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	10/03/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, facility policy review, facility investigation, and staff interviews, the facility failed to report a resident elopement to the state agency as required. This affected one resident (Resident #3) of three residents reviewed for wandering and elopement risk. The facility census was 68. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE], diagnoses included chronic obstructive pulmonary disease, heart disease, hypertension, dementia and type II diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively impaired and independently mobile with supervision for mobility required. Review of the hospital history and physical for Resident #3 completed on 07/03/24 and timed 8:35 A.M. revealed Resident #3 was brought to the hospital per emergency services from home due to increase wandering, frequent falls and family concern for safety. According to family, Resident #3 was insistent people were trying to get into the house causing Resident #3 to wander outside the home. The family was concerned Resident #3 would wander outside and get lost as Resident #3 had previously been found five miles from the home. Resident #3's family unable to continue to care for the resident at home. Resident #3 arrived at the facility on 07/31/24 at 7:45 P.M. by stretcher and was accompanied by two emergency medical service personnel. Resident #3 was alert and oriented to person and can walk independently. Review of the nursing admission assessment completed 07/31/24 at 10:56 P.M. revealed Resident #3 was confused, with aggressive behaviors and was independently mobile. Review of the elopement assessment dated [DATE] at 1:56 A.M. revealed Resident #3 was identified at risk for elopement due to cognitive impairment with a diagnosis of dementia, ambulated independently, and verbally expressed desire to go home. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Divine Rehabilitation and Nursing at Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 08/02/24 and timed 8:20 P.M. revealed a wander bracelet was placed on Resident #3's left leg. Review of the progress note dated 08/03/24 and timed 2:54 P.M. written by Registered Nurses (RN) #336 stated Resident #3 went outside the building through the back, fire safety door, Wanderguard did alarm. Resident #3 was escorted back into the building by staff that saw Resident #3 walking outside. The Director of Nursing (DON), physician, and family were notified. Resident #3 was assessed with no injuries noted. Review of the care plan dated 08/19/24 revealed Resident #3 was an elopement risk, and a wanderer related to attempts to leave the facility unattended and impaired safety awareness. Interventions included for staff to redirect resident from wandering, offer diversion and structured activities, identify patterns of wandering, monitor fatigue, and monitor the resident's location. Review of the facility investigation dated 08/05/24 regarding Resident #3's elopement on 08/03/25 stated Resident #3 was found walking outside of the building in the parking lot by a staff nurse, was brought back into the facility, assessed and the Wanderguard monitor was checked. Interview on 10/01/24 at 1:55 P.M. with RN #336 verified Resident #3 had gotten outside the building on 08/03/24 at roughly 11:45 A.M. and another staff member brought Resident #3 back into the building. RN #336 stated she was assigned to work both the 400 hall and 500 hall (Memory Care) and at the time of Resident #3 exited the building she was not in Memory Care and was unaware of Resident #3 getting outside until someone called. Interview on 10/02/24 at 1:30 P.M. with Licensed Practical Nurse (LPN) #235 revealed on 08/03/24 sometime between 11:00 A.M. and 12:00 P.M. LPN #235 went outside for break and when driving car from the front parking lot to the back parking lot, LPN #235 saw someone walking toward the front of the building from the back of the building. The person was walking in the grass to the left side of the car, as LPN #235 drove down the driveway to the rear parking lot, LPN #235 stated she did not think anything about it as there are people frequently walking in that area. LPN #235 stated she went to the back parking lot, parked the car and was finishing a phone conversation at which time LPN #235 again noticed the same man walking in the grass, walking back around the building toward the back parking lot. LPN #235 stated she had never seen this person before and wondered what he was doing and while watching noticed a wander guard. LPN #235 stated she called into the facility as she did not recognize Resident #3, and the unit manager came out and assisted to bring Resident #3 back into the building. LPN #235 verified no one was with Resident #3 and Resident #3 was not within eyesight the entire time during the episode that took between three and five minutes. LPN #235 also denied hearing an alarm sounding as Resident #3 had a wander guard on the left lower extremity. Interview on 10/02/24 at 2:45 P.M. with the DON verified she had been notified on 08/03/24 at 11:54 A.M. by a Unit Manager, that no longer works at the facility, that Resident #3 had gotten outside the building on 08/03/24 and at the time of the notification the Unit Manager was working on getting statements and providing staff education for those on duty. The DON at the time of the interview revealed the staff statements were unable to be found. Review of self-reported incidents revealed no self-reported incident related to the Resident #3's elopement. