STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366328	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Toledo	1011 North Byrne Road Toledo, OH 43607

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 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** 44815 Based on medical record review, staff interview, and review of the facility policies, the facility failed to ensure fall investigations were completed, and failed to ensure post-fall assessments were completed. This affected two (#12 and #14) of three residents reviewed for falls. The facility census was 68. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of dementia and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition, required substantial/maximal assistance for chair to bed transfers and was dependent for toileting hygiene. Further review revealed Resident #12 had no falls since the previous assessment. Review of the Fall Risk Evaluation dated 02/06/24 revealed Resident #12 was at risk for falls. Review of the Incident Log revealed Resident #12 had unwitnessed falls on 06/01/24 and 06/16/24. Review of the facility's incident report for the fall on 06/01/24 at 12:30 A.M. revealed Resident #12 fell from his wheelchair in his room. Resident #12 was assessed for injury and found to have no injuries. However, Resident #12 complained of a pain level of 3 (on a scale of 1-10) and received medication for pain. Review of the facility's incident report for the fall on 06/16/24 at 9:35 P.M. revealed Resident #12 fell in the smoking area while attempting to transfer himself from a chair to his wheelchair. Resident #12 was found to be without injury. Interview on 06/24/24 at 3:57 P.M. with the Director of Nursing (DON) confirmed no additional fall investigation including a root cause analysis was completed for Resident #12's falls beyond the information contained in the incident report. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses of alcohol abuse, epilepsy, and spinal stenosis. Further review revealed Resident #14 was admitted to the hospital during the course of this investigation. Review of the quarterly MDS assessment dated [DATE] revealed Resident #14 had intact cognition, used a wheelchair for ambulation and was independent for chair to bed transfers. Review of the current care plan for Resident #14 revealed he preferred not to wear shoes or socks. Additionally, Resident #14 had an activities of daily life self-care performance deficit and his care plan included an intervention to encourage the use of a call light for assistance. Review of the Fall Risk Evaluation dated 05/10/24 revealed Resident #14 was at risk for falls. Review of the Incident Log revealed Resident #14 fell on [DATE] at 6:22 A.M., on 06/06/24 at 4:15 P.M., on 06/10/24 at 10:30 P.M., on 06/13/24 at 1:50 P.M., on 06/13/24 at 4:02 P.M., on 06/16/24 at 7:00 P.M., on 06/17/24 at 5:00 P.M., on 06/21/24 at 6:40 P.M., on 06/21/24 at 7:27 P.M., and on 06/22/24 at 3:45 P.M. Review of the incident report and investigation for the unwitnessed fall on 05/30/24 revealed Resident #14 fell in his room while attempting to transfer himself from his wheelchair to the bed. No additional information regarding lighting in the room, footwear, or accessibility to the call light were available. Review of the incident report and investigation for the unwitnessed fall on 06/06/24 revealed Resident #14 came back from back and was lying on his back on the floor in his room. Resident #14 stated he fell while trying to get into his wheelchair. No additional information regarding footwear or the accessibility of the call light was available. Review of the incident report and investigation for the unwitnessed fall on 06/10/24 revealed Resident #14 was found on the floor in his room with an abrasion on his right temple. No additional information was available regarding lighting in the room, call light availability, or the potential cause of the abrasion. Review of the incident report and investigation for the unwitnessed fall on 06/13/24 at 1:50 P.M. revealed Resident #14 was found on the floor in his room next to the bed. Resident #14 stated he was attempting to get into his wheelchair. No additional information was included regarding footwear, accessibility to call light, or the position of the resident when he was found. Review of the incident report and investigation for the unwitnessed fall on 06/13/24 at 4:02 P.M. revealed Resident #14 was found on the floor in his room. Resident #14 stated he slipped out of bed while attempting to get into his wheelchair. No additional information, such as footwear or accessibility to the call light were included. Review of the incident report for the unwitnessed fall on 06/16/24 revealed Resident #14 was found on the ground outside with his wheelchair behind him. Resident #14 had a superficial abrasion to his right knee and a contusion on his forehead. