity Director #428, Houskeeper #436, and Certified Nurse's Aide (CNA) #487 all signed upon hire. Licensed Practical Nurse (LPN) #445, LPN #464, CNA #474, CNA #501 and CNA #512 signed two copies: one upon hire and one on their annual due date. The packets were provided for the upcoming year therefore they were signed in advance of reading the information.</p> <p>Interview on 06/05/25 at 11:30 A.M. with HRD #423 stated the facility stopped using an on-line training program and came up with these packets. She stated she did not know how to track the education otherwise.</p> <p>Interview on 06/05/25 at 1:00 P.M. with the Administrator revealed she reviewed other training/education provide by the Director of Nursing (DON) throughout the year but stated it was not enough as they were not held every month.</p> <p>Interview on 06/09/25 at 11:42 A.M. with two of the above employees, who wish to remain anonymous, revealed one who stated they briefly reviewed everything all at once but said they could review further on their own time. One stated, I don't even know what I did with my packet. The other thought her packet was in her car.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to maintain infection control practices and or ensure personal protective equipment (PPE) was readily available for two residents, Resident #6 and #104 who required enhanced barrier precautions (EBP). This affected two residents (#6 and #104) of two residents reviewed for EBP and had the potential to affect all residents residing at the facility. The facility census was 111.</p> <p>Findings include:</p> <p>1. Record review for Resident #6 revealed an admission date of 03/05/20. Diagnoses included attention deficit hyperactivity disorder and dementia.</p> <p>Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was severely cognitively impaired. Resident #6 had no impairment to the upper or lower extremities, required set up or clean up assistants with eating and bathing.</p> <p>Review of the care plan dated 05/27/25 revealed Resident #6 had cellulitis of the right lower leg related to abrasion on shin. Interventions included to complete daily treatments as ordered.</p> <p>Record review of the physician orders dated 04/01/25 revealed Resident #6 received an order for enhanced barrier precautions (EBP) due to chronic wounds. Check signage and personal protective equipment (PPE) every shift. Resident #6 received an order dated 05/30/25 to cleanse the right shin with normal saline, apply oil emulsion, cover with island dressing daily and as needed.</p> <p>Observation on 06/02/25 at 9:18 A.M. revealed Resident #6 was lying in bed. A soiled dressing (soiled with blood and brown drainage) was lying on the floor next to the bed. The dressing was dated 05/31/25.</p> <p>Observation on 06/02/25 at 9:24 A.M. with Licensed Practical Nurse (LPN) #429 confirmed Resident #6's wound dressing dated 05/31/25 was lying on the floor. LPN #429 confirmed the dressing was to be completed daily and revealed Resident #6 often removed his own dressing. LPN #429 confirmed there was an EBP sign on Resident #6's door and revealed she was not sure why it was there. No PPE was observed inside or outside the room.</p> <p>Interview and observation on 06/02/25 at 9:28 A.M. with LPN #458 confirmed Resident #6 had no PPE inside or outside his room, used or new. Resident #6 also had no trash can near the exit for disposing of used PPE. LPN #458 revealed if PPE was being utilized, it would be located hanging on the inside of the bathroom door. LPN #458 confirmed PPE was not readily available for staff use and no trash can was near the exit available for disposing of used PPE.</p> <p>2. Record review for Resident #104 revealed an admission date of 03/19/25. Diagnoses included severe protein calorie malnutrition and obstructive and reflux uropathy.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #104 had short term and long-term memory problem. Resident #104 had an indwelling catheter and a feeding tube.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan dated 04/01/25 revealed Resident #104 required enhanced barrier precautions (EBP) due to Foley (indwelling catheter) and peg (percutaneous endoscopic gastrostomy) tube. Interventions included isolation maintained by staff during acute infection period.</p> <p>Review of the physician orders for Resident #104 revealed an order dated 04/01/25 for enhanced barrier precautions due to Foley and peg, check and maintain PPE and signage every shift.</p> <p>Observation of medication administration on 06/03/25 at 9:08 A.M. with LPN #461 revealed Resident #104 was lying in bed. Resident #104 had an indwelling catheter draining urine. Resident #104's peg tube was intact and infusing Vital tube feeding at 50 milliliters (ml) and hour. LPN #461 did not don an isolation gown. LPN #461 disconnected the tube feeding and administered five medications to Resident #104 via peg tube with flushes between each medication. LPN #104 then reinitiated the tube feeding. LPN #104 confirmed she never wore an isolation gown revealing she did not need to for administering medications in tube feedings. LPN #104 revealed she did not have a consistent floor she work, she rotated floors and worked all floors with all residents.</p> <p>Review of the facility policy titled, Enhanced Barrier Precautions undated revealed it is the policy of the facility to implement EBP for the prevention of transmission of multi-drug-resistant organisms. EBP refers to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for EBP will be obtained for residents with any of the following: including wounds, and or indwelling medical devices (urinary catheters and feeding tubes). Implementation of EBP included to make gowns and gloves available immediately near or outside of the resident's room. Position a trash can inside the resident's room and near the exit for discarding PPE after removal.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on review of personnel files and interviews with staff the facility failed to provide regular training for the certified nursing assistants (CNAs) for their 12 in-services annually. This had the potential to affect all 111 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the personnel files for CNA #474 with hire date of 06/23/22, CNA #501 with hire date of 02/28/24 and CNA #512 with the hire date of 05/15/24 revealed there was no evidence they received regular training throughout the year for their required 12 hours of in-services annually.</p> <p>Interview on 06/05/25 at approximately 11:30 A.M. with Human Resource Director (HRD) #423 revealed the facility stopped using an online training program over a year ago. The facility provided staff with a stack of in-services for the whole year at one time upon orientation and annually. The first page was signed by the employee. It listed all of the in-services. The rest of the packet was information on each topic. HRD #423 stated she was not sure how to track in-services otherwise and verified there was no system in place to follow up with the employees to ensure they actually read and completed the training packet annually.</p>		