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/02/24 at 2:50 P.M. with the Administrator verified no self-reported incident was submitted to the state agency as required. Review of the undated facility policy titled, Elopements and Wandering Residents, stated the facility is equipped with locks and alarms to help avoid elopement and residents at risk for elopement and unsafe wandering will have adequate supervision to help prevent an elopement. Any staff member that becomes aware of a missing resident will alert personnel. If the resident is found the Director of Nursing, the physician and the family will be notified of the outcome and a post elopement assessment will be completed and appropriate reporting requirements to the State Survey agency shall be conducted. This deficiency represents non-compliance investigated under Compliant Number OH00157187.

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Divine Rehabilitation and Nursing at Toledo	1011 North Byrne Road Toledo, OH 43607

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on staff interviews, review of the medical record, and review of the facility investigation, the facility failed to ensure a complete and thorough investigation was conducted for a resident elopement. This affected one resident (Resident #3) of three residents reviewed for wandering and elopement risk. The facility census was 68. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE], diagnoses included chronic obstructive pulmonary disease, heart disease, hypertension, dementia and type II diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively impaired, and independently mobile with supervision for mobility required. Review of the hospital history and physical for Resident #3 completed on 07/03/24 and timed 8:35 A.M. revealed Resident #3 was brought to the hospital per emergency services from home due to increase wandering, frequent falls and family concern for safety. According to family Resident #3 was insistent people were trying to get into the house causing Resident #3 to wander outside the home. The family was concerned Resident #3 would wander outside and get lost as Resident #3 had previously been found five miles from the home. Resident #3's family unable to continue to care for the resident at home. Resident #3 arrived at the facility on 07/31/24 at 7:45 P.M. by stretcher and was accompanied by two emergency medical service personnel. Resident #3 was alert and oriented to person, can walk independently and can follow simple commence. Review of the nursing admission assessment completed 07/31/24 at 10:56 P.M. revealed Resident #3 was confused, with aggressive behaviors and was independently mobile. Review of the elopement assessment dated [DATE] at 1:56 A.M. revealed Resident #3 was identified at risk for elopement due to cognitive impairment with a diagnosis of dementia, ambulated independently, and verbally expressed desire to go home. Review of the care plan dated 08/19/24 indicated Resident #3 was an elopement risk, and a wanderer related to attempts to leave the facility unattended and impaired safety awareness. Interventions included for staff to redirect resident from wandering, offer diversion and structured activities, identify patterns of wandering, monitor fatigue, and monitor the resident's location. Review of the progress note dated 08/02/24 and timed 8:20 P.M. a wander bracelet was placed on Resident #3's left leg. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 08/03/24 and timed 2:54 P.M. written by Registered Nurses (RN) #336 stated Resident #3 went outside the building through the back, fire safety door, Wanderguard did alarm. Resident #3 was escorted back into the building by staff that saw Resident #3 walking outside. The director of nursing, physician and family were notified. Resident #3 was assessed with no injuries noted. Interview on 10/01/24 at 1:55 P.M. with RN #336 verified Resident #3 had gotten outside the building on 08/03/24 at roughly 11:45 A.M. and another staff member brought Resident #3 back into the building. RN #336 stated she was assigned to work both the 400 hall and 500 hall (Memory Care) and at the time of Resident #3 exited the building RN #336 