

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365898	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE 5757 Whiteford Rd Sylvania, OH 43560	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident, staff, and family interview, review of the facility policy, review of the facility assessment, and review of staffing schedules, the facility failed to have sufficient staffing to meet the care needs of all residents. This directly affected three residents (#41, #34, and #30) and had the potential to affect all residents residing in the facility. The facility census was 67. Findings Include:1. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes Mellitus, hypertension, depression, respiratory failure, chronic kidney disease, difficulty in walking, and muscle weakness.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #41 was cognitively intact. The resident was frequently incontinent of urine and was dependent on assistance from staff for the activities of daily living.Observation on 07/13/26 at 10:50 A.M. revealed Resident #41's call light was activated and there was a light illuminated above the door to the resident's room.Interview on 07/13/26 at 10:53 A.M. with Resident #41 revealed they had been waiting to have their incontinent brief changed and it had not been changed since 10:30 P.M. on 07/12/26. Resident #41 reported they were incontinent of urine and needed help from staff to get cleaned up and to have their brief changed. Resident #41 reported they had been activating their call light since 10:30 P.M. on 07/12/26 and staff had not yet come in to help. Resident #41 reported there were not enough aids to assist residents with care when needed.Interview on 07/13/26 at 10:55 A.M. with Resident #41's husband, who also resided in room revealed the same information and concerns.Observation on 07/13/26 at 11:01 A.M. revealed the call light system located at the nursing station showed how long call lights had been activated. Resident #41's call light had been activated for 41 minutes at this time.Interview on 07/13/26 at 11:14 A.M. with Certified Nursing Assistant (CNA) #148 revealed the unit the staff member had been working on contained a long hallway and a short hallway, both with resident rooms. The staff member had been assigned to the long hallway and did not know until sometime within the last half hour that the CNA assigned to the short hallway had walked out shortly after 6:00 A.M. and CNA #148 was supposed to cover that staff member's assigned area in addition to their own assigned area. Resident #41 resided on the short hallway and had not been changed or assisted with incontinence care from at least 6:00 A.M. until a few minutes prior to this interview. CNA #148 verified Resident #41's incontinence brief was full and that the resident had not been provided with incontinence care in a timely manner. CNA #148 also reported that she was not able to answer call lights and assist other residents with incontinence care in a timely manner due to there not being enough staff.Review of the facility policy titled Nursing Services and Sufficient Staff, dated 09/22/26, revealed the facility would provide sufficient staff with appropriate competencies.2. Interview on 07/23/26 at 12:03 P.M. with Resident #34 revealed there were not always enough aides (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and therefore her call light was not answered in a timely manner.Observation on 07/13/26 at 12:56 P.M. revealed Resident #34's call light had been activated for 50 minutes before staff entered the resident's room.Interview on 07/13/26 at approximately 1:00 P.M. with CNA #148 verified Resident #34's call light was not answered in a timely manner. CNA #148 reported they were only one person and could not help all residents in a timely manner.Interview on 07/13/26 at 3:33 P.M. with CNA #181 revealed there were supposed to be two CNAs assigned to the unit and she was often the only one working due to staffing shortages. CNA #181 reported she had approximately 11 to 12 residents who required incontinence care, and she was often not able answer call lights in a timely manner, or to provide timely incontinence care to residents.Interview on 07/14/26 at 5:35 A.M. with Registered Nurse (RN) #146 revealed there were not enough CNAs and residents often did not receive assistance with care in a timely manner.Review of the facility policy titled Nursing Services and Sufficient Staff, dated 09/22/26, revealed the facility would provide sufficient staff with appropriate competencies.3. Interview on 07/13/26 at 11:32 A.M. with Resident #30 whom the facility identified as being incontinent, revealed the resident was incontinent and was often not provided with incontinence care in a timely manner. Resident #30 reported often going between 12 and 13 hours without their incontinence brief being changed. Resident #30 reported this was due to staffing shortages and there were not enough CNAs.Interview on 07/13/26 at 11:53 A.M. with Resident #39 whom the facility identified as being incontinent, revealed the resident was incontinent and often waited a prolonged period of time for their brief to be changed when needed. Resident #39 reported they would activate