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident report for the unwitnessed fall on 06/17/24 revealed Resident #14 was found in his room on the floor with another resident. Resident #14 stated he asked another resident for assistance to get up to use the restroom and they both fell to the floor. Resident #14 had abrasions to his left and right arms. Review of the incident report for the unwitnessed fall on 06/21/24 at 6:40 P.M. revealed Resident #14 was found lying on the floor in his room. Resident #14 stated he was attempting to transfer from the bed to his wheelchair. Review of the incident report and medical record for the unwitnessed fall on 06/21/24 at 7:27 P.M. revealed Resident #14 was returned to the facility by firefighters with abrasions to the bridge of his nose, his right upper eyebrow and skin abrasion and contusion to his upper forehead. Review of the incident report for the unwitnessed fall on 06/22/24 revealed Resident #14 was found on the ground at the front entrance to the facility. Resident #14 was bleeding from the head. Staff took Resident #14 to his room and cleaned him up, then called Emergency Medical Services (EMS) to transport Resident #14 to the hospital. Interviews on 06/24/24, 07/01/24, and 07/02/24 with the DON confirmed the fall investigations were incomplete for Resident #14's falls on 05/30/24, 06/06/24, 06/10/24 and both falls on 06/13/24. Additionally, the DON confirmed the fall investigations were initiated and ongoing at the time of the investigation for the falls on 06/16/24, 06/17/24, 06/21/24 and 06/22/24. Further, the DON confirmed neurological checks should be performed for any unwitnessed falls and confirmed no neurological checks were performed per protocol for Resident #14's nine unwitnessed falls from 05/30/24 through 06/21/24. Additionally, the DON confirmed a Fall Risk Assessment should be completed after each fall, and none were completed for the nine falls from 05/30/24 through 06/21/24. The facility was unable to provide a policy regarding fall investigation processes or procedures. Review of the policy Fall Prevention Program, copyright 2023, revealed when a resident experiences a fall, the facility will complete a post-fall assessment, complete an incident report, obtain witness statements in the case of injury, and review the resident's care plan and update as indicated. Review of the policy Head Injury, copyright 2023, revealed the facility would implement interventions after a known, suspected, or verbalized head injury. Interventions would include neurological checks as indicated or as specified by the physician. This deficiency represents non-compliance investigated under Complaint Number OH00155086.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44815 Based on observation, staff interview, and review of the planned menu, the facility failed to ensure vegetables were provided per the planned menu. This affected seven (#15, #16, #17, #18, #19, #20, and #71) of 66 residents who received the noon meal. The facility identified two (#35 and #69) residents received nothing from the kitchen. The facility census was 68. Findings include: Observation during the noon meal service 06/24/24 from approximately 12:00 P.M. until 12:16 P.M. revealed [NAME] #301 plating meals. Interview with [NAME] #301 during the observation confirmed a regular meal would consist of a chicken sandwich with fries and a side of cooked vegetables. Continued observation revealed [NAME] #301 did not have enough vegetables to provide a side of vegetables on the last few meal trays. Interview on 06/24/24 at 12:16 P.M. with [NAME] #301 verified she did not have enough vegetables for the last few meal trays. [NAME] #301 did not provide an explanation regarding why there was not enough vegetable or why she did not prepare more. Observation of meal trays during meal service on 06/24/24 between 12:23 P.M. and approximately 12:35 P. M. revealed seven resident trays (#15, #16, #17, #18, #19, #20, and #71) did not have a serving of vegetables on them. State tested Nurse Aide #102 confirmed no vegetable serving was on each of the identified resident trays. Interview on 07/01/24 at 10:45 A.M. with Dietary Manager (DM) #302 revealed [NAME] #301 should have made a side salad when she ran out of vegetables during the noon meal service on 06/24/24. DM #302 stated [NAME] #301 was new and probably did not know she should make a salad to provide a vegetable after the cooked vegetables ran out. Review of the facility menu dated 06/24/24 revealed residents should receive a one-half cup portion of Italian blend mixed vegetables with their noon meal. This deficiency represents non-compliance investigated under Complaint Number OH00154416. Additionally, this deficiency represents continued non-compliance from the annual survey completed 05/23/24.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on medical record review and staff interview, the facility failed to ensure antibiotics were prescribed appropriately to treat Urinary Tract Infections (UTI). This affected one (#12) of two residents reviewed for treatment of UTIs. The facility census was 68. Findings include: Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of dementia and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition, required substantial/maximal assistance for chair to bed transfers and was dependent for toileting hygiene. Review of a progress note dated 06/13/24 revealed Resident #12 was seen by hospice who ordered Bactrim ds (antibiotic) 800 mg for 10 days and to collect urine and send for a urinalysis and culture and sensitivity (UA C&S). Review of a physician order dated 06/14/24 revealed a UA C&S were ordered for Resident #12. Review of a progress note dated 06/15/24 revealed Resident #12 continued on oral antibiotic for pain and burning during urination. Review of the lab results dated 06/19/24 revealed Resident #12's urine specimen leaked in the transport container and a new specimen should be obtained. There was no evidence a new specimen was obtained. Review of the June 2024 MAR revealed Resident #12 received Bactrim ds as ordered. Interview on 07/01/24 at 12:15 P.M. with Infection Preventionist (IP) #502 confirmed the facility could provide no evidence a UA C&S was completed for Resident #12 to determine what bacteria was present in the resident's urine, and which antibiotic would be appropriate. IP #502 confirmed the facility did not follow the Antibiotic Stewardship Protocol by not obtaining a UA C&S. This was an incidental finding discovered over the course of the complaint investigation.