was not in Memory Care and was unaware of Resident #3 getting outside until someone called. Review of the staffing for 08/03/24 for the Memory Care unit revealed the one aide assigned to the unit called off and another aide came in at 10:30 A.M. to cover. One nurse (RN #336) was assigned to both the Memory Care and the 400 hall. Interview on 10/02/24 at 1:30 P.M. with Licensed Practical Nurse (LPN) #235 revealed on 08/03/24 sometime between 11:00 A.M. and 12:00 P.M. LPN #235 went outside for break and when driving car from the front parking lot to the back parking lot, LPN #235 saw someone walking toward the front of the building from the back of the building. The person was walking in the grass to the left side of the car, as LPN #235 drove down the driveway to the rear parking lot, LPN #235 stated she did not think anything about it as there are people frequently walking in that area. LPN #235 stated she went to the back parking lot, parked the car and was finishing a phone conversation at which time LPN #235 again noticed the same man scene walking in the grass, walking back around the building toward the back parking lot. LPN #235 stated she had never seen this person before and wondered what he was doing and while watching noticed a wander guard. LPN #235 stated she called into the facility as she did not recognize Resident #3, and the unit manager came out and assisted to bring Resident #3 back into the building. LPN #235 verified no one was with Resident #3 and Resident #3 was not within eyesight the entire time during the episode that took between three and five minutes. LPN #235 also denied hearing an alarm sounding which LPN #235 thought was odd because Resident #3 had a Wanderguard on the left lower extremity. LPN #235 verified there was no further discussion with anyone about what happened. LPN #235 stated that this is first time anyone has asked her anything about the incident. Interview on 10/02/24 at 4:58 P.M. with State tested Nursing Assistant (STNA) #262 verified she came in to assist in Memory Care on 08/03/24 due to a call off, remembered being the only person in unit providing care. STNA #262 stated the nurse was back and forth between memory care and another unit. STNA #262 stated she received a phone call later in the day inquiring about Resident #3 eloping and revealed she had no knowledge of a resident eloping and further verified no knowledge of a door alarming. Review of the facility investigation dated 08/05/24 regarding Resident #3's elopement on 08/03/25 stated Resident #3 was found walking outside of the building in the parking lot by a staff nurse, was brought back into the facility, assessed and the wander guard monitor was checked. The investigation contained no staff interviews regarding the incident and no indication of when Resident #3 was last seen prior to the elopement. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 10/02/24 at 2:45 P.M. with the Director of Nursing (DON) verified she had been notified on 08/03/24 at 11:54 A.M. by a Unit Manager, that no longer works at the facility, that Resident #3 had gotten outside the building on 08/03/24 and at the time of the notification the Unit Manager was working on getting statements and providing staff education on elopement for those on duty. The DON at the time of the interview revealed the staff statements were unable to be found. Interview on 10/02/24 at 2:50 P.M. with the Administrator revealed knowledge of Resident #3 eloping, however, was unable to provide any specifics related to the incident or the investigation. This deficiency represents non-compliance investigated under Compliant Number OH00157187.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 31638 Based on record review, resident interview, staff interview, and policy review, the facility failed to timely assist dependent residents with showers. This affected three of three residents (#8, #57, #22) reviewed for showers. The facility census was 68. Findings included: 1. Review of Resident #8's medical record revealed an admitted [DATE]. Diagnoses included dementia, diabetes mellitus, urinary retention, and panic disorder. Review of Resident #8's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed she had low cognitive function. The resident was dependent on staff for showers and toileting. Review of Resident #8's care plan revealed she had a self-care deficit related to dementia. Review of Resident #8's medical record revealed she was scheduled to have showers every Tuesday and Friday on first shift. Review of Resident #8's electronic medical record dated September 2024 revealed the resident received a shower on 09/06/24 and 09/17/24. A bed bath was received on 09/10/24 and 09/20/24. This indicated that Resident #8 failed to receive a shower or bath on 09/03/24, 09/13/24, 09/24/24, and 09/27/24. Review of Resident #8's nurses notes revealed there was no documentation regarding why the showers were not given. Resident #8 was not able to be interviewed due to her cognitive decline. 