their call light and wait hours for assistance with care. Resident #39 reported this was due to there not being enough aides to assist with care.Interview on 07/13/26 at 3:33 P.M. with CNA #181 revealed there were supposed to be two CNAs assigned to the unit and she was often the only one working due to staffing shortages. CNA #181 reported she had approximately 11 to 12 residents who required incontinence care and she was often not able to answer call lights in a timely manner or to provide timely incontinence care to residents.Interview on 07/14/26 at 5:35 A.M. with Registered Nurse (RN) #146 revealed there were not enough CNAs and residents often did not receive assistance with care in a timely manner.Review of the most recent facility assessment revealed there would be a ratio of between one CNA for every nine residents, to one CNA for every 12 residents.Review of the staffing schedules for 06/27/26 through 07/12/26 revealed there was one CNA assigned to care for 22 residents on 06/29/26 from 2:00 P.M. to 10:00 P.M. with no CNA between 4:45 P.M. and 6:00 P.M., one CNA assigned to care for 22 residents on 07/04/26 from 2:00 P.M. to 10:00 P.M., one aide assigned to care for 18 memory care residents on 07/04/26 from 10:00 P.M. to 6:00 A.M., one CNA assigned to care for 22 residents on 07/05/26 from 10:00 P.M. to 6:00 A.M., one CNA assigned to care for 18 memory care residents on 07/05/26 from 10:00 P.M. to 6:00 A.M., no CNAs assigned to care for 11 residents on 07/06/26 from 10:00 P.M. to 6:00 A.M., one CNA assigned to care for 22 residents on 07/07/26 from 2:00 P.M. to 10:00 P.M., one aide assigned to care for 22 residents on 07/10/26 from 2:00 P.M. to 10:00 P.M., one CNA assigned to care for 18 memory care residents on 07/10/26 from 10:00 P.M. to 6:00 A.M., no CNA assigned to care for 11 residents on 07/12/26 from 2:00 P.M. to 10:00 P.M., one CNA assigned to care for 18 memory care residents on 07/12/26 from 10:00 P.M. to 6:00 A.M., and one CNA assigned to care for 22 residents on 07/13/26 from 2:00 P.M. to 10:00 P.M.Review of the facility policy titled Incontinence, dated 06/01/24, revealed all residents who were incontinent would receive appropriate treatment and services.Review of the facility policy titled Nursing Services and Sufficient Staff, dated 09/22/26, revealed the facility would provide sufficient staff with appropriate competencies.This deficiency represents non-compliance investigated under Complaint Number 3069054, and Complaint Number 3070777.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, record review, resident interview, and staff interview, the facility failed to ensure the pre-planned menu was followed. This affected all 67 residents who received food from the facility kitchen. The facility census was 67. Findings include: 1. Review of the facility menu and meal tickets for the lunch meal on 07/13/26 revealed residents were supposed to receive baked beans with the lunch meal. Observation on 07/13/26 at 12:10 P.M. of the lunch meal service revealed residents received a pork loin, mixed vegetables, and corn bread. Residents did not receive baked beans with the lunch meal. Interview and observation on 07/13/26 at 12:16 P.M. with Resident #31 revealed the resident did not receive baked beans with their lunch meal, although their meal ticket listed baked beans as an item that would be served. The resident reported they never knew what they were going to have for meals. Interview and observation on 07/13/26 at 12:21 P.M. with Resident #34 revealed the resident did not receive baked beans with the lunch meal, although their meal ticket listed baked beans as an item that would be served. The resident reported the meal tickets often did not reflect what was actually served for meals. Interview and observation on 07/13/26 at 12:23 P.M. with Resident #51 revealed the resident did not receive baked beans with the lunch meal, although their meal ticket listed baked beans as an item that would be served. The resident reported the meal ticket was not accurate. Interview on 07/13/26 at 12:30 P.M. with Dietary Aide #195 verified residents did not receive baked beans with the lunch meal and should have. Dietary Aide #195 reported a new company recently took over, and staff did not always know what was supposed to be served for meals, so they just had to make something up. 2. Review of the facility menu and meal tickets for the lunch meal on 07/15/26 revealed residents were supposed to receive meatloaf, mashed potatoes, cooked zucchini, a dinner roll, and cherry cheesecake. Observation on 07/15/26 at 11:57 A.M. of the lunch meal revealed the facility served meatloaf, mashed potatoes, cooked squash with minimal zucchini, a dinner roll, and strawberry shortcake. An interview on 07/15/26 at 12:10 P.M. with Dietary Manager #196 verified the vegetable served contained mostly squash rather than zucchini as listed, and strawberry shortcake was served rather than cherry cheesecake. Dietary Manager #196 reported the facility had not had these substitutions approved by the dietitian. This deficiency was an incidental finding discovered during the course of this complaint investigation.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, and review of the facility policy for environment, the facility failed to maintain a clean, safe, and homelike environment. This directly affected Resident #55 and had the potential to affect 18 residents who resided on the memory care unit (#60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, and #77). The facility also failed to ensure cleanliness of shower chairs. This had the potential to affect all but 13 residents (#13, #16, #17, #19, #22, #29, #31, #40, #53, #58, #63, #66, and #69) in the facility who were identified to not utilized shower chairs. The facility census was 67. Findings include: 1. Observation on 07/13/26 at 10:32 A.M. of the living room located on the memory care unit revealed there were three lightly colored walls and one blue accent wall. The blue wall had thick gouges that were past the first layer of drywall, a dark substance smeared across the wall, a broken outlet cover with the top portion missing, and torn edges of drywall all along the bottom of the wall where the drywall meets the baseboard heater. An interview on 07/13/26 at 10:35 A.M. with Registered Nurse (RN) #158 confirmed the above concerns. RN #158 stated she was unsure of how long the areas of concern have been that way, although it looked like it had been awhile. 2. Observation on 07/13/26 at 10:41 A.M. of Resident #55's room revealed there were puddles of water on the floor and some of the floor tile was broken and crumbling. An interview on 07/13/26 at 10:36 A.M. revealed Certified Nursing Assistant (CNA) #180 reported the floor tiles had been broken for awhile and the puddles on the floor were from a shower chair used earlier in the day. 3. Observation on 07/13/26 at 11:14 A.M. of a shower chair located in the shower room on Evergreen Hall revealed a dried brown substance on the support bar under the open seat of the chair. Interview on 07/13/26 at 11:15 A.M. with Maintenance Manager #150 confirmed there was a dried brown substance on the shower chair. Subsequent observation revealed he obtained cleaning supplies and was able to remove the dried brown substance. Review of facility policy titled Resident Rights, dated 06/01/24, revealed residents had the right to a clean and homelike environment. Review of the facility policy titled Safe and Homelike Environment, dated 02/01/25, revealed the facility would provide a safe, clean, comfortable and homelike environment. This deficiency represents non-compliance investigated under Complaint Numbers 3075845, 3070777 and 3069054.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure infection control measures were followed. This affected two residents (#46 and #48) of three residents observed during medication administration, two residents (#32 and #46) of two residents observed while obtaining vital signs, one resident (#46) of three residents observed during medication preparation, and one resident (#55) of one resident observed during incontinence care. The facility census was 67. Findings include: 1. Review of the medical record for Resident #46 revealed he was admitted on [DATE] with diagnoses including right sided hemiplegia, hypertension, alcohol use, and cognitive communication deficit. Review of the annual Minimum Data Set 3.0 dated 05/27/26 revealed he was cognitively impaired and did not display any behaviors nor refusals of care at the time of the assessment. He utilized a wheelchair and required maximal assistance to dependence with activities of daily living. Review of the medical record for Resident #48 revealed he was admitted on [DATE] with diagnoses including congestive heart failure, hypertension, Type Two Diabetes Mellitus, and malignant neoplasm of the prostate. Review of the admission Minimum Data Set 3.0 dated 05/08/26 revealed he was cognitively impaired and did not display any behaviors nor refusals of care at the time of the assessment. He utilized a wheelchair and required maximal assistance to dependence with activities of daily living. Observation on 07/14/26 at 7:35 A.M. of Licensed Practical Nurse (LPN) #172 during medication administration for Residents #46 and #48 revealed she did not perform hand hygiene prior to or after preparing and administering medications to Resident #46 and Resident #48. Interview on 07/14/26 at 8:10 A.M. with LPN #172 confirmed she did not perform hand hygiene prior to or after preparing and administering medications to Residents #46 and #48. Review of facility policy titled Medication Administration, dated 08/22/22, revealed hand hygiene would be performed prior to preparing medications and after administering medications to residents. 