2. Review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, congestive heart failure, lymphedema, epilepsy, and chronic kidney disease. Review of Resident #57's quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent on staff for showers and bathing. Review of Resident #57's care plan revealed she had an activity of daily living self-care deficit and required extensive assistance with bathing and showering. Review of Resident #57's medical record revealed she was scheduled for showers/baths on the evening shift every Monday and Thursday. Review of Resident #57's electronic medical record dated September 2024 revealed the resident received a bed bath on 09/02/24 and 09/05/24. The resident refused bathes on 09/12/24, 09/14/24, and 09/16/24. This resulted in Resident #57 not being offered nor receiving a bath on 09/09/24, 09/19/24, 09/23/24, 09/26/24, and 09/30/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #57's nurses notes revealed there was no documentation regarding why the showers were not given. Interview with Resident #57 on 10/01/24 at 7:56 A.M. revealed only one bed bath was received in the previous month. She stated that she was unable to shower or get the bath supplies by herself and required assistance. At times she had to wait until family visited to receive bathing care. 3. Review of the medical record for Resident #22 revealed an admitted [DATE], diagnoses include heart failure, anemia, morbid obesity hypertension and type II diabetes mellitus. Review of the quarterly MDS assessment completed on 07/14/24 revealed Resident #22 was cognitively intact, and was dependent on staff for showers, dressing and personal hygiene. Review of the care plan dated 10/22/21 revealed Resident #22 had an activities of daily living self-care deficit related to shortness of breath, weakness, activity intolerance, fatigue and limited mobility. Resident #22 requested showers. Interventions included total dependence for transfers with use of mechanical lift, one to two staff extensive assistance for showering twice weekly and for a bed bath to be provided when a shower cannot be. Review of the bathing record indicated Resident #22 was to have a shower or bed bath if shower unable to be provided on the day shift each Wednesday and Saturday. Review of the bathing record with a look back period of thirty days from 09/28/24 revealed Resident #22 received a shower on 09/11/24, 09/18/24 and 09/28/24. This resulted in Resident #22 not being offered nor receiving a shower or bath on 09/04/24, 09/07/24, 09/14/24, 09/21/24, and 09/25/24. Review of the nurses progress notes from 09/02/24 to 09/30/24 revealed Resident #22 had not refused a shower or bed bath and contained no documentation related to why showers were not provided. Interview on 09/30/24 at 11:00 A.M. with Resident #22 revealed showers are preferred as the resident likes to be clean. Resident #22 verified showers are hit and miss and further verified bed baths are also not provided in place of the missing shower. Interviews with Licensed Practical Nurse (LPN) #281 and State tested Nursing Aides (STNA) #202 and #286 on 10/01/24 between 3:23 P.M. and 3:35 P.M. and on 10/02/24 between 10:10 A.M. and 10:25 A.M. with LPN #281 and #273 revealed showers were not being completed timely. Reasons included a lack of staff or staff not willing to do the work. Interview with the Director of Nursing (DON) on 10/01/24 at 2:38 P.M. verified Residents #8, #22, and #57's showers and bathes were failed to be given timely. She stated showers are completed approximately 40% of the time. The showers were to be documented in the electronic medical record. Review of the facility policy titled, Resident Showers, undated revealed it was the practice of the facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 31638 Based on record review, resident interview, staff interview, and policy review, the facility failed to complete weekly skin assessments per physician order. This affected two residents (#8, #57) of three residents reviewed for skin assessments. The facility census was 68. Findings included: 1. Review of Resident #8's medical record revealed an admitted [DATE]. Diagnoses included dementia, diabetes mellitus, urinary retention, and panic disorder. Review of Resident #8's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed she had a low cognitive function. The resident was dependent on staff for showers and toileting. Review of Resident #8's care plan revealed she had the potential/actual impairment to skin integrity related to fragile skin and had a self-care deficit. Interventions included the resident required skin inspections to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. Review of Resident #8's Weekly Skin Observation Sheets dated August 2024 and September 2024 revealed the resident received skin checks on 08/13/24, 08/21/24, and 08/29/24. No skin checks were performed in September 2024. Review of Resident #8's nurses notes revealed the record was silent of documentation regarding why the skin checks were not received. 