2. Review of the medical record for Resident #32 revealed he was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, schizophrenia, Type Two Diabetes Mellitus, and depression. Review of the quarterly Minimum Data Set 3.0 dated 06/29/26 revealed he was cognitively intact, displayed behaviors toward others, and rejected care daily. He utilized a wheelchair and required partial assistance with activities of daily living. Review of the medical record for Resident #46 revealed he was admitted on [DATE] with diagnoses including right sided hemiplegia, hypertension, alcohol use, and cognitive communication deficit. Review of the annual Minimum Data Set 3.0 dated 05/27/26 revealed he was cognitively impaired and did not display any behaviors nor refusals of care at the time of the assessment. He utilized a wheelchair and required maximal assistance to dependence with activities of daily living. Observation on 07/14/26 at 7:35 A.M. of LPN #183 revealed she obtained a blood pressure reading for Resident #46 using a computerized vital sign machine on wheels by placing the blood pressure cuff on his bare left upper extremity and did not clean the blood pressure cuff prior to or after using the cuff. Observation on 07/14/26 at 8:05 A.M. of LPN #183 revealed she obtained a blood pressure reading for Resident #32 using the same computerized vital sign machine on wheels by placing the blood pressure cuff on his bare right upper extremity and did not clean the blood pressure cuff prior to or after using the cuff. Interview on 07/14/26 at 8:10 A.M. with LPN #183 and LPN #172 confirmed the blood pressure cuff was not cleaned between uses for Residents #32 and Resident #46. Subsequent observation revealed disinfecting wipes were added to the basket on the vitals machine. Interview on 07/15/26 at 9:30 A.M. with the Director of Nursing confirmed the blood pressure cuff should be cleaned between residents. Review of facility policy titled Routine Cleaning (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and Disinfection, dated 2022, revealed routine surface cleaning and disinfection will be conducted with detailed focus on visibly soiled surfaces and high touch areas to include but not limited to blood pressure cuffs, intravenous (IV) poles, sinks and faucets, monitor control panels, touch screens and cables, bed rails, and call buttons. 3. Review of the medical record for Resident #46 revealed he was admitted on [DATE] with diagnoses including right sided hemiplegia, hypertension, alcohol use, and cognitive communication deficit. Review of the annual Minimum Data Set 3.0 dated 05/27/26 revealed he was cognitively impaired and did not display any behaviors or refusals of care at the time of the assessment. He utilized a wheelchair and required maximal assistance to dependence with activities of daily living. Observation on 07/14/26 at 7:35 A.M. of LPN #172 preparing medications for Resident #46 revealed she placed a pill in a medication cup and accidentally knocked it over causing the pill to spill on the medication cart. LPN #172 proceeded to use her bare contaminated hand to pick the pill up and put it back into the medication cup. Interview on 07/14/26 at 8:10 A.M. with LPN #172 confirmed she touched a pill prepared for Resident #46 with her bare contaminated hand that had been in contact with the top of the medication cart and administered the pill to Resident #46. Interview on 07/15/26 at 9:30 A.M. with the Director of Nursing confirmed pills should not be touched by hands while preparing and administering medications to residents. Review of facility policy titled Medication Administration, dated 08/22/22, revealed medications should not be touched with bare hands. 4. Review of the medical record for Resident #55 revealed she was admitted on [DATE] with diagnoses including anoxic brain damage, malnutrition, gastrostomy status, and anemia. Review of the quarterly Minimum Data Set 3.0 (MDS) dated [DATE] revealed she was cognitively impaired and did not display any behaviors or refusals of care. She was dependent for all activities of daily living, transfers, and mobility. She was incontinent of bowel and bladder and had a feeding tube. Review of physician orders for Resident #55 revealed an order dated 12/26/25 for Enhanced Barrier Precautions to be utilized during high touch care, including incontinence care and bathing. Observation on 07/14/26 at 10:50 A.M. of Certified Nurse Assistant (CNA) #105 and CNA #118 providing incontinence care and a gown change for Resident #55 revealed they did not wear gowns while providing care as required by Enhanced Barrier Precautions. Interview on 07/14/26 at 11:00 A.M. with CNA #105 and CNA #118 confirmed they did not wear gowns while providing incontinence care and a gown change for Resident #55. Both acknowledged they should have worn gowns. Review of facility policy titled Enhanced Barrier Precautions, dated 07/13/22, revealed gowns would be worn by staff while providing high-contact resident care including changing briefs and dressing. This deficiency represents non-compliance investigated under Complaint Number 3070777.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, staff interviews, and review of facility policy, the facility failed to ensure protected health information was secured. This affected one resident (#50) of six residents reviewed for secured health information. The facility census was 67. Findings include: Observation on 07/13/26 at 4:00 P.M. revealed a written podiatry order dated 07/13/26 for Resident #50 on the nurse desk at [NAME] Hall. The order was face-up, visible to anyone who would pass by the desk. The desk was approximately three feet high and did not have anything obstructing the view of the desktop. Interview on 07/13/26 at 4:05 P.M. with the Director of Nursing confirmed the order for Resident #50 should not have been face-up on the nurse station desk. Subsequent observation revealed she turned the order over and moved it away from the accessible part of the desk. Observation on 07/15/26 at 4:50 P.M. revealed a written provider order dated 07/15/26 for Resident #50 on the nurses' desk at [NAME] Hall. The order was face-up, visible to anyone who would pass by the desk. The desk was approximately three feet high and did not have anything obstructing the view of the desktop. Interview on 07/15/26 at 4:52 P.M. with LPN #183 confirmed the order for Resident #50 was face-up on the nurse station desk. Subsequent observation revealed LPN #183 relocated the order to an area of the desk that was not visible to people walking past the desk. Review of facility policy titled HIPAA Security Measures, dated 01/01/25, revealed the facility would implement reasonable measures to protect residents' electronic identifiable information and protected health information. Interview on 07/15/26 at 9:01 A.M. with Regional Director of Clinical Services #192 confirmed the facility's HIPAA (Health Insurance Portability and Accountability Act) policy was also applicable to paper documents.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, observation, and facility policy review, the facility failed to ensure a resident who was dependent on staff for Activities of Daily Living (ADLs) received assistance with eating. This affected one (#23) of one resident reviewed for assistance with eating. The facility census was 67. Findings Include: Review of the medical record revealed Resident #23 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes Mellitus, dementia, hyponatremia, hypertension, Alzheimer's disease, and dysphagia. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #23 was severely cognitively impaired. The resident was dependent on staff for eating. Review of the plan of care dated 06/29/26 revealed Resident #23 had a nutritional problem or potential nutritional problem related to diagnoses and required total assistance with feeding themselves. Interventions included observing for, documenting, and reporting as needed signs or symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appearing concerned during meals. Observation on 07/15/26 at 12:00 P.M. revealed Resident #23 was sitting in the facility dining room and there were no staff members or other residents present in the room. Resident #23 was seated in a wheelchair with a table in front of him, containing a plate full of pureed carrots and pureed meatloaf. A spoon was stuck and indented into the pureed food items on the plate. Resident #23 was holding a cup sideways and there was spilled, thickened liquid on the floor in front of him with a large puddle underneath of his right foot/slipper. There were also pureed carrots on the front of his pants and down the front of a clothing protector he was wearing. Resident #23 picked up a bowl of vanilla pudding and was unsuccessfully attempting to drink and lick the substance out of the bowl. Dietary Aide #195 entered the area at approximately 12:07 P.M. and pushed Resident #23's wheelchair into a nearby hallway. Interview on 07/15/26 at 12:17 P.M. with Dietary Aide #195 and Dietary Aide #197 verified Resident #23 required assistance for eating and had been sitting there attempting to feed himself until he was rolled away in his wheelchair. Dietary Aide #197 stated Resident #23 had made a mess all over and needed help eating. Interview on 07/16/26 at approximately 12:30 P.M. with Certified Nursing Assistant #132 revealed Resident #23 was totally dependent on staff for feeding assistance. Review of the facility policy titled Activities of Daily Living (ADLs), dated 10/01/22, revealed residents who were unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Number 3070777.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to answer call lights in a timely manner. This affected two (#34 and #38) of two residents reviewed for call light response. The facility census was 67. Findings include: Review of the medical record for Resident #34 revealed she was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, Type Two Diabetes Mellitus, left-sided hemiplegia, and atherosclerotic heart disease. Review of the annual Minimum Data Set 3.0 dated 04/23/26 revealed Resident #34 was cognitively impaired and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a wheelchair and required partial to maximal assistance with activities of daily living. Review of the medical record for Resident #38 revealed he was admitted on [DATE] with diagnoses including right sided hemiplegia, chronic obstructive pulmonary disease, repeated falls, and dementia. Review of the quarterly Minimum Data Set 3.0 dated 04/10/26 revealed Resident #38 was cognitively impaired and did not display any behaviors nor refusals of care. He was dependent for activities of daily living. Observation on 07/13/26 at 12:02 P.M. of the call light console at [NAME] Hall nurse station revealed two call lights were alarming, one for Resident #34 and one for Resident #38. The call light display revealed Resident #34's call light had been on for 27 minutes and Resident #38's call light had been on for 10 minutes. Observation on 07/13/26 