2. Review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, congestive heart failure, lymphedema, epilepsy, and chronic kidney disease. Review of Resident #57's quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent on staff for showers and bathing. Review of Resident #57's care plan revealed the resident required skin inspections every shift and as needed. Staff were to observe for redness, open areas, scratches, cuts, bruises, and report any changes to the nurse. Review of Resident #57's electronic medical record revealed a physician's order dated 09/11/24 to complete skin observation assessment under assessment tab every Thursday evening shift. Review of Resident #57's medical record revealed the resident was scheduled for showers/bathes on the evening shift every Monday and Thursday. Review of Resident #57's Skin Observation Sheets dated August 2024 and September 2024 revealed the resident received skin checks on 08/17/24 and 09/01/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #57's nurses notes revealed there was no documentation regarding why the weekly skin checks were not performed. Interview with Licensed Practical Nurse (LPN) #281 on 10/01/24 at 3:23 P.M. and on 10/02/24 between 10:10 A.M. and 10:25 A.M. with LPNs #281 and #273 verified skin assessments were not being completed timely. Interview with the Director of Nursing (DON) on 10/01/24 at 2:38 P.M. verified Residents #8 and #57's skin evaluations were failed to be given timely. She stated all Weekly Skin Observation forms were to be completed in the electronic medical record. Review of the facility policy titled, Skin Assessment, undated, revealed it was the policy to perform a full body skin assessment as part of the systematic approach to pressure injury prevention and management. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45445 Based on review of the medical record, staff interview, and review of the facility policy, the facility failed to conduct timely fall reviews for three residents (#5, #70 and #71) and further failed to complete a quarterly fall assessment for a resident identified as a high fall risk (Resident #62). This affected four (#5, #70, #62 and #71) of four residents reviewed for falls. The facility census was 68. Findings include: 1. Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, type II diabetes mellitus and metabolic encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment revealed low cognitive function. Resident #70 required the extensive assistance of staff for transfers, toilet hygiene, and mobility. Review of the progress note dated 09/05/24 and timed 5:34 P.M. revealed Resident #70 was observed sitting on the floor with the wheelchair next to him while holding a tissue to the forehead. A laceration was observed with a moderate amount of serous drainage. Review of the post fall evaluation completed 09/13/24 at 10:46 P.M. revealed Resident #70 experienced a fall on 09/05/24, had one to two falls in the last 90 days, was a high risk for falls, had a history of falls. 2. Review of the medical record for Resident #71 revealed an admitted [DATE] with a diagnosis of dementia. Resident #71 had low cognitive function. Review of the post fall evaluation dated 09/27/24 and timed 10:51 A.M. revealed Resident #71 experienced a fall on 09/14/24 at 12:00 P.M. with no injuries. 3. Review of Resident #5's medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, dementia, chronic obstructive pulmonary disease, and malnutrition. Review of Resident #5's MDS assessment dated [DATE] revealed low cognitive function. The resident required substantial assistance rolling left to right and toileting. Supervision was required when going from sit to lying, lying to sitting, and walking 10 to 50 feet. Review of Resident #5's Fall Risk Evaluation dated 09/14/24 revealed the resident was at high risk for falls. Review of Resident #5's care plan revealed she was at a high risk for falls related to confusion, deconditioning, gait/balance problems, and recent falls. Interventions included to follow the facility fall protocol and review information on past falls and attempt to determine the cause of falls. Record possible root causes and remove any potential causes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Divine Rehabilitation and Nursing at Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 North Byrne Road Toledo, OH 43607	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's progress note revealed on 09/06/24 at 1:20 A.M. the resident was found yelling for help and was seen on the floor next to her bed with the wheelchair at the foot of the bed. Review of Resident #5's progress note dated 09/06/24 at 7:56 P.M. revealed the resident was found on the floor near her bed and stated she was making her bed before she fell . Review of Resident #5's medical record revealed post fall Internal Disciplinary Team (IDT) notes failed to be completed within 72 hours. The notes were dated 09/16/24 and 09/17/24 which reviewed the falls from 09/06/24. 