at 12:04 P.M. at the [NAME] Hall nurse station revealed Certified Nurse Assistant (CNA) #107 exited the employee restroom adjacent to the [NAME] Hall nurse station and walked off of the unit without acknowledging the alarming call lights. Observation on 07/13/26 at 12:10 P.M. of the call light console at [NAME] Hall nurse station revealed the call lights for Resident #34 and Resident #38 were still alarming. The call light display revealed Resident #34's call light had been on for 35 minutes and Resident #38's call light had been on for 18 minutes. Observation on 07/13/26 at 12:12 P.M. at the [NAME] Hall nurse station revealed CNA #105 and CNA #148 walked by the nurse station without acknowledging the alarming call lights. The two aides walked toward a meal tray cart that was being distributed by two other staff members and began passing meal trays while the call lights for Residents #34 and #38 continued to alarm. Interview on 07/13/26 at 12:18 P.M. with the Director of Nursing confirmed the resident's call lights should be prioritized, the DON confirmed the call lights were alarming and verified call lights should not be ignored by staff. Interview on 07/13/26 at 2:00 P.M. with the Administrator revealed the facility was unable to run a call light audit report for review. Interview on 07/13/26 at 3:28 P.M. with the Director of Nursing revealed a written counseling had been completed for CNA #107 regarding not acknowledging the call lights for Residents #34 and #38. DON revealed CNA #107 had stated she heard the call light alarms and did not answer them. Review of facility policy titled Call lights: Accessibility and Timely Response, dated 04/01/22, revealed all staff who saw or heard an activated call light were responsible for responding. This deficiency represents non-compliance investigated under Complaint Number 3070777.		

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NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE 5757 Whiteford Rd Sylvania, OH 43560	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to timely implement wound care orders. This affected one resident (#14) of three residents reviewed for wound care. The facility census was 67. Findings include: Review of the medical record for Resident #14 revealed she was re-admitted on [DATE], initial admission was on 02/13/26 with diagnoses including osteomyelitis of lumbar vertebra, acute endocarditis, heart failure, alcoholic cirrhosis of the liver, rheumatic mitral valve disease, and pneumonia. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a wheelchair and required moderate assistance to dependence with activities of daily living. She had one stage four pressure ulcer which was present when she was admitted to the facility. Review of wound care visit notes and orders for Resident #14, dated 07/08/26, revealed a new order for negative pressure wound therapy. Observation on 07/15/26 at 11:00 A.M. of Resident #14 resting in bed revealed no negative pressure wound therapy was in place. Review of orders, treatment administration records, and nursing progress notes dated 07/08/26 to 07/15/26 for Resident #14 revealed no indication negative pressure wound therapy was in place. Interview on 07/15/26 at 2:35 P.M. with the Assistant Director of Nursing confirmed negative pressure wound therapy was ordered for Resident #14 on 07/08/26 and the therapy had not yet been implemented as she was unsure where to obtain the equipment. Review of facility policy titled Wound Treatment Management, dated 12/01/21, revealed the facility would provide wound treatment in accordance with physician orders, including the type of dressing. This deficiency represents non-compliance investigated under Complaint Numbers 3069054 and 3070777.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews, and review of facility policies, the facility failed to ensure fall interventions were in place for one (#28) out of two residents reviewed for falls. The facility also failed to ensure hazardous items were secure. This had the potential to affect 21 residents (#15, #20, #23, #24, #27, #31, #35, #37, #42, #43, #48, #61, #63, #64, #65, #66, #68, #69, #72, and #77) identified by the facility as cognitively impaired and independently mobile. The facility census was 67. Findings include: 1. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, chronic pain, depression, anxiety, muscle spasm, tremors, weakness, and seizures. Review of the plan of care, revised 05/12/26, revealed Resident #28 was at risk for falls related to weakness, loss of function, impaired judgement, impulsive behavior, would not wait for assistance to transfer, and had been known to throw themselves on the floor when angry. Interventions included mattress with bolsters attached to bed and to encourage the resident to keep their bed in the lowest position. Observation on 07/16/26 at 11:55 A.M. revealed Resident #28 was lying in bed and their bed was extremely high in the air. The resident was yelling out for help and stated they were trying to get out of bed. There were no bolsters observed on the bed. Interview on 07/16/26 at 10:02 A.M. with Certified Nursing Assistant (CNA) #132 verified Resident #28's bed was high in the air and not at the lowest level. CNA #132 reported the resident controlled the height of their bed and staff did not mess with it. Observation and interview on 07/16/26 at 10:30 A.M. with the Director of Nursing (DON) confirmed there were no bolsters on Resident #28's bed. 2. Observation on 07/15/26 at 12:33 P.M. of a floor care storage closet adjacent to [NAME] Hall nurse's station revealed it was unlocked and accessible to anyone. Inside the closet was observed a three-liter bottle of odor remover labeled as an eye and skin irritant, a three-liter bottle of floor cleaner labeled as an eye irritant and harmful if swallowed, and a three-liter bottle of disinfectant cleaner labeled danger to keep out of reach of children and contact poison control if swallowed or contact with skin or eyes occurred. Observation on 07/15/26 at 12:33 P.M. of a biohazard storage closet adjacent to [NAME] Hall nurse's station revealed a key was in the door handle and the closet was accessible to anyone. Inside the closet was a biohazard bin with five full sharps containers, a one-quart size bottle of window cleaner, a gallon of spray polish, and a gallon of buffer cleaner marked harmful if swallowed. Observation on 07/15/26 at 12:33 P.M. of a housekeeping storage closet adjacent to [NAME] Hall (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse's station revealed it was unlocked and accessible to anyone. Inside the closet was a full bag of hand soap labeled keep out of reach of children and to contact poison control if swallowed, a half-gallon bucket, three-quarters full, of an unidentified clear substance, a mop bucket three-quarters full of a brown colored liquid, one 28 ounce opened can of scouring powder labeled as an eye irritant and do not swallow, a one-quart bottle of antibacterial cleaner labeled as a moderate eye irritant and not to be ingested, and wash cloths. Interview on 07/15/26 at 12:45 P.M. with Licensed Practical Nurse #172 confirmed the three closets were unlocked. She stated the housekeeping closet should be locked and confirmed the key was typically housed in the door handle of the biohazard storage closet. Interview on 07/15/26 at 12:50 P.M. with Maintenance Manager #150 revealed he was instructed by the Housekeeping Manager to lock all three doors. Interview on 07/15/26 at 1:00 P.M. with Housekeeping Director #101 revealed the doors to the biohazard closet, and housekeeping closet adjacent to [NAME] Hall nurse's station should be locked, but the floor care closet is typically unlocked. Review of facility policy titled Chemical Storage, dated May 2016, revealed all chemicals for cleaning would be locked at all times and if staff observed a door to an area securing chemicals as unlocked, staff would correct the situation immediately. This deficiency represents non-compliance investigated under Complaint Number 3069054.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and review of facility policy, the facility failed to ensure urinary catheter securement devices were utilized. This affected two residents (#14 and #59) of two residents reviewed for urinary catheters. Additionally, the facility failed to ensure urinary catheter care was completed each shift. This affected one resident (#59) of two residents with urinary catheters. Finally, the facility failed to ensure residents received assistance with incontinence care in a timely manner. This affected one resident (#41) out of three residents reviewed for incontinence care. The facility census was 67. Findings include: 1. Review of the medical record for Resident #14 revealed she was re-admitted to the facility on [DATE] with diagnoses including osteomyelitis of lumbar vertebra, acute endocarditis, heart failure, alcoholic cirrhosis of the liver, rheumatic mitral valve disease, and neurogenic bladder. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact and did not display any behaviors nor refusals of care at the time of the assessment. She utilized a wheelchair and required moderate assistance to dependence with activities of daily living. She did not have an indwelling catheter at the time of this assessment and was frequently incontinent of bowel and bladder. Review of the care plan dated 07/02/26 for Resident #14 revealed an intervention to utilize a catheter securement device with the urinary catheter. Observation on 07/14/26 at 1:10 P.M. of indwelling urinary catheter care for Resident #14, provided by Licensed Practical Nurse (LPN) #146, revealed there was not a catheter securement device in place. Interview on 07/14/26 at 1:17 P.M. with LPN #146 confirmed the absence of a catheter securement device and indicated one should be there. 