4. Review of the medical record for Resident #62 revealed an admitted [DATE], diagnoses included chronic kidney disease and dementia. Review of the MDS assessment dated [DATE] revealed Resident #62 had moderate cognitive impairment, had no functional impairments and utilized a wheelchair. Resident #62 required the assistance of staff for mobility. Review of the care plan dated 08/08/19 revealed Resident #62 was a risk for falls related to weakness, bowel and bladder incontinence and impaired cognition. Interventions included observation for fatigue or unsteadiness, encourage the use of appropriate footwear and provide assistive devices as needed. Additional interventions added 01/03/24 included frequent checks, complete fall risk assessment per facility protocol, keep call light within reach and utilize two wheeled walker. Review of the fall risk assessments revealed a quarterly assessment was completed on 02/06/24 and two post fall risk assessments were completed on 06/01/24 and 06/16/24. Interview with the Director of Nursing on 10/03/24 at 3:34 P.M. verified post fall evaluations are required to be completed within 72 hours of a fall and fall risk assessments are to be completed at least quarterly. The DON also verified that the 72 hour Fall Evaluations for Residents #5, #70 and #71 failed to be completed timely and further verified Resident #62 was past due for a quarterly fall risk assessment as the last fall risk assessment was completed on 06/16/24. Review of the undated facility policy titled, Fall Prevention Program, stated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall risk assessment will be completed upon admission to determine fall risk protocols for low, moderate fall risk and high risk. When a resident experiences a fall, the facility will assess the resident, complete a post fall assessment, complete an incident report, notify physician and family, review the resident's care plan, document assessment and actions and obtain witness statements in the case of injury. Residents at identified as a fall risk will have fall risk assessments completed every 90 days and when any resident experiences a fall, the facility will complete a 72 hour post fall assessment. This deficiency represents non-compliance investigated under Compliant Number OH00157187.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on observation, staff interview, record review, review of facility policy, and review of manufacturer's instruction for use the facility failed to ensure insulin pens were primed prior to administration resulting in a significant medication error. This affected two residents (Resident #42 and #38) of three residents observed for insulin administration. The facility census was 68. Findings include: 1. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including dementia, anxiety, and type II diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #42 was cognitively intact and received insulin injections. Review of physician orders for Resident #42 revealed an order for insulin Lispro, 100 units per milliliter per sliding scale before meals and at bedtime. The sliding scale included two units of insulin to be administered using a pen injector for a blood sugar of 151 to 200, four units for a blood sugar of 201 to 250, six units for a blood sugar of 251 to 300, eight units for a blood sugar between 301 and 350, and 10 units for a blood sugar between 351 and 400. Observation on 09/30/24 at 11:18 A.M. of RN #208 preparing to administer Lispro insulin to Resident #42. RN #208 removed the cap from the insulin pen, inverted the pen, inspected the tip, attached the needle cap, and dialed the pen to four units. RN #208 opened the alcohol pad, cleaned the right lower quadrant of Resident #42's stomach, placed the injector pen against the skin of Resident #42 and pressed the dose button. RN #208 did not prime the insulin pen prior to administration. 