2. Review of the medical record for Resident #59 revealed she was admitted on [DATE] with diagnoses including Type Two Diabetes Mellitus, local infection of the skin, gangrene, anxiety, chronic obstructive pulmonary disease, and neurogenic bladder. She was admitted to hospice care on 04/28/26. Review of the significant change Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #59 experienced mild cognitive impairment and did not display any behaviors nor refusals of care during the assessment period. She was dependent for activities of daily living and required maximal assistance with transfers and mobility. She had an indwelling urinary catheter. Review of physician orders for Resident #59 revealed an order dated 03/03/26 to secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction, and an order dated 03/03/26 to change the indwelling urinary catheter every month and as needed and on 07/13/26 for (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter care every shift and as needed. Review of the Treatment Administration Records (TAR) for March 2026 through July of 2026 for Resident #59 revealed the absence of documented indwelling urinary catheter care. Observation and interview with Certified Nurse Assistant #118 on 07/14/26 at 1:34 P.M. of Resident #59's indwelling urinary catheter revealed she did not have a securement device in place. Certified Nurse Assistant #118 confirmed the absence of a catheter securement device and indicated one should be there. Interview on 07/15/26 at 9:30 A.M. with the Director of Nursing confirmed urinary catheter securement devices should be in place and this is a standard of practice. Interview on 07/15/26 at 10:40 A.M. with the Assistant Director of Nursing confirmed there was no evidence urinary catheter care was being completed each shift for Resident #59. Review of facility policy titled Catheter Care, dated 03/02/22, revealed the facility would provide catheter care every shift and as needed. 3. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes Mellitus, hypertension, depression, respiratory failure, chronic kidney disease, difficulty in walking, and muscle weakness. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #41 was cognitively intact. The resident was frequently incontinent of urine and was dependent on assistance from staff for the activities of daily living. Observation on 07/13/26 at 10:50 A.M. revealed Resident #41's call light was activated and there was a light illuminated above the door to the resident's room. An interview on 07/13/26 at 10:53 A.M. with Resident #41 revealed they had been for their incontinent brief to be changed and stated they had not been changed since 10:30 P.M. on 07/12/26. Resident #41 reported they were incontinent of urine and needed help from staff to get cleaned up and to have their brief changed. Resident #41 reported they had been activating their call light since 10:30 P.M. on 07/12/26 and staff had not yet come in to help. An interview on 07/13/26 at 10:55 A.M. with Resident #41's husband, who also resided in room revealed the same information and concern. Observation on 07/13/26 at 11:01 A.M. revealed the call light system located at the nursing station showed how long call lights had been activated. Resident #41's call light had been activated for 41 minutes at this time. Interview on 07/13/26 at 11:14 A.M. with Certified Nursing Assistant (CNA) #148 revealed the unit the staff member had been working on contained a long hallway and a short hallway, both with resident (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms. The staff member had been assigned to the long hallway and did not know until sometime within the last half hour that the CNA assigned to the short hallway had walked out shortly after 6:00 A.M. and CNA #148 was supposed to cover that staff member's assigned area in addition to their own assigned area. Resident #41 resided on the short hallway and had not been changed or assisted with incontinence care from at least 6:00 A.M. until a few minutes prior to this interview. CNA #148 verified Resident #41's incontinence brief was full and that the resident had not been provided with incontinence care in a timely manner. CNA #148 also reported she was not able to assist other residents with timely incontinence care due to there not being enough staff. Interview on 07/13/26 at 11:32 A.M. with Resident #30 whom the facility identified as being incontinent, revealed the resident reported they had incontinence and were often not provided with incontinence care in a timely manner. Resident #30 reported often going between 12 and 13 hours without their incontinence brief being changed. Interview on 07/13/26 at 11:53 A.M. with Resident #39 whom the facility identified as being incontinent, revealed the resident reported they had incontinence and often waited a prolonged period of time for their brief to be changed when needed. Resident #39 reported they would activate their call light and wait hours for assistance with care. Interview on 07/13/26 at 3:33 P.M. with CNA #181 revealed there were supposed to be two CNAs assigned to the unit and she was often the only one working due to staffing shortages. CNA #181 reported there were approximately 11 to 12, check and changes and she was often not able to provide timely incontinence care to residents. Interview on 07/14/26 at 5:35 A.M. with Registered Nurse (RN) #146 revealed there were not enough CNAs and residents often did not receive assistance with incontinence care in a timely manner. Review of the facility policy titled Incontinence, dated 06/01/24, revealed all residents who were incontinent would receive appropriate treatment and services. This deficiency represents non-compliance investigated under complaint numbers 3075845, 3070777, and 3069054.		