2. Review of the medical record for Resident #38 revealed an admitted [DATE], diagnoses included hypertension, type II diabetes mellitus, and hypothyroidism. Review of the quarterly MDS assessment dated [DATE] revealed Resident #38 was cognitively intact. Review of the physician order dated 01/09/24 revealed Resident #38 was ordered blood sugars before meals and at bedtime with coverage using Insulin Aspart per Novolog Flex Pen 100 units per milliliter (u/ml) per sliding scale. The sliding scale included two units of insulin to be administered using a Flex Pen for a blood sugar of 151 to 200, four units for a blood sugar of 201 to 250, six units for a blood sugar of 251 to 300, eight units for a blood sugar between 301 and 350, and 10 units for a blood sugar between 351 and 400. Observation on 09/30/24 at 11:31 A.M. revealed RN #208 preparing to administer insulin to Resident #38. RN #208 verified the order and the dose of insulin, turned the dose selector on the pen to display four. RN #208 pulled up Resident #38's sleeve, opened the alcohol pad, cleansed the lateral left arm, waited a few seconds to allow the alcohol to dry and then placed the injector pen against the skin of the of Resident #38's left arm and pressed the dose button. RN #208 did not prime the insulin pen prior to administration of insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/30/24 at 11:35 A.M. with RN #208 revealed RN #208 was unaware of the need to prime insulin pens prior to use. Interview on 10/01/24 at 10:00 A.M. with the Director of Nursing (DON) verified insulin pens require priming after the needle is applied and before dialing the prescribed dose into the pen for administration to a resident. The DON verified nurses are provided education upon hire on medication administration including the use of insulin pens. Review of the manufacturer's instructions for use for the Novolog Flex Pen revealed after the needle is in place, prime the needle before taking the injection. To prime the needle, dial the pen to two units, and holding the pen with the needle pointing upward, press the push button until insulin appears at the tip of the needle. Once the priming is complete, make sure the dose selector is set at zero and then dial the number of units needed to inject. Review of the Lispro Kwik Pen instructions for use dated July 2023 revealed priming the pen before each injection removes the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. Also, if the pen is not primed before each injection the resident may get too much or too little insulin. Review of the undated facility policy titled, Administration and Documentation of Medications, stated every resident receives medication by a licensed nurse as prescribed by a licensed physician safely, properly and in a timely manner and that medications shall be accurately completed and documented. The policy also stated nurses are responsible for proper administration of all medications scheduled during their shift. This deficiency represents non-compliance investigated under Compliant Number OH00157187.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review, staff interview, and review of facility policy, the facility failed to ensure the timely physician notification of laboratory results affecting one Resident (#57) of three residents reviewed for physician laboratory services. The facility census was 68. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE], diagnoses included major depressive disorder, lymphedema, chronic kidney disease, congestive heart failure, and morbid obesity. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #47 was cognitively intact, was dependent on staff to meet activities of daily living and was incontinent of bowel and bladder. Review of the physician order dated 08/09/24 revealed a urinalysis with culture and sensitivity to be completed once due to confusion. An additional physician order was placed for a urinalysis with culture and sensitivity on 08/17/24 and included may straight catheterize if needed. Review of the Laboratory Results Report dated 08/15/24 revealed Resident #47 had urine collected for a urinalysis on 08/11/24 at 5:00 P.M., the urine was received in the laboratory on 08/12/24 and resulted on 08/15/24. Review of the laboratory results for the urinalysis revealed positive blood (normal is negative), greater than 50 white blood cells and a few bacteria with the urine culture results showing Klebsiella pneumoniae with the medications listed for the organism sensitivity. Review of the medical record and the nurse progress notes for Resident #46 revealed the urinalysis results were called to the provider on 08/19/24 at 1:54 P.M. (four days later) with an order for Cipro 500 milligrams (mg) once a day for three days obtained. Interview on 10/01/24 at 10:30 A.M. with Licensed Practical Nurse (LPN) #235 verified LPN #235 had collected the urine on 08/11/24. LPN #235 further stated she was off for a few days and upon returning noted the urinalysis results had not been reviewed and on 08/19/24 LPN #235 called the provider with the results and obtained the antibiotic order. Review of the undated facility policy titled, Laboratory Services and Reporting, stated the facility must provide laboratory services to meet the needs of residents. Nurses are required to promptly notify the ordering physician of laboratory results that fall outside the clinical reference range. This deficiency represents non-compliance investigated under Compliant Number OH00157792.